





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

EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2019-2020
(July 1, 2019-June 30, 2020)

Illinois Department of Healthcare
and Family Services
Division of Medical Programs

Summary of Contents

6 Beneficiary Satisfaction With Care

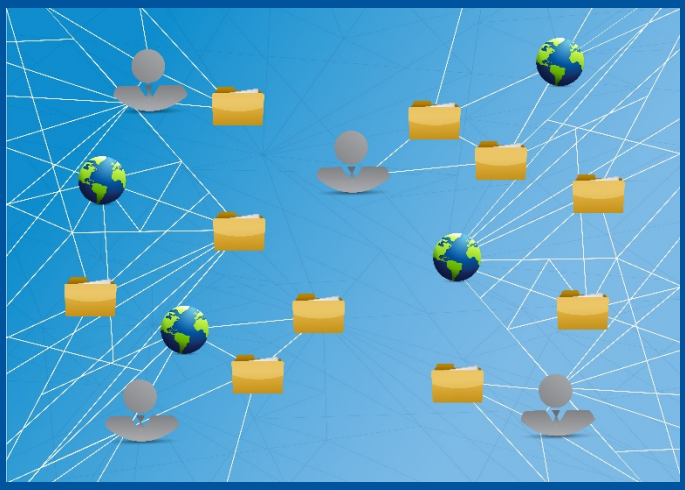
7 Additional EQR Activities

8 Appendices

1. Executive Summary

Overview

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the external quality review organization (EQRO) for the Illinois Department of Healthcare and Family Services (HFS). As required by the Code of Federal Regulations (CFR) at Title 42, Section (§)438.364, HFS contracted with HSAG to prepare an annual, independent technical report that provides a description of how the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the Medicaid managed care health plans (health plans). The CFR requires that states contract with an EQRO to conduct an annual evaluation of health plans that serve Medicaid beneficiaries to determine each health plan's compliance with federal quality assessment and performance improvement (QAPI) standards.



Purpose of This Report

The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO. This state fiscal year (SFY) 2020 External Quality Review (EQR) Technical Report focuses on federally mandated EQR activities that HSAG performed from July 1, 2019, to June 30, 2020. See the federal requirements for this report in Appendix A2.

Scope of Report

In accordance with 42 CFR §438.364, this report describes the EQR results for the mandatory and optional EQR activities set forth in §438.356. Additional details about the EQR activities conducted in SFY 2020 are described in Appendix A2. This report includes methodologically appropriate, comparative information to provide an assessment of each health plans' strengths and weaknesses with respect to the quality of, timeliness of, and access to healthcare services furnished to Medicaid beneficiaries and recommendations for improving quality of healthcare services. In Appendix A3, this report includes an assessment of the degree to which each health plan has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Illinois Medicaid Overview

Illinois Medicaid Expansion

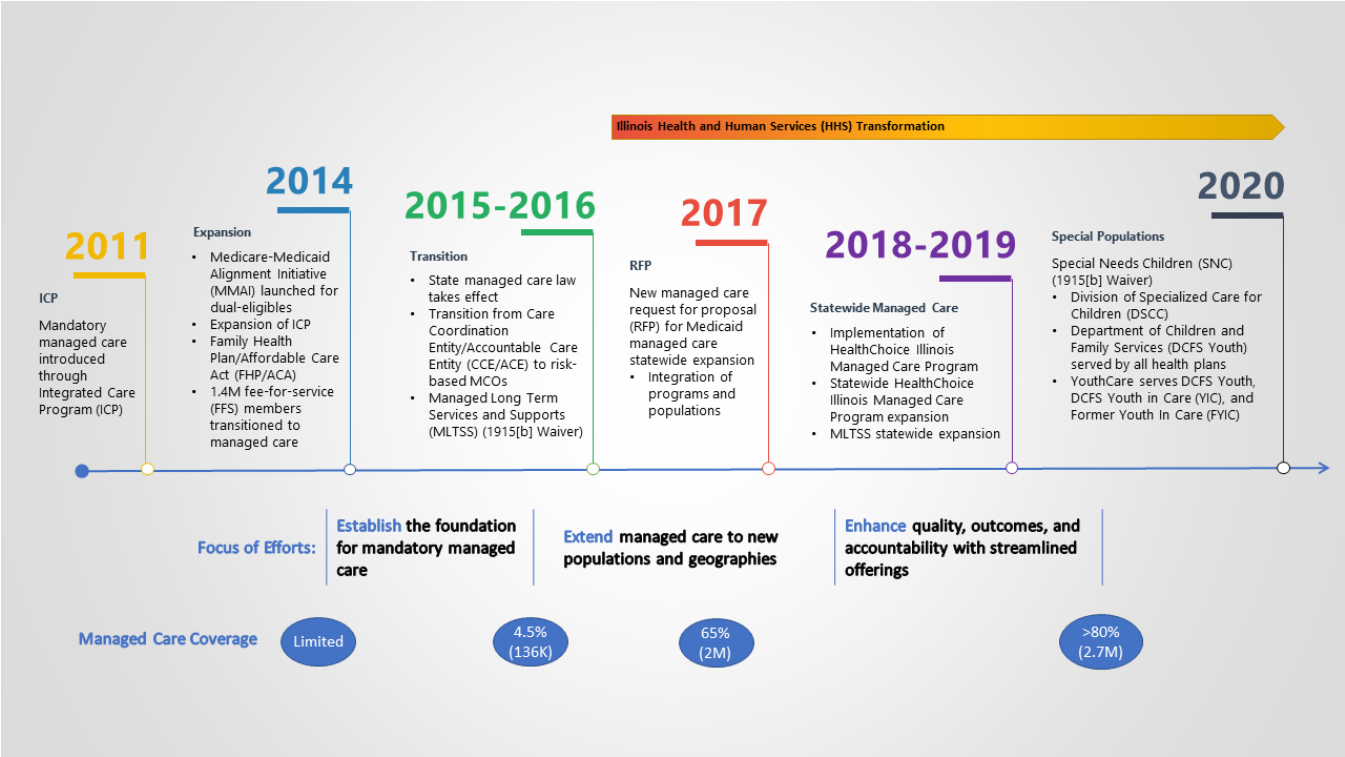
Effective managed care expansion was central to HFS' planning as it began implementing both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148). Care coordination was the centerpiece of Illinois' Medicaid reform. Initial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

In 2018, HFS launched the HealthChoice Illinois Managed Care Program (HealthChoice Illinois) to serve approximately 2.7 million residents. HFS announced that seven health plans would provide the full spectrum of Medicaid covered services through HealthChoice Illinois, which included the State's existing Medicaid managed care population and the statewide expansion of managed care. HealthChoice Illinois also consolidated previous programs and reduced the number of contracted health plans.

In 2019, Harmony Health Plan of Illinois, Inc. (Harmony), merged with MeridianHealth, Inc. (Meridian), so HealthChoice Illinois is now served by six health plans. Four of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only.

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

Figure 1-1—Illinois Medicaid Expansion



Medicaid Managed Care Health Plans (Health Plans)

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

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

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

Quality Strategy

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

Performance Domains

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

Performance Snapshot

Table 1-2 and Table 1-3 provide a high-level snapshot of statewide performance for HEDIS measures, compliance monitoring, Performance Improvement Projects (PIPs), and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] results for SFY 2020. The HEDIS results represent the HFS priority measures (listed in Appendix A2), and percentiles refer to national Medicaid percentiles. Additional details about these results can be found in Appendix A2 and in subsequent sections of this report.

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

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

Table 1-2—Performance Snapshot SFY 2020

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	26 Quality Measure Rates[i]	4 Timeliness Measure Rates[ii]	6 Access Measure Rates[iii]
Notable	HEDIS	**≥90th Percentile and Above** • 1 of 26 measure rates (3.8%) o *Statin Therapy for Patients with Diabetes—Received Statin Therapy* **Between the 75th and 89th Percentiles** • 1 of 26 measure rates (3.8%) o *Immunizations for Adolescents—Combination 1* **Between the 50th and 75th Percentiles** • 10 of 26 measure rates (38.5%)	**Between the 50th and 75th Percentiles** • 2 of 4 measure rates (50%) o *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment (IET)—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*	**Between the 50th and 75th Percentiles** • 3 of 6 measure rates (50%) o *Annual Dental Visits* o *IET—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*
	Compliance	An Evaluation of Administrative Processes & Compliance Review (Compliance Review) for a subset of standards for HealthChoice Illinois demonstrated that all health plans achieved an overall compliance score between 81 and 87%.		
	PIPs	As approved by CMS, HFS implemented a new rapid-cycle approach for PIPs. The duration of rapid-cycle PIPs is 18 months; therefore, the two new mandatory PIPs, *Follow-Up After Hospitalization for Mental Illness* and *Transitions of Care—Patient Engagement After Inpatient Discharge*, will continue into the next fiscal year.		
	CAHPS	**At or Between the 50th and 74th Percentiles** Adult Aggregate Results: • *How Well Doctors Communicate* • *Customer Service* • *Rating of All Health Care* • *Rating of Personal Doctor* Child Aggregate Results: • *How Well Doctors Communicate* • *Rating of All Health Care* • *Rating of Personal Doctor* • *Rating of Specialist Seen Most Often*	No measures achieved notable performance.	No measures achieved notable performance.

Table 1-3—Performance Snapshot SFY 2020

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	26 Quality Measures Rates[i]	4 Timeliness Measures Rates[ii]	6 Access Measures Rates[iii]
Needs Work	HEDIS	**≤ 25th Percentile** • 5 of 26 measure rates (19.2%) o *Adult Body Mass Index (BMI) Assessment* o *Childhood Immunization Status (CIS)—Combination 3* o *Controlling High Blood Pressure* o *Follow-Up After Hospitalization for Mental Illness (FUH)—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Between the 25th and 50th Percentiles** o 9 of 26 measure rates (34.6%)	**≤ 25th Percentile** • 2 of 4 measure rates (50%) o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*	**≤ 25th Percentile** • 2 of 6 measure rates (33.3%) o *FUH—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* **Between the 25th and 50th Percentiles** o *Adults' Access to Preventive/Ambulatory Health Services—Total*
	Compliance	A Compliance Review for a subset of standards for HealthChoice Illinois identified the standards of Children's Behavioral Health (CBH) Services and Subcontractual Relationships and Delegation as needing the most improvement. File reviews identified that quality improvement efforts are needed in the following areas: case management, denials, CBH, appeals, grievances, delegation, provider complaints, and provider directories. See Section 3 of this report for more details.		
	PIPs	During SFY 2020, the primary PIP activities included Module 3 and Module 4 of the process—identifying and testing interventions. At this stage, PIPs are not yet formally evaluated on the Specific, Measurable, Applicable, Realistic, and Time-bound (SMART) Aim measure outcomes. The PIPs will receive a final validation status after the completed Module 4s and Module 5s are submitted to HSAG in February 2021.		
	CAHPS	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Rating of Specialist Seen Most Often* • *Rating of Health Plan* **< 25th Percentile** Child Aggregate Results: • *Customer Service* • *Rating of Health Plan*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Care Quickly* Child Aggregate Results: • *Getting Care Quickly*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Needed Care* **< 25th Percentile** Child Aggregate Results: • *Getting Needed Care*

i. HEDIS results are based on the statewide weighted average (inclusive of all health plans). The Quality Measures reported for this table are those that could be compared to NCQA's Quality Compass national Medicaid percentiles for HEDIS 2019. Refer to Appendix A2 for a list of the measures and rates that are included in the quality,

timeliness, and access domains. Due to changes in the technical specifications for *Prenatal and Postpartum Care* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics* (*Blood Glucose Testing—Total* and *Cholesterol Testing—Total* rates), NCQA recommends a break in trending between 2020 and prior years; therefore, comparisons to benchmarks are not performed for this measure. Four quality measure rates (two measures) are also included in the timeliness and access domains.

ii. Four timeliness measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that both measures (four measure rates) are also included in the quality and access domains.

iii. Six access measure rates were compared to national Medicaid percentiles for HEDIS 2019, but please note that two measures (four measure rates) are also included in the quality and timeliness domains.

Performance Measures Summary

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

Recommendations: Biggest Opportunities for Improvement

Recommendations for improvement are identified below.

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

Recommendations for Health Plans	♦ **Enhance timely communication with primary care provider (PCP),** including the sharing of care plans and coordination of services to meet enrollees' needs. ♦ **Monitor case activity and provide regular feedback to care managers** to ensure timely completion of assessments/reassessments, care plans, and PCP communication. ♦ **Implement organization-wide strategies to identify** difficult-to-locate beneficiaries with complex needs and connect them with care managers during each contact. ♦ **Continue improvements to the children's behavioral health (BH) CC/CM program** to implement effective strategies for locating members, completing screenings, and crisis safety plans; enhance communication with PCPs; and ensure timely follow-up. ♦ **Continue oversight and monitoring of caseload requirements** for high-risk and moderate-risk enrollees. ♦ **Continue to strengthen the use of internal audit tools** to address findings of the Home- and Community-Based Services (HCBS) waiver record reviews and focus on remediation findings that result from the quarterly record reviews. ♦ **Consider care management system enhancements** to alert CC/CM of time frames to update waiver service plans and contact with beneficiaries. ♦ **Establish a process to complete ongoing claims validation** of the waiver service plan. ♦ **Conduct a root cause analysis to identify service providers** who may benefit from outreach and education regarding claims submission. ♦ **Improve documentation of valid contact** with brain injury (BI) waiver enrollees at least one time per month. ♦ **Improve documentation of valid contact** with human immunodeficiency virus (HIV) waiver enrollees once per month, with a face-to-face contact bimonthly.
Recommendations for HFS	♦ **Establish monitoring of health plans to validate provision of required CC/CM services for children with BH needs** through the review of case files. ♦ **Provide direction to the health plans related to caseload requirements for CC/CMs managing HIV and BI waiver members.** Discussion with health plans found that the health plans interpret the contract to mean that the 30-caseload limit pertains only to HIV and/or BI caseloads, as opposed to CC/CM total caseload (which may include other waiver and non-waiver cases).

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

Recommendations for Health Plans	♦ **The statewide average and measure rates for all six health plans ranked below the 50th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators,** demonstrating opportunities to ensure timely follow-up with beneficiaries after a discharge for mental illness from a hospital. ♦ **Enhance communication and collaboration with hospitals** to improve effectiveness of transitions of care from emergency department (ED) settings, discharge planning, and handoffs to community settings for members with BH needs.
Recommendations for HFS	♦ **Consider strategies for moving forward with the BH rapid-cycle PIP.**

Increase beneficiary participation in prevention and screenings.

Recommendations for Health Plans	♦ **Health Plans should identify quality improvement opportunities to improve preventive screenings for enrollees** as the statewide average for the *Adults' Access to Preventive and Ambulatory/Ambulatory Health Services* measure rates for five of six health plans fell below the 50th percentile. ♦ **Health plans should identify quality improvement opportunities to ensure that women receive appropriate screenings** as the statewide average for the *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators fell below the 50th percentile for HEDIS 2020. ♦ **Implement organization-wide strategies to contact members for preventive screenings,** such as flagging enrollees who need screenings in the system, and training member services staff, nurse advice line staff, and care managers to address the reasons for flagging during contact with members. ♦ **Use the results of the annual access and availability survey** to evaluate provider compliance with appointment availability and after-hours telephone access and to follow up with providers who are noncompliant with appointment standards. ♦ **Use patient navigators for individualized assistance** in scheduling and completing screenings. ♦ **Evaluate care gap outreach programs** by evaluating methods used to identify care gaps, evaluating engagement programs and closure of care gaps through direct member, and provider engagement. ♦ **Evaluate appointment access barriers** by assessing availability of after-hours and weekend appointments, mobile screenings, and community-based screening events.
Recommendations for HFS	♦ **Consider a statewide focused study or survey** to identify barriers/facilitators to the provision/utilization of preventive screening services.

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

Recommendations for Health Plans	♦ **Require service recovery programs** so health plan call center representatives have guidelines to follow for problem resolution. ♦ **Track trends and use data to improve service processes**, including service level reporting for customer service. ♦ **Train and empower front line employees to resolve enrollee complaints and grievances quickly and effectively,** including evaluation of data to identify failure points/root causes. ♦ **Evaluate the effectiveness of grievance and appeals resolution process** to address member dissatisfaction. ♦ **Use health consumer advisory committees** to determine opportunities to improve beneficiary satisfaction, including benefits or incentives. ♦ **Implement a provider complaint resolution process** to address provider dissatisfaction with timely resolution of provider complaints.
Recommendations for HFS	♦ **Continue to publish the HealthChoice Illinois Plan Report Card** to assist consumer choice when selecting a health plan. ♦ **Continue to work with the health plans to streamline the provider complaint resolution process** to address timely resolution and provider complaint dissatisfaction.

Improve Compliance with Provider Network Requirements

Recommendations for Health Plans	♦ **Continue to Improve accuracy of network provider data submission** by obtaining updated rosters from provider organizations that include all contracted providers within provider/physician groups, community mental health centers (CMHCs), federally qualified health centers (FQHCs), and rural health clinics (RHCs). ♦ **Continue to Improve accuracy of the Specialty Pediatric Provider Network** through review of specialty provider contracts to validate the age groups served by network providers. ♦ **Improve accuracy of the HCBS Provider Network** through review of contracts and validation of the types of HCBS services provided. ♦ **Improve accuracy of the online and hard copy provider directory** by evaluating the frequency and effectiveness of completing directory audits and process for updating changes to the online and paper provider directory. ♦ **Improve accuracy of delegated vendor online directories** by conducting audits of the delegated dental and vision provider directories and holding delegated vendors accountable for remediation of audit findings. ♦ **Evaluate methods used to monitor open and closed PCP panels** and the process for updating the online directory for panel status changes. ♦ **Consider conducting a review of provider offices' appointment scheduling requirements** to ensure the barriers are not unduly burdening enrollees' ability to schedule an appointment.

	♦ **Health plans should work with obstetrics/gynecology (OB/GYN) providers** to ensure (1) that providers are aware of the different appointment availability standards based on a woman's trimester and (2) that barriers to scheduling appointments are identified and corrected.
Recommendations for HFS	♦ Continue to work with the HCBS waiver agencies to **develop an official list of approved HCBS waiver service providers** to allow for a more robust validation of network capacity for these providers. ♦ **Consider developing requirements for Long-Term Services and Supports (LTSS) providers** that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule. ♦ **Consider requiring the health plans to conduct a review of the provider offices' appointment scheduling requirements** to ensure the barriers are not unduly burdening enrollees' ability to schedule an appointment.

Improve Oversight of Delegated Vendors

Recommendations for Health Plans	♦ **Improve oversight of delegated vendors** through compliance with conducting monthly joint operations meetings and quarterly review of vendor performance by the delegation oversight committee. ♦ **Continue to work with HFS to establish a joint oversight process** of the mobile crisis line (Chrysalis). ♦ **Continue to monitor Chrysalis crisis line call center reporting** to ensure timely referral to mobile crisis response (MCR) providers and revised internal processes to ensure MCR providers, inpatient hospitalization staff, and health plan staff roles are clearly defined. ♦ **Improve oversight of delegated dental and vision vendors** through regular audits of compliance with directory requirements and compliance with remediation of deficiencies identified as a result of directory audits. ♦ **Improve monitoring and oversight of delegated CC/CM vendors** for compliance with HCBS waiver caseloads requirements for CC/CM assigned to waiver enrollees. ♦ **Improve monitoring and oversight of delegated CC/CM vendors for compliance with waiver CC/CM training requirements**, including Elderly (ELD), BI, HIV, and Supportive Living Facility (SLF) waiver-specific required training.
Recommendations for HFS	♦ **Consider continuing efforts to streamline oversight of Chrysalis** by working with the HealthChoice Illinois (HCI) health plans to establish a joint oversight process. ♦ **Consider working with MCR providers and health plans** on expectations for provision of the MCR providers' crisis safety plan to health plans. ♦ **Consider the appropriateness of the requirement for holding health plans responsible** for ensuring that a CBH enrollee receives a physical examination within 24 hours of admission to an inpatient facility.

Improve Critical Incident (CI) Reporting

Recommendations for Health Plans	♦ **Continue reeducation of CI staff** to improve compliance with reporting to the appropriate investigating authority. ♦ **Develop and implement consistent policy and procedures** for information required for closure of a CI event. The process should include evidence of outreach to the enrollee to ensure their health, safety, and welfare (HSW). ♦ **Improve documentation of unable to reach (UTR) attempts** for enrollees who cannot be located following identification/report of a CI and improved communication with the investigating authority (IA) after initial CI report.
Recommendations for HFS	♦ Consider further refining CI definitions in order to ensure consistent reporting by the health plans. ♦ Consider providing education or guidance to the health plans on expected processes that must be documented to consider an incident closed/resolved. ♦ Consider providing guidance, or a formal approval of health plan process, on appropriate actions required to consider an incident closed/resolved if the enrollee is unable to reach post-event. ♦ Consider providing guidance to the health plans on whether fraud cases should be included in HSW/CI reporting or only included in compliance/fraud, waste, and abuse (FWA) reporting. If HFS intends for the health plans to include fraud cases in reporting, HFS should consider including the category in the *Critical Incident Guide* and providing additional direction related to appropriate reporting processes.

Improve Compliance with Key Leadership and CC/CM Staffing Requirements

Recommendations for Health Plans	♦ **Establish a process to confirm compliance with credentials/qualifications/experience** prior to hiring/assigning staff to manage waiver caseloads, especially for the physical disabilities (PD) and BI waivers. ♦ **Conduct ongoing review of staffing ratios** to ensure that case coordinators/care managers who manage HIV and BI waiver caseloads are not assigned caseloads greater than 30 enrollees. ♦ **Improve compliance with HCBS mandatory training requirements for care coordinators/care managers assigned to HCBS waiver enrollees** by updating annual and waiver-specific training curriculum to comply with waiver-specific training requirements and establish methods to track completion of required training. ♦ **Continue to improve monitoring of compliance with** key leadership staffing requirements. ♦ **Improve internal processes to notify the department** within two business days as required by contract for any staffing changes to key leadership positions.

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

Promising Practices

The following quality improvement initiatives implemented by the health plans were identified as promising practices that have the potential to impact population health outcomes.

BCBSIL has established the following initiatives to improve care coordination and transitions of care for enrollees with disabilities and BH conditions:

- Established two programs: the Complex Case Management (CCM) program and the Intensive Engagement of Supports and Services (IESS) program. These programs provide support to BCBSIL's most frequently admitted, most acute adult members and tend to fall within the disabled adult populations. The goals of these two programs are to reduce the rates of unnecessary inpatient admissions, promote continuity of care, and meet members' social determinants of health through providing a more intensive level of care coordination support. The programs work with identified members through ongoing engagement efforts in treatment and stabilization of their living situations to promote improved health outcomes.
- Improved BH outpatient appointment scheduling post-discharge with providers by coordinating reserved appointment times for BCBSIL enrollees. During interviews, health plan staff reported that they have engaged 35 BH providers throughout Illinois that are participating in the reserved scheduling for BCBSIL enrollees.

CountyCare established the following initiatives to enhance the effectiveness of its chronic condition and disease management programs:

- Continued to use and enhance its chronic condition and disease management programs, including a self-management texting program for members diagnosed with diabetes, asthma, hypertension, or obesity, and support of large provider-based initiatives such as the Diabetes Prevention Program and the Depression Collaborative Care Model CountyCare launched a telepsychiatry program during the coronavirus disease 2019 (COVID-19) public health emergency to provide telehealth counseling and psychiatry services for any CountyCare member. Other efforts included the use of community-based workers who act as trusted resources in the community for outreach to members, education, informal counseling, referrals, and social supports.

IlliniCare established the following initiatives to enhance the effectiveness of its CC/CM programs:

- Continued the Accountable Care Communities program, which provides multiple levels of outreach and engagement to meet members and providers where they are and facilitate meaningful care coordination when members are most in need. A strategy shift was necessary due to COVID-19 to move to a telemedicine model for physical and BH services for the second half of SFY 2020. The health plan continued with the embedded model with staff in 15 provider offices and 26 medical and behavioral facilities statewide until the onset of COVID-19, which necessitated the need to move to a virtual model.
- Continued to leverage digital solutions technologies for immediate notification to the care team when members are admitted to network hospitals and EDs (PatientPing), and remote care management programs to improve early member participation in prenatal care, drive better birth

outcomes, and increase engagement in postpartum and well-child infant care through education and member incentives (Pacify).

Meridian established the following initiatives to enhance the effectiveness of its preventive screenings and customer services programs:

- Established a Member and Provider Satisfaction Workgroup in February 2020 that includes the Appeals, Care Coordination, Customer Experience, Grievances, and Quality Improvement departments. The purpose of the workgroup is to review annual CAHPS results; identify barriers to low scores; and create collaborative, interdepartmental, multifaceted solutions to improve ratings for future surveys.
- Partnered with a third-party vendor, NovuHealth, to conduct outreach to Medicaid members due for pay-for-performance (P4P) measures and offer incentives for completing services. In SFY 2020, the partnership resulted in 80,520 unique members receiving outreach who had one or more open care gaps across all HEDIS measures. Of those members, 1,604 (2 percent) activated an account with NovuHealth. A total of 630 gift card redemptions were completed for members who attested to completing services.

Molina established the following initiatives to enhance access to BH appointments:

- Created the Telepsychiatry Grant program, which offered $100,000 each to five BH providers to support capacity for telepsychiatry services.
- Since its launch last year, Molina's Behavioral Health Excellence Program has realized improved engagement from provider discharge planners in scheduling specific follow-up appointments with members in place of general walk-in clinic referrals that had become common. Molina's CM department participated in dedicated engagement meetings with larger providers to discuss clinical opportunities and best practices. The program offers an incentive for facilities to achieve follow-up and readmission goals while collaborating with Molina quality staff and provides quarterly scorecard reporting to facilities.

NextLevel established the following initiatives to enhance notification of ED visits and inpatient admissions, and improve community-level access to BH services:

- Partnered with PatientPing to receive real-time notifications from facilities within the PatientPing network when a member presents to the ED or is otherwise admitted, allowing the transition of care (TOC) team to identify high-risk members in real time and monitor specific member populations to allow for immediate course correction.
- Launched a grassroots approach to create specific service areas in the diverse neighborhoods of Cook County by creating eight "Community Wellness Zones" with the goal of facilitating access to locally curated, tailored, culturally competent physical and BH services, including prevention services, social services, education, and wellness programs.

2. Performance Measures

Overview

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

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

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

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

Understanding Results

HEDIS is a nationally recognized set of performance measures used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[2-1] To evaluate performance levels and to provide an objective, comparative review of Illinois health plans' quality-of-care outcomes and performance measures, HFS required its health plans to report results following the NCQA's HEDIS protocols.

A key element of improving healthcare services is easily understood, comparable information on the performance of health plans. Systematically measuring performance provides a common language based on numeric values and allows the establishment of benchmarks, or points of reference, for performance. Performance measure results allow health plans to make informed judgments about the effectiveness of existing processes, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives. HFS requires health plans to monitor and evaluate the quality of care using HEDIS and HFS-defined performance measures. This section of the report displays results for measures selected by HFS that demonstrate health plan performance in domains of care that HFS prioritizes for improvement.

With statewide Medicaid expansion (HealthChoice Illinois) beginning in January 2018, HFS contracted with seven health plans to provide healthcare services to HealthChoice Illinois beneficiaries in SFY 2019. Due to Harmony acquiring Meridian, their data have been combined throughout this report and are displayed as Meridian for SFY 2019, for a total of six health plans. Four of the HealthChoice Illinois health plans serve beneficiaries statewide, and two health plans serve beneficiaries in Cook County only.

In this report, Illinois health plans' performance for required HEDIS 2020 measures is compared to NCQA's Quality Compass®[2-2] national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019, when available, which is an indicator of health plan performance on a national level (referred to as "percentiles" throughout this section of the report). Of note, rates for the *Medication Management for People With Asthma—Medication Compliance 50%—Total* measure were compared to NCQA's Audit Means and Percentiles national Medicaid HMO percentiles for HEDIS 2019 since this indicator is not published in Quality Compass.

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

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

Where:

n_1 = number of Harmony beneficiaries in the eligible population
n_2 = number of Meridian beneficiaries in the eligible population

$\overline{X}_1$ = Harmony eligible population rate
$\overline{X}_2$ = Meridian eligible population rate

[2-1] NCQA. HEDIS & Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Nov 6, 2020.

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

Details regarding the methodology are provided in Appendix B1 of this report.

Due to changes in the technical specifications for some measures for HEDIS 2020 (e.g., *Prenatal and Postpartum Care*), NCQA does not recommend trending between 2020 and prior years; therefore, prior year rates are not displayed, and comparisons to benchmarks are not performed.

Benchmarking data (e.g., Quality Compass) are the proprietary intellectual property of NCQA; therefore, this report does not display actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS 2019 results are calculated using calendar year (CY) 2018 data and HEDIS 2020 results are calculated using CY 2019 data.

Health Plans

Table 2-1 displays the health plans for SFY 2020.

Table 2-1—Health Plans for HEDIS 2020 Measure Performance

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

* Harmony Health Plan of Illinois, Inc.'s data are combined with Meridian's data for SFY 2019 in this section of the report.

Measures

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

Table 2-2—HFS Required Measures by Domain of Care for HEDIS 2020

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

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

Measures
Living With Illness
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Testing
Eye Exam (Retinal) Performed
Medical Attention for Nephropathy
Controlling High Blood Pressure
Controlling High Blood Pressure
Medication Management for People With Asthma
Medication Compliance 50%—Total
Medication Compliance 75%—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Statin Adherence 80%
Behavioral Health
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
Initiation of AOD Treatment—Total
Engagement of AOD Treatment—Total
Mental Health Utilization
Any Service—Total
Inpatient—Total
Intensive Outpatient or Partial Hospitalization—Total
Outpatient—Total
ED—Total
Telehealth—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose Testing—Total
Cholesterol Testing—Total
Blood Glucose and Cholesterol Testing—Total

Summary of Performance

COVID-19 Related Considerations

In response to the impact of COVID-19 on healthcare providers and the health plans' ability to procure clinical records, HFS, in alignment with NCQA guidance, modified the reporting requirements for RY 2020 hybrid measures. While health plans were still required to report HEDIS 2020 results for administrative-only measures, they were granted a one-year allowance to report HEDIS 2019 audited hybrid rates in place of HEDIS 2020 hybrid rates if the health plans' audited HEDIS 2019 hybrid rate were better than their HEDIS 2020 hybrid rate as a result of low chart retrieval. Health plans were able to select which hybrid measures they rotated; however, once a measure was selected for rotation, all related indicators were required to be rotated, reflecting HEDIS 2019 results. Since NCQA's Interactive Data Submission System (IDSS) was not configured to capture rotation decisions, all data in IDSS reflected 2019 regardless of rotation decisions.

Access to Care

Access to and utilization of primary and preventive care is essential for Illinois Medicaid beneficiaries to achieve the best health outcomes. Obtaining good access to care often requires Medicaid beneficiaries to find a trusted PCP to meet their needs. Medicaid beneficiaries should utilize their PCP to help them prevent illnesses and encourage healthy behaviors through needed services.[2-3]

Table 2-3 presents the HEDIS 2019 and HEDIS 2020 rates for the measures in the Access to Care domain for the health plans and the statewide average compared percentiles, where applicable.

Table 2-3—Access to Care Domain Results for HEDIS 2019 and HEDIS 2020

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Access to Care								
Adults' Access to Preventive/Ambulatory Health Services								
Total	2019	★★★★★ 94.55%	★★ 77.14%	★ 74.68%	★★ 79.53%	★ 71.61%	★ 48.62%	★ 75.80%
	2020	★★★★ 85.49%	★★ 79.24%	★★ 77.04%	★★ 81.23%	★ 76.02%	★ 54.64%	★★ 79.78%

[2-3] Agency for Healthcare Research and Quality. National Healthcare Disparities Report, 2011. Available at: https://archive.ahrq.gov/research/findings/nhqrdr/nhdr11/chap9.html#. Accessed on: Nov 6, 2020.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Adult BMI Assessment								
Adult BMI Assessment	2019	★ 77.86%	★★ 87.79%	★★ 83.70%	★ 80.55%	★★★ 89.05%	★ 69.59%	★ 82.07%
	2020	★ 74.70%	★★ 87.79%	★ 83.70%	★★ 86.13%	★★★ 92.44%	★ 69.59%	★ 82.73%
Ambulatory Care (per 1,000 Member Months)								
*ED Visits—Total**	2019	★★★ 53.47	★★★ 56.64	★★ 63.83	★★★ 59.42	★★ 65.00	★★ 64.68	★★★ 59.07
	2020	★★★ 54.31	★★ 58.42	★★ 65.23	★★★ 58.14	★★ 65.03	★ 67.67	★★ 59.51
Outpatient Visits—Total	2019	★★★ 370.24	★ 254.62	★ 275.87	★★ 308.34	★ 289.46	★ 136.85	★ 301.04
	2020	★★★ 386.38	★ 281.39	★ 303.56	★★ 333.33	★ 302.62	★ 175.58	★★ 324.10
Annual Dental Visits								
Annual Dental Visits	2019	★★★★★ 69.31%	★★ 52.81%	★★★ 61.41%	★★★ 58.22%	★★ 55.27%	BR	★★★ 60.15%
	2020	★★★★ 69.12%	★★★★ 64.84%	★★ 55.93%	★★ 55.08%	★★ 54.81%	★ 42.53%	★★★ 59.33%

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

BR indicates the rate was materially biased.

Star ratings represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ *= 50th to 74th percentile*

★★ *= 25th to 49th percentile*

★ *= Below 25th percentile*

Notable

- The statewide average and measure rates for two of six (33.3 percent) health plans ranked at or above the 50th percentile for the *Annual Dental Visits* measure indicator for HEDIS 2020.
- BCBSIL was the only health plan to exceed the 75th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator, and BCBSIL and CountyCare were the only health plans to exceed the 75th percentile for the *Annual Dental Visits* measure indicator, demonstrating strength in these domains. However, BCBSIL's measure rate for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator declined by approximately 9 percentage points from HEDIS 2019 to HEDIS 2020. CountyCare's measure rate for the *Annual Dental Visits* measure indicator improved by approximately 12 percentage points from HEDIS 2019 to HEDIS 2020.

Needs Work

- The statewide average and measure rates for five of six (83.3 percent) health plans fell below the 50th percentile for the *Adults' Access to Preventive/Ambulatory Health Services—Total* and *Adult BMI Assessment* measure indicators for HEDIS 2020.
- IlliniCare and NextLevel performed below the 50th percentile on every reportable measure indicator in this domain for HEDIS 2020, despite demonstrating improvement from HEDIS 2019 for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator.

Access to Care Conclusions

In the Access to Care domain, the HEDIS 2020 statewide average for the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure indicator fell below the 50th percentile and the HEDIS 2020 statewide average for the *Adult BMI Assessment* measure indicator fell below the 25th percentile, indicating an area for improvement. The HEDIS 2020 statewide average for the *Annual Dental Visit* measure indicator ranked at or above the 50th percentile.

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

Keeping Kids Healthy

Illinois Medicaid provides healthcare to over 1.3 million children, nearly half of the population HFS serves.[2-4] Appropriate standardized measures of health are needed to improve the overall quality of child healthcare, as the health status of children and adolescents is important for society, helping to determine the health of the next generation.[2-5]

Table 2-4 presents the HEDIS 2019 and HEDIS 2020 rates for the measures in the Keeping Kids Healthy domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-4—Keeping Kids Healthy Domain Results for HEDIS 2019 and HEDIS 2020

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Keeping Kids Healthy								
Childhood Immunization Status								
Combination 2	2019	★★★ 76.64%	★★★ 75.18%	★ 51.34%	★ 69.35%	★★★★ 78.35%	★ 2.76%	★ 67.17%
	2020	★ 66.91%	★★★ 75.18%	★ 64.48%	★★ 69.35%	★★★★ 78.35%	★ 47.93%	★★ 69.09%
Combination 3	2019	★★★ 73.72%	★★★ 73.24%	★ 47.20%	★ 64.37%	★★ 69.59%	★ 2.34%	★ 63.08%
	2020	★ 61.80%	★★★ 73.24%	★ 61.80%	★ 64.37%	★★ 69.59%	★ 43.80%	★ 64.30%
Immunizations for Adolescents								
Combination 1 (Meningococcal, Tdap)	2019	★★★ 85.40%	★★★ 80.29%	★★ 79.56%	★★★ 85.57%	★★★★ 85.89%	★ 28.04%	★★★ 83.77%
	2020	★★★★ 86.86%	★★★ 85.16%	★★★ 85.64%	★★★★ 88.32%	★★★ 85.89%	★ 69.59%	★★★★ 86.63%
Combination 2 (Meningococcal, Tdap, HPV)	2019	★★★ 37.23%	★★★★ 39.42%	★★ 28.71%	★★★ 33.27%	★★★★ 38.93%	★ 6.27%	★★★ 34.84%
	2020	★★★ 39.90%	★★★★ 43.31%	★★ 30.17%	★★ 34.31%	★★★ 38.93%	★ 22.14%	★★★ 36.86%

[2-4] Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2018. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2019HFSAnnualReportFINAL.pdf. Accessed on: Nov 6, 2020.

[2-5] National Quality Forum. Pediatric measures: Final Report, June 15, 2016. Available at: https://www.qualityforum.org/Publications/2016/06/Pediatric_Measures_Final_Report.aspx. Accessed on: Nov 6, 2020.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile Documentation—Total	2019	★★ 73.72%	★★★★ 84.74%	★★★ 77.62%	★★ 70.98%	★★★ 77.62%	★★ 69.10%	★★ 75.28%
	2020	★ 61.56%	★★★ 84.74%	★★ 77.62%	★★ 70.98%	★★ 77.62%	★★ 69.10%	★★ 72.11%
Counseling for Nutrition—Total	2019	★★ 62.77%	★★★★ 81.31%	★★ 69.34%	★★ 64.25%	★★★ 69.59%	★★ 67.64%	★★ 67.79%
	2020	★ 50.61%	★★★★ 81.31%	★★ 69.34%	★★ 64.25%	★★ 69.59%	★★ 67.64%	★★ 64.63%
Counseling for Physical Activity—Total	2019	★★ 61.56%	★★★★ 78.19%	★★★ 66.91%	★★ 61.61%	★★ 63.26%	★★ 63.02%	★★★ 65.14%
	2020	★ 48.91%	★★★★ 78.19%	★★★ 66.91%	★★ 61.61%	★★ 63.26%	★★ 63.02%	★★ 61.85%
Well-Child Visits in the First 15 Months of Life								
Six or More Well-Child Visits	2019	★★ 63.02%	★★ 65.45%	★★ 61.31%	★★ 64.95%	★★★ 67.88%	★ 32.74%	★★ 63.92%
	2020	★★ 65.45%	★★ 65.45%	★★ 61.31%	★★★★★ 76.89%	★★★ 68.37%	★ 37.77%	★★★ 69.03%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life								
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	2019	★★★ 76.40%	★★★★ 80.29%	★★ 70.80%	★★★ 76.31%	★★ 69.83%	★ 58.15%	★★★ 75.68%
	2020	★★★ 75.18%	★★★★ 80.29%	★★ 70.80%	★★★ 75.05%	★★ 69.83%	★ 58.15%	★★★ 74.93%

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for five of six (83.3 percent) health plans ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS 2020. The statewide average and measure rates for three of six (50.0 percent) health plans ranked at or above the 50th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator for HEDIS 2020.
- The statewide average for the *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits* measure indicator demonstrated an increase of approximately 5 percentage points from HEDIS 2019 to rank at or above the 50th percentile for HEDIS 2020.
- CountyCare performed at or above the 50th percentile for eight of nine (88.9 percent) measure indicators in the Keeping Kids Healthy domain for HEDIS 2020, demonstrating strength in this domain for the health plan.

Needs Work

- Despite demonstrating improvement from HEDIS 2019 to HEDIS 2020, the statewide average for the *Childhood Immunization Status—Combination 2* measure indicator the measure continued to fall below the 50th percentile for HEDIS 2020, and the *Childhood Immunization Status—Combination 3* measure indicator continued to fall below the 25th percentile.
- The statewide average ranked below the 50th percentile for all the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measure indicators for HEDIS 2020. Further, five of six (83.3 percent) health plans ranked below the 50th percentile for the *WCC—BMI Percentile Documentation—Total* and *WCC—Counseling for Nutrition—Total* measure indicators, and four of six (66.7 percent) health plans ranked below the 50th percentile for the *WCC—Counseling for Physical Activity—Total* measure indicator.
- Despite some large increases in measure rates from HEDIS 2019 to HEDIS 2020 (due to NextLevel reporting some measure indicators using the hybrid methodology in HEDIS 2020), NextLevel performed below the 25th percentile for six of nine (66.7 percent) measure indicators in the Keeping Kids Healthy domain for HEDIS 2020.

Keeping Kids Healthy Conclusions

In the Keeping Kids Healthy domain, the HEDIS 2020 statewide average ranked above the 50th percentile for only four of nine (44.4 percent) measure rates. Despite slight increases in the rates from HEDIS 2019, the *Childhood Immunization Status* measure rates continued to fall below the 50th percentile, indicating opportunities to increase immunizations for children. Additionally, the statewide average fell below the 50th percentile for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, demonstrating opportunities for health plans to ensure young children receive weight assessment and counseling for nutrition and physical activity during well-child visits.

Women's Health

Quality in women's healthcare is assessed with preventive measures such as *Breast Cancer Screening* and obstetrical measures such as *Prenatal and Postpartum Care*. Appropriate cancer screenings for women can lead to early detection, more effective treatment, and fewer deaths.[2-6]

Table 2-5 presents the HEDIS 2019 and HEDIS 2020 rates for the measures in the Women's Health domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-5—Women's Health Domain Results for HEDIS 2019 and HEDIS 2020

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Women's Health								
Breast Cancer Screening								
Breast Cancer Screening	2019	★★ 56.28%	★★★★ 64.28%	★★ 53.41%	★★ 57.25%	★ 47.22%	★ 22.26%	★★ 55.91%
	2020	★★ 57.92%	★★★★ 65.09%	★★ 53.87%	★★★ 59.01%	★ 50.99%	★ 25.14%	★★ 57.23%
Cervical Cancer Screening								
Cervical Cancer Screening	2019	★ 53.53%	★★★ 61.22%	★ 51.58%	★★★ 60.72%	★★ 56.20%	★ 34.06%	★★ 56.83%
	2020	★★ 55.72%	★★★ 61.22%	★ 51.58%	★★★ 60.72%	★★ 56.20%	★ 34.79%	★★ 57.59%
Chlamydia Screening in Women								
Total	2019	★★★ 58.42%	★★★★ 66.39%	★★★ 58.50%	★★ 55.36%	★★★ 60.60%	★★★ 63.92%	★★★ 59.38%
	2020	★★ 56.82%	★★★★ 67.72%	★★ 57.35%	★★ 55.60%	★★ 58.06%	★★★★ 69.51%	★★★ 58.39%
Prenatal and Postpartum Care[1]								
Timeliness of Prenatal Care	2019	NC —	NC —	NC —	NC —	NC —	NC —	NC —
	2020	NC 87.83%	NC 93.92%	NC 86.62%	NC 93.19%	NC 98.05%	NC 74.94%	NC 91.56%

[2-6] The Community Guide. *Cancer Screening: Evidenced-Based Interventions for Your Community*. Available at: https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-CancerScreening.pdf. Accessed on: Nov 6, 2020.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Postpartum Care	2019	NC —	NC —	NC —	NC —	NC —	NC —	NC —
	2020	NC 81.27%	NC 78.83%	NC 76.16%	NC 83.45%	NC 76.40%	NC 60.58%	NC 80.15%

[1] *Due to changes in the technical specifications for this measure, NCQA recommends a break in trending between 2020 and prior years; therefore, prior years' rates are not displayed, and comparisons to benchmarks are not performed for this measure.*

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

— indicates that NCQA recommended a break in trending; therefore, the HEDIS 2019 rate is not displayed.

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average and measure rates for two of six (33.3 percent) health plans ranked at or above the 50th percentile for the *Chlamydia Screening in Women—Total* measure indicator for HEDIS 2020. CountyCare and Meridian were the only health plans to perform at or above the 50th percentile for the *Breast Cancer Screening* and *Cervical Cancer Screening* measures for HEDIS 2020.

Needs Work

- The statewide average and measure rates for four of six (66.7 percent) health plans fell below the 50th percentile for the *Breast Cancer Screening* and *Cervical Cancer Screening* measures for HEDIS 2020. Of note, two of these health plans (Molina and NextLevel) fell below the 25th percentile for the *Breast Cancer Screening* measure, and two of these health plans (IlliniCare and NextLevel) fell below the 25th percentile for the *Cervical Cancer Screening* measure.

Women's Health Conclusions

In the Women's Health domain, the HEDIS 2020 statewide average ranked above the 50th percentile for one of the three (33.3 percent) measure rates. Conversely, the statewide average for the *Breast Cancer Screening* and *Cervical Cancer Screening* measure indicators fell below the 50th percentile, demonstrating opportunities for health plans to ensure women receive appropriate screenings.

Living With Illness

For Medicaid beneficiaries living with illness (i.e., chronic conditions), it is essential to effectively manage the care provided to those beneficiaries and improve health outcomes for those beneficiaries.[2-7]

Table 2-6 presents the HEDIS 2019 and HEDIS 2020 rates for the measures in the Living With Illness domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-6—Living With Illness Domain Results for HEDIS 2019 and HEDIS 2020

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Living with Illness								
Comprehensive Diabetes Care								
HbA1c Testing	2019	★★★ 90.27%	★★★ 90.27%	★★★ 88.56%	★★★ 88.08%	★★ 86.62%	★ 76.89%	★★★ 88.89%
	2020	★★★★ 91.00%	★★★ 88.81%	★★★ 88.56%	★★ 88.08%	★★★ 89.29%	★ 76.92%	★★★ 89.06%
Eye Exam (Retinal) Performed	2019	★★ 57.66%	★★ 53.28%	★★★ 58.39%	★★★ 60.88%	★★ 54.01%	★ 31.14%	★★ 56.69%
	2020	★★ 55.59%	★★ 55.96%	★★ 58.39%	★★★ 60.88%	★★ 53.28%	★ 34.24%	★★ 56.68%
Medical Attention for Nephropathy	2019	★★★★★ 94.16%	★★ 90.27%	★★★ 91.31%	★★ 90.35%	★ 87.59%	★ 84.67%	★★★ 91.24%
	2020	★★★★ 92.94%	★★★★ 92.46%	★★★ 91.31%	★★★ 90.35%	★★★ 91.00%	★ 87.33%	★★★ 91.70%
Controlling High Blood Pressure								
Controlling High Blood Pressure	2019	NC 48.66%	NC 50.12%	NC 48.91%	NC 50.90%	NC 57.66%	NC 37.71%	NC 50.04%
	2020	★ 39.66%	★ 50.12%	★ 48.91%	★ 50.90%	★★ 59.55%	★ 37.71%	★ 47.83%

[2-7] Kronick, RG, Bella, M, Gilmer, TP, et al. Faces of Medicaid II: Recognizing the care needs of people with multiple chronic conditions. October 2007. Available at: https://www.chcs.org/resource/the-faces-of-medicaid-ii-recognizing-the-care-needs-of-people-with-multiple-chronic-conditions/. Accessed on: Nov 6, 2020.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Medication Management for People With Asthma								
Medication Compliance 50%—Total[1]	2019	★★ 55.95%	★ 53.35%	★★ 58.42%	★★ 55.43%	★ 53.38%	★★ 54.74%	★★ 55.44%
	2020	★★ 59.66%	★★ 55.97%	★★ 59.87%	★★ 60.43%	★ 54.64%	★ 50.52%	★★ 58.48%
Medication Compliance 75%—Total[1]	2019	★★ 32.46%	★ 26.84%	★★ 35.05%	★★ 32.04%	★★ 30.54%	★ 22.11%	★★ 31.59%
	2020	★★ 36.15%	★ 31.26%	★★ 34.95%	★★ 36.10%	★★ 34.27%	★ 24.74%	★★ 34.53%
Statin Therapy for Patients With Diabetes								
Received Statin Therapy	2019	★★★★★ 70.74%	★★★★★ 69.60%	★★★★★ 69.84%	★★★★ 66.80%	★★★ 64.49%	★ 54.04%	★★★★ 68.49%
	2020	★★★★★ 73.48%	★★★★ 68.95%	★★★★★ 71.50%	★★★★★ 70.30%	★★★★ 68.20%	★ 59.02%	★★★★★ 70.73%
Statin Adherence 80%	2019	★★ 58.90%	★★★ 61.12%	★★★★ 66.11%	★★ 57.58%	★★★ 60.50%	★ 47.35%	★★★ 60.28%
	2020	★★★ 62.89%	★★★ 63.87%	★★★ 66.38%	★★★ 63.84%	★★★ 62.38%	★ 54.03%	★★★ 63.69%

[1] *Quality Compass benchmarks were not available for this measure; therefore, the Audit Means and Percentiles were used for comparative purposes. NC indicates that the measure was not compared to national percentiles, due to NCQA's recommendation for a break in trending for this measure in HEDIS 2019.*

Star ratings represent the following percentile comparisons:

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

Notable

- The statewide average ranked at or above the 50th percentile for two of the *Comprehensive Diabetes Care* measure indicators *(HbA1c Testing* and *Medical Attention for Nephropathy)*. For the *HbA1c Testing* measure indicator, rates for all four health plans that did not rotate measure rates demonstrated improvement from HEDIS 2019. For the *Medical Attention for Nephropathy* measure indicator, measure rates for five of six (83.3 percent) health plans ranked at or above the 50th percentile for HEDIS 2020.
- The statewide average and measure rates for five of six (83.3 percent) health plans ranked at or above the 75th percentile for the *Statin Therapy for Patients with Diabetes—Received Statin Therapy* measure indicator.
- The statewide average and measure rates for five of six (83.3 percent) health plans ranked at or above the 50th percentile for the *Statin Therapy for People With Diabetes—Statin Adherence 80%* measure indicator. Further, all six health plans demonstrated improvement from HEDIS 2019.
- All health plans except NextLevel ranked at or above the 50th percentile for at least four of eight (50.0 percent) measure rates for HEDIS 2020. Of note, three of these measure rates for BCBSIL ranked at or above the 75th percentile, demonstrating strength for BCBSIL in the Living With Illness domain.

Needs Work

- The statewide average and measure rates for five of six (83.3 percent) health plans for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator fell below the 50th percentile for HEDIS 2020.
- The statewide average and measure rates for five of six (83.3 percent) health plans for the *Controlling High Blood Pressure* measure fell below the 25th percentile.
- Despite the statewide average measure rates for both *Medication Management for People With Asthma* measure indicators demonstrating improvement from HEDIS 2019, the statewide averages continued to fall below the 50th percentile. Of note, measure rates for all six health plans for both measure indicators also fell below the 50th percentile for HEDIS 2020.
- NextLevel's rates for all eight measure indicators fell below the 25th percentile for HEDIS 2020.

Living With Illness Conclusions

In the Living With Illness domain, the HEDIS 2020 statewide average exceeded the 90th percentile for the *Statin Therapy for People With Diabetes—Received Statin Therapy* measure indicator, indicating strength. Conversely, the statewide average fell below the 50th percentile for four of the eight (50.0 percent) measure rates. Of note, the statewide average for the *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* measure indicator ranked below the 50th percentile in HEDIS 2019 and HEDIS 2020, and demonstrated a slight rate decline from HEDIS 2019. The health plans should ensure that beneficiaries with diabetes receive appropriate eye exams to prevent the measure rate from continuing to fall.

Behavioral Health

Good mental health is important for productivity, building relationships, and personal well-being. Mental illnesses, such as anxiety and depression, affect physical health by hindering health-promoting behaviors.[2-8]

Table 2-7 presents the HEDIS 2019 and HEDIS 2020 rates for the measures in the Behavioral Health domain for the health plans and the statewide average compared to percentiles, where applicable.

Table 2-7—Behavioral Health Domain Results for HEDIS 2019 and HEDIS 2020

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Behavioral Health								
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	2019	★ 17.87%	★ 25.38%	★ 28.75%	★★ 31.08%	★★ 29.69%	★ 5.27%	★ 26.08%
	2020	★ 21.30%	★ 24.04%	★ 26.87%	★★ 34.07%	★★ 30.90%	★ 5.05%	★ 27.78%
30-Day Follow-Up—Total	2019	★ 33.70%	★ 41.48%	★ 49.37%	★★ 51.36%	★★ 52.25%	★ 11.84%	★ 44.54%
	2020	★ 40.15%	★ 40.80%	★ 48.11%	★★ 56.21%	★★ 51.96%	★ 10.54%	★ 47.76%
Initiation and Engagement of AOD Abuse or Dependence Treatment								
Initiation of AOD Treatment—Total	2019	★★★ 45.18%	★★★ 44.03%	★★★★ 47.55%	★★★ 42.23%	★★ 40.16%	★★★★★ 50.25%	★★★ 44.14%
	2020	★★★ 44.30%	★★★ 44.56%	★★★ 46.13%	★★ 42.36%	★★★ 42.50%	★★★ 46.59%	★★★ 43.97%
Engagement of AOD Treatment—Total	2019	★★★ 14.32%	★★ 12.67%	★★★ 16.93%	★★★ 15.42%	★★ 9.44%	★★ 12.74%	★★★ 14.15%
	2020	★★★ 14.26%	★★ 12.55%	★★★ 16.63%	★★★ 14.81%	★★ 11.21%	★★ 13.75%	★★★ 14.23%
Mental Health Utilization[1]								
Any Service—Total	2019	—	—	—	—	—	—	—
	2020	★★ 10.55%	★★ 9.89%	★★ 11.64%	★★ 12.14%	★★ 11.69%	★ 7.43%	★★ 11.26%

[2-8] U.S. Department of Health and Human Services. 2020 Topics & Objectives: Mental Health and Mental Disorders. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders. Accessed on: Nov 6, 2020.

Measure	Year	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Average
Inpatient—Total	2019	—	—	—	—	—	—	—
	2020	★★★★ 1.55%	★★★★ 1.46%	★★★★★ 1.94%	★★★ 1.20%	★★★★ 1.57%	★★★★★ 2.65%	★★★★ 1.50%
Intensive Outpatient or Partial Hospitalization—Total	2019	—	—	—	—	—	—	—
	2020	★★★ 1.12%	★★★ 0.99%	★★★ 1.17%	★★★ 1.13%	★★★ 1.16%	★★★ 0.75%	★★★ 1.11%
Outpatient—Total	2019	—	—	—	—	—	—	—
	2020	★★ 10.14%	★★ 9.45%	★★ 11.06%	★★ 11.90%	★★ 11.00%	★ 6.37%	★★ 10.84%
ED—Total	2019	—	—	—	—	—	—	—
	2020	★ 0.03%	★★★ 0.59%	★ 0.07%	★ 0.03%	★★★ 0.74%	★★ 0.11%	★★ 0.19%
Telehealth—Total	2019	—	—	—	—	—	—	—
	2020	★★ 0.09%	★★ 0.09%	★★★ 0.14%	★★★ 0.15%	★★★ 0.18%	★★ 0.05%	★★★ 0.13%
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose Testing—Total[2]	2019	—	—	—	—	—	—	—
	2020	NC 63.38%	NC 60.30%	NC 60.64%	NC 57.19%	NC 57.39%	NC 54.29%	NC 59.14%
Cholesterol Testing—Total[2]	2019	—	—	—	—	—	—	—
	2020	NC 44.73%	NC 41.83%	NC 37.40%	NC 33.11%	NC 35.77%	NC 40.00%	NC 37.01%
Blood Glucose and Cholesterol Testing—Total	2019	★★★ 40.82%	★★★ 32.95%	★★★ 33.24%	★★★ 33.03%	★★★ 35.25%	★ 25.00%	★★★ 35.08%
	2020	★★★★ 44.06%	★★★ 39.70%	★★★ 36.25%	★★ 32.09%	★★ 32.97%	★★★ 40.00%	★★★ 35.74%

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

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

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

— indicates that NCQA recommended a break in trending; therefore, the HEDIS 2019 rate is not displayed. This symbol may also indicate that the health plans were not required to report the measure in 2019.

Star ratings represent the following percentile comparisons:

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

Notable

- For both the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure indicators, the statewide average ranked at or above the 50th percentile, with five of six (83.3 percent) health plans ranking at or above the 50th percentile for the *Initiation of AOD Treatment—Total* measure indicator and three of six (50.0 percent) health plans ranking above the 50th percentile for the *Engagement of AOD Treatment—Total* measure indicator.
- The statewide average and measure rates for four of six (66.7 percent) health plans ranked at or above the 50th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure indicator. Of note, the measure rate for BCBSIL ranked at or above the 75th percentile for HEDIS 2020.

Needs Work

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

Behavioral Health Conclusions

Within the Behavioral Health domain, the statewide average for HEDIS 2020 ranked at or above the 50th percentile for three of five (60.0 percent) measure rates. Conversely, the statewide average and measure rates for all six health plans ranked below the 50th percentile for both *Follow-Up After Hospitalization for Mental Illness* measure indicators, demonstrating opportunities to ensure timely follow-up with beneficiaries after a discharge for mental illness from a hospital.

Of note, the measure rates for *Mental Health Utilization* should be used strictly for informational purposes only.

Recommendations for Improving Performance Measure Rates

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

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

[2-9] Institute for Healthcare Improvement. *Plan-Do-Study-Act (PDSA) Worksheet*. Available at: http://www.ihi.org/resources/Pages/Tools/PlanDoStudyActWorksheet.aspx. Accessed on: Nov 19, 2020.

Centers for Medicare & Medicaid Services (CMS) Home- and Community-Based Services (HCBS) Waiver Performance Measures Record Reviews

Overview

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

This summary of findings for the SFY 2020 HCBS Waivers CMS Performance Measures Record provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for HealthChoice Illinois, including the MLTSS 1915(b) waiver program and the MMAI managed care population. Details about the methodology are included in Appendix B5.

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

HealthChoice Illinois Record Reviews

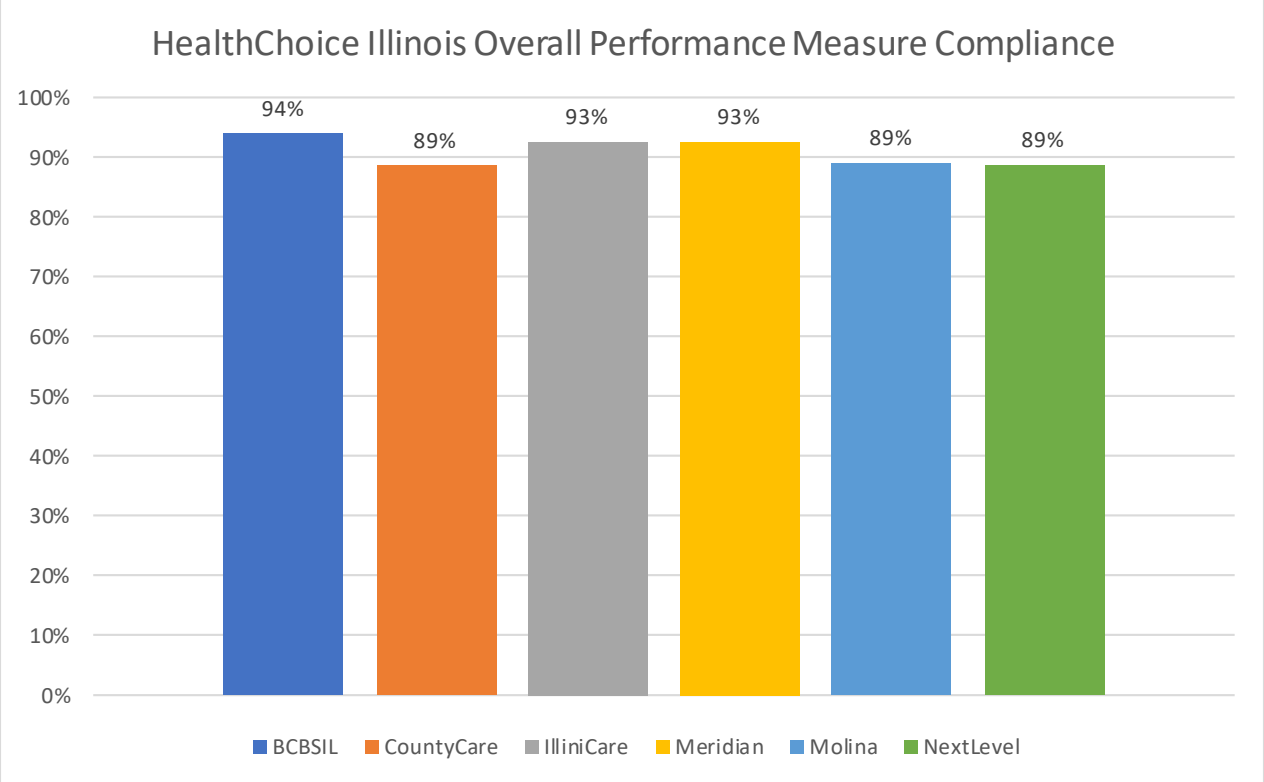
Table 2-8 displays the HealthChoice Illinois health plans reviewed by quarter for SFY 2020. A total of six HealthChoice Illinois health plans were reviewed. During SFY 2020, 2,117 HealthChoice Illinois records were reviewed using HSAG's web-based data collection tool. As a result, 1,727 findings of noncompliance were identified.

Table 2-8—HealthChoice Illinois Plans Reviewed by Quarter (Q) SFY 2020

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

Figure 2-1 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 15 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Figure 2-1—Overall Compliance



Three of the six health plans averaged greater than 90 percent compliance in SFY 2020. There was a 5-percentage point difference (89 percent to 94 percent) among health plans.

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

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, averaged 23 percent compliance in SFY 2019. All six health plans performed at a rate of less than 50 percent in SFY 2020. A detailed analysis related to measure 4A is provided in Section 3 of this report.
- Measure 36D, the case manager made timely contact with the beneficiaries or there is valid justification in the record, averaged 52 percent and 44 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to measure 36D is provided in Section 3 of this report.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, averaged 78 percent compliance in SFY 2020. A detailed analysis related to measure 39D is provided in Section 3 of this report.

MLTSS Record Reviews

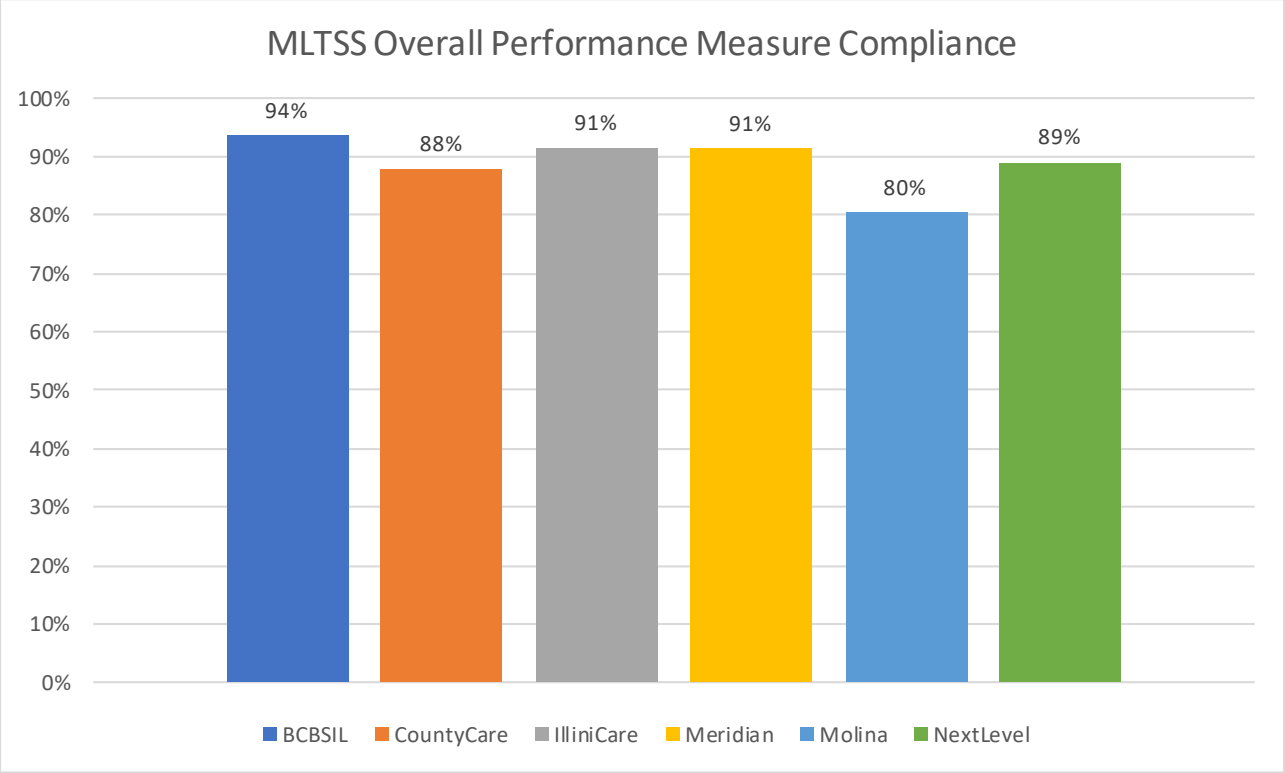
Table 2-9 displays the MLTSS health plans reviewed by quarter for SFY 2020. A total of six health plans were reviewed. During SFY 2020, 1,357 MLTSS records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,294 findings of noncompliance were identified.

Table 2-9—HealthChoice Illinois Plans Reviewed by Quarter SFY 2020

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

Figure 2-2 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 15 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Figure 2-2—Overall Compliance



Three of the six health plans averaged greater than 90 percent compliance in SFY 2020. There was a 14-percentage point difference (80 percent to 94 percent) among health plans.

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

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, averaged 22 percent compliance in SFY 2019. All six health plans performed at a rate of less than 50 percent in SFY 2020. A detailed analysis related to measure 4A is provided in Section 3 of this report.
- Measure 36D, the case manager made timely contact with the beneficiaries or there is valid justification in the record, averaged 53 percent and 50 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to measure 36D is provided in Section 3 of this report.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, averaged 75 percent compliance in SFY 2020. A detailed analysis related to measure 39D is provided in Section 3 of this report.

MMAI Record Reviews

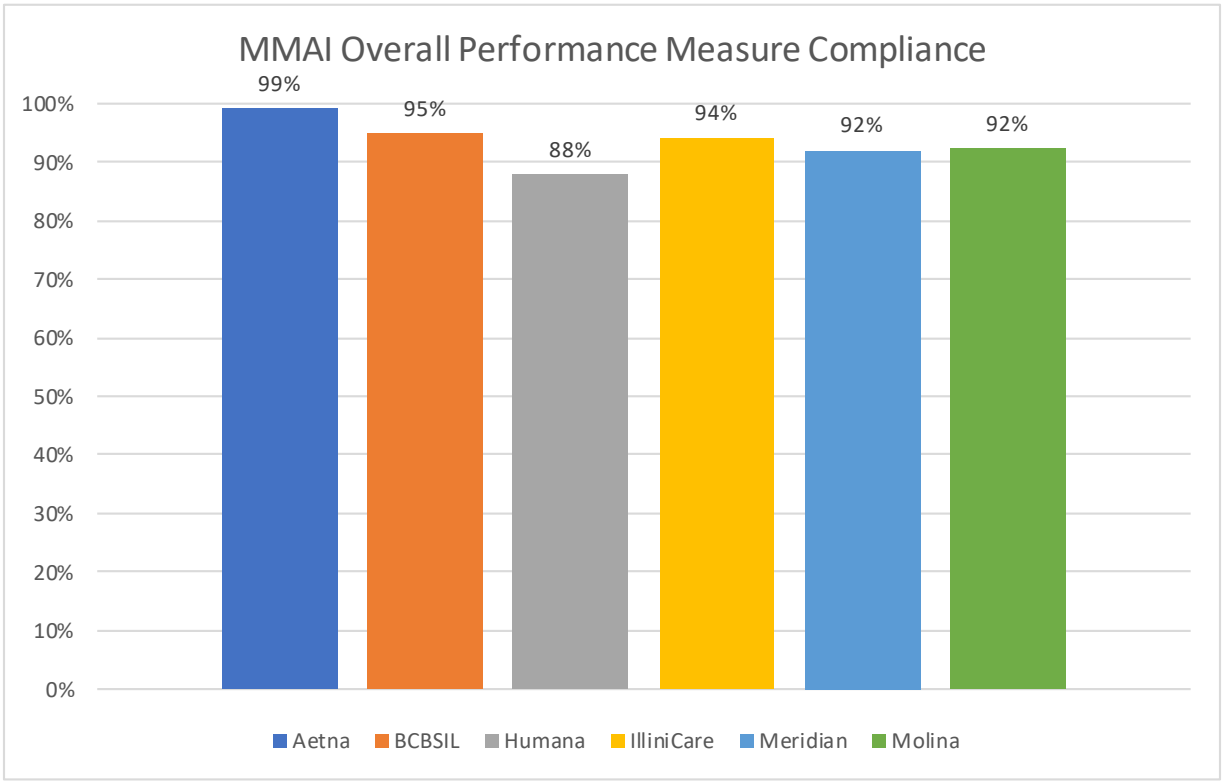
Table 2-10 displays the MMAI health plans reviewed by quarter. A total of six MMAI health plans were reviewed during SFY 2020. During SFY 2020, 1,218 MMAI records were reviewed using HSAG's web-based data collection tool. As a result, 782 findings of noncompliance were identified.

Table 2-10—MMAI Health Plans Reviewed by Quarter SFY 2019

MMAI Health Plan	Q1	Q2	Q3	Q4
Aetna Better Health, Inc. (Aetna)	—	X	—	X
BCBSIL	X	X	X	X
Humana	—	X	—	X
IlliniCare	X	X	X	X
Meridian	X	X	X	X
Molina	X	X	—	X

Figure 2-3 displays a computed average of the total performance achieved by each health plan on all 15 CMS waiver performance measures reviewed by HSAG during SFY 2020. Each health plan's overall average on the 15 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Figure 2-3—Overall Compliance



Five of the six health plans averaged greater than 90 percent overall compliance in SFY 2020. There was an 11-percentage point difference (88 percent to 99 percent) among health plans.

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

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, averaged 33 percent compliance in SFY 2020. All five health plans with applicable cases performed at a rate of 50 percent or less in SFY 2020. A detailed analysis related to measure 4A is provided in Section 3 of this report.
- Measure 36D, the case manager made timely contact with the beneficiaries or there is valid justification in the record, averaged 75 percent and 70 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to measure 36D is provided in Section 3 of this report.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, averaged 80 percent compliance in SFY 2019. A detailed analysis related to measure 39D is provided in Section 3 of this report.

Remediation, Health Plan Interventions, and Process Improvements

Remediation

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

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

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of beneficiaries was maintained. HSAG will complete remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans. Results of this validation are included in Appendix B5.

Health Plan Interventions

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2019 reviews, efforts to incorporate technical assistance received during on-site reviews, and efforts to integrate HFS guidance into internal processes. Interventions and process improvements are summarized in Appendix B5.

HCBS Provider Network Monitoring

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

EQRO TA

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY 2020. Technical assistance was provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- Validation of waiver service provision.
- Timely case reassignment for beneficiaries who require a new case manager.
- Timely completion of annual reassessments, care plan, and waiver service plan.
- Timely completion of assessment, care plan, and waiver service plan update for beneficiary change in condition and/or needs.
- Timely completion of the initial service plan for beneficiaries determined to be newly waiver eligible.
- Effective use of online record review result reports.

3. Evaluation of Administrative and Compliance Processes

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

Administrative Compliance Reviews

One mandatory EQR requirement is a review, conducted within the previous three-year period, to determine the health plan's compliance with the standards set forth in subpart D of 42 CFR §438.358 and the quality assessment and performance improvement requirements described in 42 CFR §438.330. In fiscal year (FY) 2019, the first year of a new three-year review cycle, HSAG conducted an Evaluation of Administrative Processes & Compliance Review (Compliance Review) in accordance with §438.358 on a subset of standards selected by HFS for the six health plans serving HealthChoice Illinois (HCI). On-site reviews began in September 2019. The remainder of the HCI standards will be reviewed during FY 2020, along with a full set of standards for the MMAI program.

HSAG uses information and data derived from compliance reviews to reach conclusions and make recommendations about the quality, timeliness, and access of care of Medicaid services provided to Medicaid enrollees.

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

Standards

The Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards in operational areas of access, structure and operations, and measurement and improvement. Policies and procedures (P&Ps) related to the standards were reviewed via desk review, on-site interviews were conducted with key operational health plan staff, and a series of file reviews was completed to assess how well the health plan operationalized and followed those P&Ps, as listed in Table 3-1.

Table 3-1—Summary of SFY 2020 Standards and File Reviews

Standards	File Review
Access	
Standard III—Coordination and Continuity of Care	Care Management (CM) Record Review, Care/Disease Management Program Description (CMPD) Review
Standard IV—Coverage and Authorization of Services	Denials, Utilization Management Program Description (UMPD) Review, Peer Review Program Description (PRPD) Review
Standard VI—Children's Behavioral Health (CBH) Services	CBH Record Review

Standards	File Review
Structure and Operations	
Standard XI—Grievance and Appeal System	Appeals, State Fair Hearing/Independent Review Entity (SFH/IRE), Grievances
Standard XII—Organization and Governance	NA
Standard XV—Subcontractual Relationships and Delegation	Delegation, Provider Complaints, Provider Directory
Measurement and Improvement	
Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)	Quality Assurance Program Description (QAPD) Review

Health Plans

The Compliance Review was conducted with the six HCI health plans shown in Table 3-2. Four of the six HCI health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only.

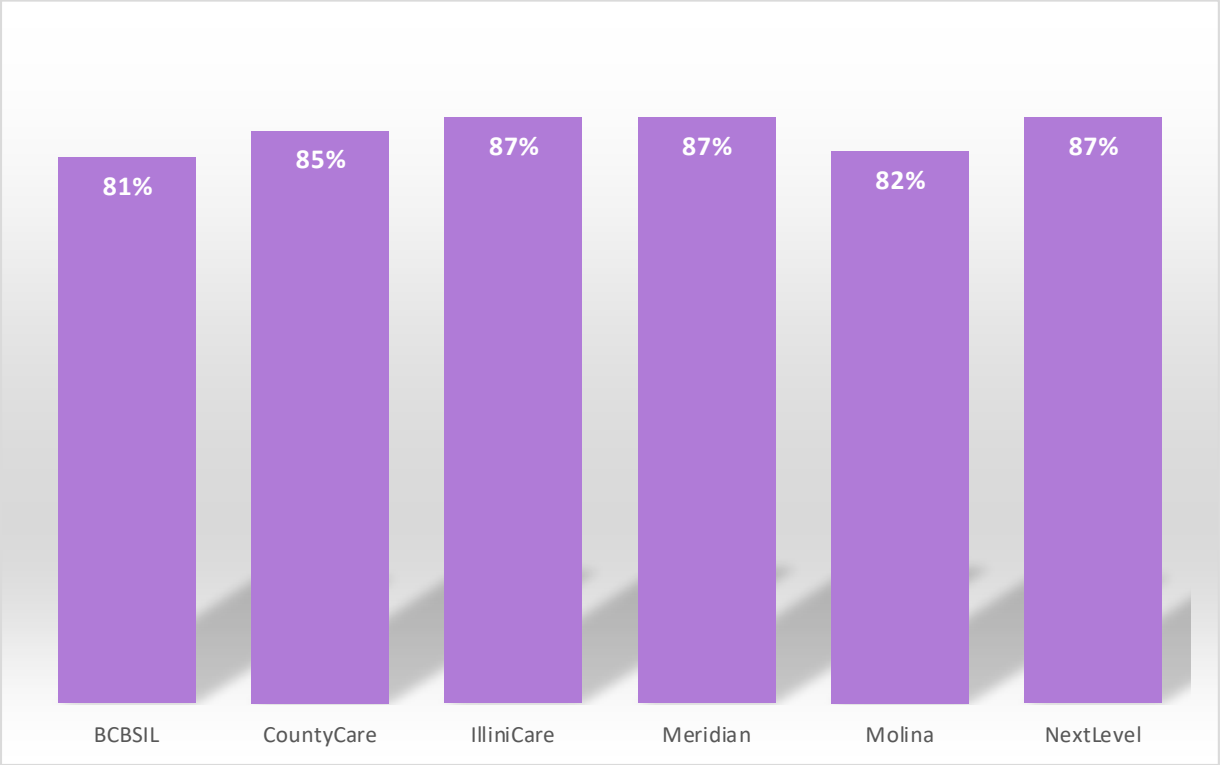
Table 3-2—HealthChoice Illinois Health Plans

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

Compliance with Standards

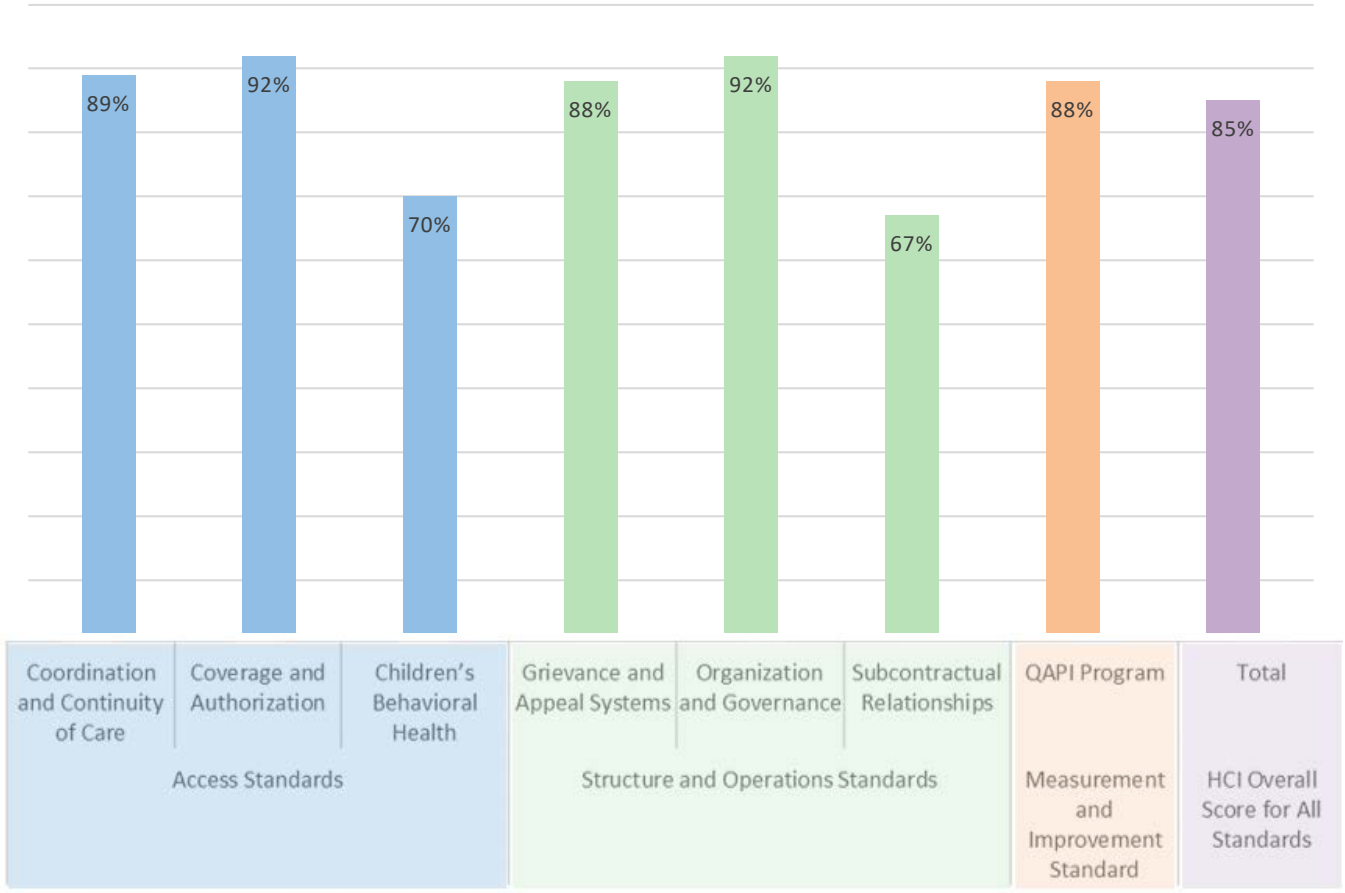
Figure 3-1 details the overall plan-specific compliance score for the seven standards reviewed during the Compliance Review.

Figure 3-1—Overall Compliance Ratings by Health Plan



As shown in Figure 3-1, all health plans achieved an overall compliance score between 81 and 87 percent. Generally, the health plans were compliant with policies and procedures, as well as program descriptions. However, opportunities for improvement were identified in file reviews, as shown in Figure 3-2.

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

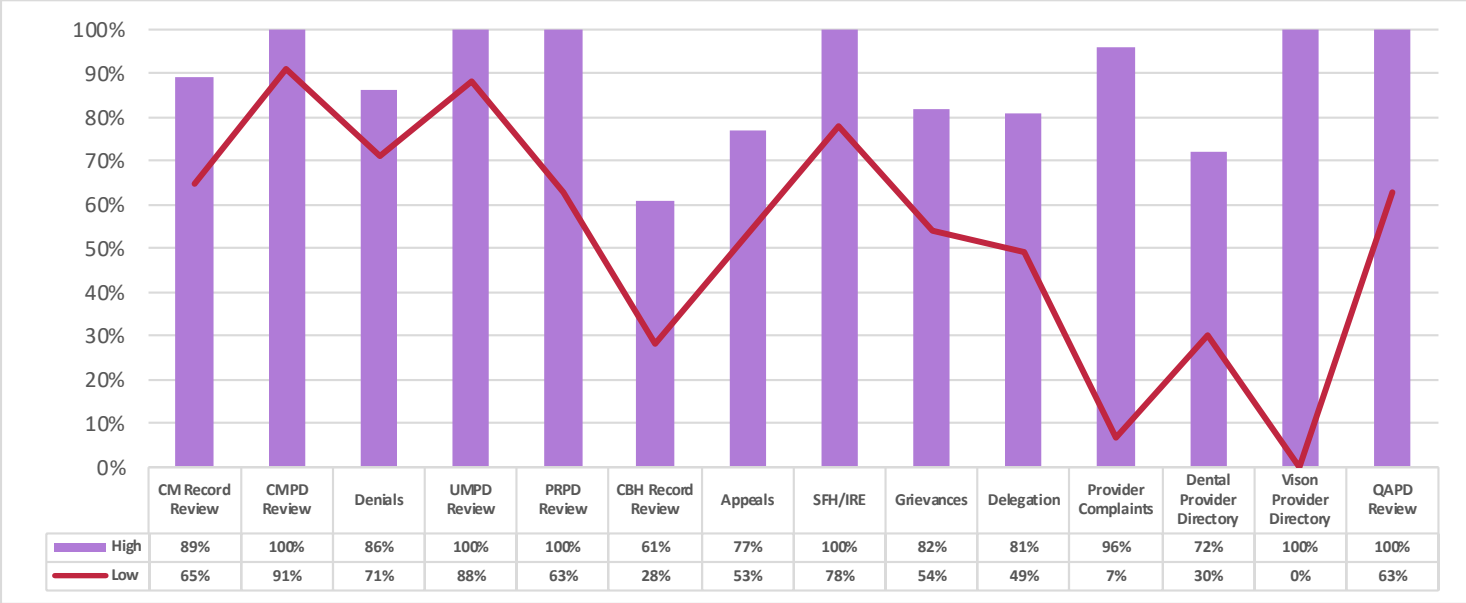


As shown in Figure 3-2, five of the seven standards scored between 85 percent and 92 percent and the overall score for all standards was 85 percent. The two standards identified as needing the most improvement were CBH Services and Subcontractual Relationships and Delegation. The Subcontractual Relationships and Delegation standard has been an area that continues to require improvement efforts across all health plans; therefore, health plans need to improve oversight of their delegated subcontractors through ongoing audits, monthly meetings, and quarterly review of subcontractor performance. For the CBH Services standard, the health plans have immediate opportunities for improving care management/care coordination services for children with behavioral health (BH) conditions. Contract requirements for conducting interdisciplinary care team meetings, improving enrollee contact and communication, follow-up with post discharge transitions of care, and oversight and monitoring of mobile crisis response providers require immediate quality improvement efforts to improve care coordination/care management (CC/CM) services to children with BH conditions.

Compliance with File Reviews

Figure 3-3 displays the high and low scores across the HCI plans for the file reviews and program description reviews to demonstrate the range of compliance identified.

Figure 3-3—HCI File Review Scores



	CM Record Review	CMPD Review	Denials	UMPD Review	PRPD Review	CBH Record Review	Appeals	SFH/IRE	Grievances	Delegation	Provider Complaints	Dental Provider Directory	Vison Provider Directory	QAPD Review
High	89%	100%	86%	100%	100%	61%	77%	100%	82%	81%	96%	72%	100%	100%
Low	65%	91%	71%	88%	63%	28%	53%	78%	54%	49%	7%	30%	0%	63%

As shown in Figure 3-3, file reviews identified that quality improvement efforts are needed in the following areas: care management, denials, CBH, appeals, grievances, delegation, provider complaints, and provider directories.

Plan-Specific Results

The Compliance Review included requirements that addressed Federal Medicaid managed care regulations and State standards. Many standards include requirements that address elements of access, timeliness, and quality of care; therefore, HSAG grouped the standards into operational domains of access, structure and operations, and measurement and improvement for the purposes of the Compliance Review.

BCBSIL

In the access domain, BCBSIL achieved an overall score of 90 percent for the coverage and authorization requirements, scores greater than 80 percent for three of the four domains in the care management/care coordination (CM/CC) file reviews, and a high level of compliance for the review of the CMPD review. Opportunities were identified to improve processing of denials and care

management/care coordination processes, including enrollee outreach, screenings, assessments, development and sharing of the care plan, and completion of crisis safety plans.

Review of structure and operations requirements identified that BCBSIL implemented process improvements to improve processing of grievances and appeals and to comply with delegation oversight requirements. However, opportunities were identified to continue improvement efforts for processing of appeals and grievances, including timeliness of processing appeals and resolution of grievances, use of approved HFS template letters for grievance resolution, and compliance with reading requirements. Opportunities were also identified to improve compliance with completion of required training of delegated vendors and inclusion of required language in delegated service agreement. An overall score of 57 percent compliance for the provider complaint file review identified opportunities to improve the provider complaint resolution process.

In the measurement and improvement domain, BCBSIL's policies and procedures lacked several contract requirements for the quality assurance program and opportunities were identified for improving the QAPD to clearly describe its methods for quality assessment and ongoing quality improvement. In addition, interview with key quality improvement staff did not verify compliance with oversight of the quality improvement program through activities conducted by the quality assurance committee.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication with primary care provide (PCP), establish effective enrollee outreach programs, and monitor timely completion of health risk screenings and care plans.
- Improve communication with enrollees regarding benefit determinations by monitoring denials processes, utilizing HFS letter template, monitoring denial letters, and revising the PRPD.
- Improve communication with providers and enrollees regarding appeal and grievance resolution by continuing to evaluate monitoring and oversight processes for timely resolution of grievances and appeals, establishing a monitoring and oversight process for appeal and grievance letters as well as the SFH/IRE process.
- Comply with requirements for key required positions by revising job descriptions and enhancing training for provider services staff.
- Implement effective oversight of delegated entities by monitoring training compliance, revising delegation service agreements, and continuing to improve delegation oversight.
- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements, implementing monitoring and oversight of the provider complaint resolution process, and establishing methods to evaluate provider satisfaction.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories, maintaining a paper form of the directory, and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.

- Evaluating review findings to revise and approve QAPI policies and procedures and enhance the QAPD.
- Improve documentation and oversight of QAPI activities by strengthening the oversight and evaluation of the quality improvement program and initiatives..

CountyCare

In the access domain, CountyCare achieved an overall score of 83 percent for the access domain and a high level of compliance for the review of the PRPD and CMPD. Opportunities were identified to improve processing of denials and care management/care coordination processes, including enrollee outreach, screenings, assessments, and development and coordination of the care plan.

Review of structure and operations requirements identified that CountyCare achieved a high level of compliance for required staffing. Opportunities were identified to improve timeliness of processing appeals and timely acknowledgement of grievances, use of approved HFS template letters, and compliance with reading requirements. In addition, findings demonstrated that CountyCare needed to improve oversight of delegated vendors, including compliance with completion of annual audit, completion of required training, quarterly review of vendor performance, and delegated service agreement required language

In the measurement and improvement domain, CountyCare achieved an overall score of 87 percent. The plan's QAPI policies and procedures did not clearly describe the activities of the quality assurance program and the QAPD methodology did not include review of care for all demographics and population groups and how those findings are communicated.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication with PCP, establish effective enrollee outreach programs, and monitor timely completion of health risk screenings and crisis safety plans.
- Improve communication with enrollees regarding benefit determinations by monitoring denials processes, utilizing HFS letter template, and implementing methods to meet reading level requirements for enrollee communication.
- Improve communication with providers and enrollees regarding appeal and grievance resolution by implementing effective monitoring and oversight processes for timely resolution of grievances and appeals and establishing a monitoring and oversight process for appeal and grievance letters.
- Comply with requirements for key required positions by revising job descriptions and enhancing training.
- Implement effective oversight of delegated entities by conducting pre-delegation and annual audits; reviewing, evaluating, and documenting quarterly performance of subcontractors during quarterly delegation oversight committee meetings; and monitoring training compliance.

- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements, implementing monitoring and oversight of the provide complaint resolution process, and establishing methods to evaluate provider satisfaction.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories, maintaining a paper form of the directory, and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.
- Evaluate review findings and revise QAPI policies and procedures to meet compliance with contract requirements for quality assurance program, utilization processes, quality assurance plan, focus on health outcomes, monitoring of all population groups, analysis of clinical care and related services, QAPI findings, actions taken, and results of actions taken.
- Revise and enhance the QAPD to describe methodology for review of the entire range of care provided; include all demographic groups, care settings, and health outcomes; and identify how the results of the review are communicated within the health plan.

IlliniCare

In the access domain, IlliniCare achieved full compliance for the review of the CMPD and PRPD, and a high level of compliance with the MLTSS CM File review. Opportunities were identified to improve processing of denials and care management/care coordination processes, including enrollee outreach, screenings, assessments, development and coordination of the care plan and completion of crisis safety plans.

Review of structure and operations requirements identified that IlliniCare achieved a HCI score of 100 percent for the SFH/IRE file review. Opportunities were identified to improve processing of appeals and grievances, including timeliness of processing expedited appeals and acknowledgement of grievances and compliance with reading level requirements. In addition, the plan needed to improve oversight of delegated vendors including compliance with completion of annual audit, completion of required training, quarterly review of vendor performance, and delegated service agreement required language.

In the measurement and improvement domain, IlliniCare achieved an overall score of 93 percent for the standard and 100 percent for the QAPD review. However, QAPI policies and procedures did not address women's access to contraception and the plan's process for developing, implementing, and evaluating care plans for children transitioning to adulthood as required.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication PCP, establish effective enrollee outreach programs, monitor timely completion of health risk screenings, and implement processes to ensure development of care plans.
- Improve communication with enrollees regarding benefit determinations by implementing a process to review denial language, ensure use of HFS letter template, and meet reading level requirements for enrollee communication.

- Improve communication with providers and enrollees regarding appeal and grievance resolution by implementing effective monitoring and oversight processes for timely resolution of grievances and appeals, evaluating system used to capture grievance system and add a data field to capture time a grievance is received, and establishing a monitoring and oversight process for appeal and grievance letters.
- Comply with requirements for key required positions by revising job descriptions and obtaining an HFS exception approval for the Care Management Manager who does not meet the qualifications requirements.
- Implement effective oversight of delegated entities by conducting annual audits; reviewing, evaluating, and documenting quarterly performance of subcontractors during quarterly delegation oversight committee meetings; monitoring training compliance; and revising delegation service agreements to include all contract requirements.
- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements and establishing methods to evaluate provider satisfaction with the complaint resolution process.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.
- Evaluate review findings and revise QAPI policies and procedures to meet compliance with contract requirements for addressing women's access to contraception and a process for developing, implementing, and evaluating care plans for children transitioning to adulthood as required.
- Demonstrate compliance with monitoring the quality of care across all services and all treatment modalities and that the plan's Quality Management Committee was co-chaired by a member of the Family Leadership Council as required.

Meridian

In the access domain, Meridian achieved an overall score of 93 percent for the Coverage and Authorization standard and a high level of compliance for the review of the CMPD and UMPD. Opportunities were identified to improve processing of denials and care management/care coordination processes, including enrollee outreach and contact, screenings, assessments, and development and coordination of the care plan.

Review of structure and operations requirements identified that Meridian's policies and procedures were generally compliant with program requirements. Opportunities were identified to improve timeliness of processing expedited appeals, use of approved HFS template letters, and compliance with reading requirements. The plan also needed to improve compliance with delegated vendor contracts and improve oversight of delegated vendors, including conducting delegated oversight committee meetings and completing required training for vendors.

In the measurement and improvement domain, Meridian achieved an overall score of 93 percent for the standard a score of 91 percent for the QAPD review. The QAPD did not have evidence of the required approvals and the quality assurance plan methodology failed to address the following requirements: inclusion of all demographics and population groups; health outcomes; monitoring and evaluation of the quality, appropriateness of, and timely access to care and service to enrollees; and description of analysis of clinical care and related services.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication with PCP and long-term care facilities, establish effective enrollee outreach programs, monitor timely completion of health risk screenings, implement processes to complete face-to-face contacts, and continue to recruit and hire CM/CC staff to fill open positions.
- Improve communication with enrollees regarding benefit determinations by continuing to monitor denials process through the use of frequent review of determination turnaround time reports to ensure timely response to service requests and monitor denial letters to ensure use of templates and appropriate reading levels, and personalized responses.
- Revise PRPD to describe system of internal review or a process to review the peer review procedures.
- Improve communication with providers and enrollees regarding appeal and grievance resolution by implementing effective monitoring and oversight processes for timely resolution of grievances and appeals and establishing a monitoring and oversight process for appeal and grievance letters.
- Comply with requirements for key required positions by revising job descriptions and recruiting and hiring a MIS Director that meets the qualifications of the position.
- Implement effective oversight of delegated entities by reviewing, evaluating, and documenting quarterly performance of subcontractors during quarterly delegation oversight committee meetings; monitoring training compliance; and revising delegation service agreements to include all contract requirements.
- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements, establishing methods to evaluate provider satisfaction with the complaint resolution process, and continuing initiative to implement a tracking number system to streamline issue resolution monitoring and to comply with HFS future contract requirements.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories, maintaining a paper form of the provider directory, and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.
- Update QAPD to reflect the required approvals.
- Revise and enhance the QAPD to describe methodology for review of the entire range of care provided; include all demographic groups, care settings, and health outcomes; identify how the results of the review are communicated within the health plan; monitor and evaluate the quality, appropriateness of, and timely access to care and service to enrollees; and describe analysis of clinical care and related services.

Molina

In the access domain, Molina achieved an overall score of 85 percent for the access domain and a high level of compliance for the review of the CMPD, UMPD, and PRPD. Opportunities were identified to improve processing of denials and care management/care coordination processes, including enrollee outreach, screenings, assessments, development and coordination of the care plan, and completion of crisis safety plans.

Review of structure and operations requirements identified that Molina achieved an overall score of 98 percent for the provider complaint resolution file review. Opportunities were identified to improve processing of appeals and grievances, including timeliness of processing expedited appeals and resolution of grievances, use of approved HFS template letters, compliance with reading requirements, and personalized resolutions. The plan also needed to improve oversight of delegated vendors, including compliance with completion of annual audit, completion of required training, quarterly review of vendor performance, and delegated service agreement required language. An overall score of 30 percent for compliance with dental directory requirements identified significant opportunities for improving oversight of the delegated dental vendor's compliance with directory requirements.

In the measurement and improvement domain, Molina achieved an overall score of 85 percent for the standard a score of 87 percent for the QAPD review. Opportunities were identified to revise QAPI policies and procedures to clearly describe the activities of the quality assurance program and revise the QAPD to enhance the methodology for review of care for all demographics and population groups and how those findings are communicated.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication with PCP, establish effective enrollee outreach programs, and monitor timely completion of health risk screenings.
- Improve communication with enrollees regarding benefit determinations by continuing to monitor denials process to ensure timely response and monitor denial letters to ensure use of templates and appropriate reading levels.
- Improve communication with providers and enrollees regarding appeal and grievance resolution by implementing effective monitoring and oversight processes for timely resolution of grievances and appeals, evaluating system used to capture grievances and add a data field to capture date and time a grievance is received, and establishing a monitoring and oversight process for appeal and grievance letters.
- Comply with requirements for key required positions by revising job descriptions and obtaining HFS exception approval for the care management manager who does not meet the qualifications requirements.
- Implement effective oversight of delegated entities by conducting annual audits; reviewing, evaluating, and documenting quarterly performance of subcontractors during quarterly delegation oversight committee meetings; monitoring training compliance; and revising delegation service agreements to include all contract requirements.

- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements and establishing methods to evaluate provider satisfaction with the complaint resolution process.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories, maintaining a paper form of the provider directory, and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.
- Evaluate review findings and revise policies and procedures to meet compliance with contract requirements for quality assurance program, utilization processes, and quality assurance plan, including: focusing on health outcomes; monitoring of all population groups; analyzing clinical care and related services; and describing findings, actions taken, and results of actions taken.
- Revise and enhance the QAPD to describe methodology for review of the entire range of care provided; include all demographic groups, care settings, and health outcomes; and identify how the results of the review are communicated within the health plan.

NextLevel

In the access domain, NextLevel achieved a high level of compliance for the CMPD and UMPD review and the MLTSS CM file review. Opportunities were identified to improve to improve processing of denials as well as HCI care management/care coordination processes, including enrollee outreach, completion of assessments, care plan documentation, and face-to-face contacts.

Review of structure and operations requirements identified that NextLevel achieved an overall score of 90 percent for the Grievance and Appeal System standard. Opportunities were identified to improve processing of appeals, acknowledgement of resolution of grievances, use of approved HFS template letters, compliance with reading requirements, and personalized resolutions. The plan also needed to improve oversight of delegated vendors, including compliance with completion of annual audit, completion of required training, quarterly review of vendor performance, and delegated service agreement required language.

In the measurement and improvement domain, NextLevel achieved an overall score of 90 percent for the standard and a score of 87 percent for the QAPD review. The QAPI policies and procedures did not clearly describe all activities of the quality assurance program and the QAPD methodology did not include a review of care for all demographics and population groups and how those findings are communicated. The QAPD also failed to specify the quality of care studies and methodologies and organizational arrangements used to accomplish them.

Based on the findings of the Compliance Review, HSAG recommended the following:

- Implement effective CM/CC processes to monitor timely communication with PCP, establish effective enrollee outreach program, monitor timely completion of health risk screenings, and implement process to complete face-to-face contacts.

- Improve communication with enrollees regarding benefit determinations by continuing to monitor denials process to ensure timely response, monitor denial letters to ensure use of templates and appropriate reading levels, and revise policy to include the required timeframe (48 hours) for processing of expedited denials.
- Improve communication with providers and enrollees regarding appeal and grievance resolution by implementing effective monitoring and oversight processes for timely resolution of grievances and appeals and establishing a monitoring and oversight process for appeal and grievance letters.
- Implement effective oversight of delegated entities by conducting annual audits; reviewing, evaluating, and documenting quarterly performance of subcontractors during quarterly delegation oversight committee meetings; conducting joint operations committee meetings; monitoring training compliance; and revising delegation service agreements to include all contract requirements.
- Revise provider complaint and resolution process by implementing changes necessary to comply with new HFS requirements, establishing methods to evaluate provider satisfaction with the complaint resolution process, and improving documentation of the provider complaint and resolution process.
- Establish process for updating provider directories including: conducting routine audits of delegated vendors' directories, maintaining a paper form of the provider directory, and complying with Federal and State provider directory requirements 305 ILCS 5/5-30.3 and 42 CFR §438.10.
- Evaluate review findings and revise policies and procedures to meet compliance with contract requirements for quality assurance program, utilization processes, and quality assurance plan, including: focusing on health outcomes; monitoring of all population groups; analyzing clinical care and related services; and describing findings, actions taken, and results of actions taken.
- Revise and enhance the QAPD to describe methodology for review of the entire range of care provided; include all demographic groups, care settings, and health outcomes; and identify how the results of the review are communicated within the health plan.

CBH Services Findings

The CBH Services program requirements were reviewed during the Compliance Review for the HCI health plans. The CBH assessment included a desk review of policies and procedures, care management file review, and interviews with key health plan staff. The CBH case management file review evaluated compliance with program requirements across four domains: mobile crisis, community stabilization, inpatient admission, and assessment. The HCI statewide overall compliance rating for the CBH Services standard was 65 percent. Opportunities for improvement were identified across all health plans regarding assessments and care plans, interdisciplinary care team meetings, enrollee contact and communication, post-discharge transitions of care, and oversight and monitoring of mobile crisis response providers. Plans received extensive recommendations for revamping their CBH care management programs.

As a result of poor performance, HFS required HSAG to conduct remediation follow-up for the CBH program requirements as part of the 2020 Compliance Review.

Remediation

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

For areas the health plans were found to not be meeting expected performance levels or standards, a corrective action plan (CAP) was developed. The CAP detailed the identified deficiencies and provided a reporting structure for the health plan to demonstrate progress toward improvement, including the goals of the corrective action; the timelines associated with the actions; the identified changes in processes, structure, and internal and external education; the type of follow-up monitoring, evaluation, and improvement required; and the identified improvements and enhancements of existing outreach and care-management activities, if applicable. HSAG monitored and evaluated corrective actions taken to assure that appropriate changes were made and were effective and conducted reevaluations to assess the sufficiency of the health plan's interventions, activities, and timelines to determine whether the actions would reasonably bring the health plan's performance into full compliance with the requirements.

Additional Information

HSAG produced individual reports for each health plan to detail strengths, weaknesses, and recommendations for improvement. Those reports are available upon request.

Readiness Reviews

Federal regulations at 42 CFR §438.66(d)(2) require states to conduct comprehensive readiness reviews to verify whether contracted health plans are prepared to provide services prior to enrolling Medicaid beneficiaries in managed care. In SFY 2020, HSAG conducted several program-specific readiness reviews at HFS' request. The details of each review are included below.

Special Needs Children

Introduction

HFS' statewide expansion plans included special needs children (SNC). HFS obtained a 1915(b) waiver to include populations of children with complex health and social service needs in the State's comprehensive mandatory Medicaid managed care program, HealthChoice Illinois. HFS defined the SNC population as individuals under the age of 21 who meet any of the following criteria:

1. Are eligible for Supplemental Security Income (SSI) under Title XVI;
2. Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the CORE Program);
3. Qualify as disabled;
4. Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS); or
5. Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E.

One health plan (YouthCare) was selected to provide services to DCFS Youth; however, all of the HealthChoice Illinois health plans were contracted to provide services for the remainder of the SNC population. Prior to implementation, HFS contracted with HSAG to conduct an SNC readiness review.

Scope of Review

To ensure health plans' readiness to serve the SNC population, HSAG incorporated and built upon the results of the HealthChoice Illinois Pre-Implementation and Post-Implementation readiness reviews and the corrective actions performed by the plans as a result of those reviews. As many of the requirements assessed in those reviews were applicable to the SNC program, HSAG worked with HFS to determine contract requirements specific to the SNC population and reviewed the 1915(b) waiver requirements to select the criteria for the SNC readiness review in order to evaluate health plan readiness to provide services to SNC for the statewide expansion. The purpose of the readiness review was to assess that health plans had the structural and operational capacity to perform the functions described in Illinois' SNC 1915(b) waiver, which delineates program requirements specific to the SNC population.

The SNC readiness review assessed the ability and capacity of health plans to perform satisfactorily for the following domains as specific to serving SNC in managed care: access, program operations, and quality. The SNC readiness reviews included an assessment of 17 elements specific to the population that span requirements in the SNC 1915(b) waiver and the Medicaid Model Contract. Fourteen elements were identified as critical.

The SNC readiness review included a Care Management (CM) Staffing Review and Provider Network Analysis. For the CM Staffing Review, HSAG analyzed the SNC 1915(b) waiver and the HealthChoice Illinois contract requirements related to CM staffing to evaluate the health plans' compliance with the requirements based on an analysis of staffing data as of January 1, 2020. HSAG analyzed non-contractually required data and information to inform HFS of the health plans CM program scope. In addition, HSAG analyzed the health plans' staffing submissions for the following contract requirements:

- Educational requirements of CM supervisors and CM staff members
- Qualification and training requirements of CM supervisors and CM staff members
- Caseload totals by risk stratification
- Weighted totals of caseload assignments
- IM-CANS trainer employment

Two network adequacy activities were conducted to evaluate and report on the capacity of the health plans' provider networks to serve the SNC population.

Results

Health plans were required to remediate all critical elements prior to the SNC implementation and demonstrate progress toward full compliance for all elements following implementation.

Illinois Department of Children and Family Services

Introduction

In addition, under HealthChoice Illinois, children in the care of DCFS are served by YouthCare. HSAG conducted a readiness review process throughout SFY 2020 specific to the DCFS population.

Scope of Review

The readiness review assessed the ability and capacity of YouthCare to perform satisfactorily for the following areas as specific to the DCFS managed care program:

- Operations/administration—administrative staffing and resources, delegation and oversight of health plan entity responsibilities, enrollee and provider communications, grievances and appeals, member services and outreach, provider network management, and program integrity/compliance.
- Service delivery—case management/care coordination/service planning, quality improvement, and utilization review.
- Financial management—financial reporting and monitoring, and financial solvency (assessed by HFS).

The purpose of the readiness review was to assess that YouthCare had the structural and operational capacity to perform the Medicaid managed care functions described in the Contract for Furnishing Health Services by a Managed Care Organization through the DCFS Youth Managed Care Specialty Plan 2020-24-401 between YouthCare and HFS, which delineates program requirements specific to the DCFS Youth population and ensures appropriate and timely access to quality healthcare services for DCFS Youth.

Results

The readiness review remediation tracking grid was used to track YouthCare's compliance with the remediation plan as a result of the readiness review findings. The columns within the tracking grid—initial scoring, additional submissions, submission sufficient and current scoring—were used to track YouthCare's progress toward remediation of noncompliant elements. The tracking grid was designed to track remediation efforts over time.

As of September 2020, YouthCare demonstrated 100 percent compliance with all readiness review elements, as displayed in Table 3-3.

Table 3-3—YouthCare Readiness Review Compliance

YouthCare Readiness Review Scoring—September 2020	
Percent Elements Completed	100% (51/51)
Percent Elements Not Completed	0% (0/51)
Percent Critical Elements Completed	100% (16/16)

The findings of the readiness review and subsequent remediation activities indicate that YouthCare has demonstrated compliance with the requirements for structural and operational capacity to perform the managed care functions for the youth in care (YIC) program described in the aforementioned contract between YouthCare and HFS.

Ongoing Monitoring

Throughout the postimplementation period, YouthCare will be required to submit updates on care coordinator staffing, provider network, and HealthWorks agency delegation reports to monitor ongoing compliance with contract requirements. In addition, HSAG will conduct a postimplementation review approximately six months after implementation.

4. Performance Improvement Projects (PIPs)

Overview

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

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

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

Introduction to Rapid-Cycle PIPs

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

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

Statewide Mandatory Topics

The MCOs submitted two State-mandated PIPs for validation: *Follow-Up After Hospitalization for Mental Illness,* with emphasis on 30-day follow-up, and *Transitions of Care—Patient Engagement After Inpatient Discharge.* Both topics are based on HEDIS measures; however, with the rapid-cycle approach, the MCOs use data analyses to determine a narrowed focus for each PIP. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of and access to care and services. The MCOs continued the topics from the prior fiscal year and will conclude the PIPs December 31, 2020.

Implementation and Training

Prior to the initial submission of Module 3 and Module 4, HSAG provided training to the MCOs and HFS on requirements of the targeted module and validation criteria. The MCOs may seek one-on-one individualized technical assistance throughout the PIP process and between the initial submission and resubmission(s) of modules. HSAG also conducts Module 4 check-ins with the MCOs while intervention testing to review progress and provide feedback and recommendations.

Objectives

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

Federal regulations, specifically 42 CFR §438.350, requires states that contract with MCOs to conduct an EQR of each contracting MCO. An EQR includes analysis and evaluation by an EQRO of aggregated

information on healthcare quality, timeliness, and access. HSAG serves as the EQRO for HFS, which is responsible for the overall administration and monitoring of the HealthChoice Illinois program.

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

Validation of PIPs

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

Plan-Specific Validation Results

Table 4-1 and Table 4-2 summarize the MCOs' performance for each PIP topic validated during SFY 2020. During SFY 2020, the primary PIP activities included Module 3 and Module 4 of the process—identifying and testing interventions. At this stage, PIPs are not yet formally evaluated on the SMART Aim measure outcomes. The PIPs will receive a final validation status after the completed Module 4s and Module 5s are submitted to HSAG in February 2021.

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

Follow-Up After Hospitalization for Mental Illness

Table 4-1—Plan-Specific Validation Results

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
BCBSIL	⇨ Goal: 33.4% to 43.4% By 12/31/2020, increase the percentage of 30-day follow-up rate for Hartgrove Hospital from 33.4% to 43.4% for members ages 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm who maintained their 30-day *FUH* appointment following a visit from each acute inpatient discharge from Hartgrove Hospital.	Module 1	3	Completed and Passed in SFY 2019
		Module 2	3	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
CountyCare	⇨ Goal: 34.84% to 50% By 12/31/2020, increase the percentage of acute inpatient discharges for members assigned to Care Management Entity (CME)-Complex Care Coordination with a principle diagnosis of mental health or intentional self-harm for which members 6 years of age and older received a follow-up visit with a mental health practitioner within 30 days from 34.84% to 50%.	Module 1	3	Completed and Passed in SFY 2019
		Module 2	3	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
IlliniCare	⇨ Goal: 43.97% to 59.66% By 12/31/2020, increase the percentage of discharges from Universal Health Service of Hartgrove, Presence Hospitals, Chicago Behavioral Hospital, and Riveredge Hospital for members 6 years of age and older who were hospitalized for treatment of selected mental illness or intentional self-harm diagnoses that are followed by an office visit within 30 days with a mental health practitioner from 43.97% to 59.66%.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
Meridian	⇨ Goal: 52.80% to 57.23% By 12/31/2020, increase the percentage of follow-up visits with a mental health practitioner for acute inpatient discharges for *FUH—30 Day* among members who were discharged from Chicago Behavioral, Riveredge or Touchette Hospitals from 52.80% to 57.23%.	Module 1	1	Completed and Passed in SFY 2019
		Module 2	1	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
Molina	⇨ Goal: 43.3% to 59.7% By 12/31/2020, increase the percentage of acute inpatient discharges with a principal diagnosis of mental illness or intentional self-harm from Methodist Medical Center for which HealthChoice Illinois members 6 years of age and older had a follow-up visit with a mental health practitioner within 30 days of discharge from 43.3% to 59.7%.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
NextLevel	⇨ Goal: 13.5% to 50% By 12/31/2020, increase the percentage of follow-up after hospitalization with a mental health practitioner within 30 days from 13.5% to 50% or greater for acute inpatient discharges ages 6 or greater with a principal diagnosis of mental health or intentional self-harm receiving care or care coordination through ACCESS Community Health Network.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and one progress check-in

Transitions of Care–Patient Engagement After Inpatient Discharge

Table 4-2—Plan-Specific Validation Results

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
BCBSIL	➡ Goal: 58% to 60% By 12/31/2020, increase the percentage of acute or nonacute discharges from Advocate Christ Hospital for which BCBSIL members 18 years of age and older had patient engagement (outpatient visit with or without a telehealth modifier, a telephone visit, or transitional care management services) follow-up within 30 days of discharge from 58% to 60%.	Module 1	3	Completed and Passed in SFY 2019
		Module 2	3	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
CountyCare	➡ Goal: 64.74% to 70% By 12/31/2020, increase the percentage of discharges 18 years and older, as of the last day of the baseline measurement period, with engagement through an outpatient visit, telephone visit, or other transitional care management service provided within 30 days of discharge from J H Stroger Hospital and assigned to CME-Complex Care Coordination from 64.74% to 70%.	Module 1	1	Completed and Passed in SFY 2019
		Module 2	1	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
IlliniCare	⇨ Goal: 47.57% to 62.17% By 12/31/2020, increase the percentage of acute and nonacute discharges for which the discharged member from Presence Rural Health Clinic (RHC), Ingalls, and Metro South has a patient engagement (e.g., office visits, visits to the home, telehealth) follow-up event within 30 day after discharge for members 18 years of age and older, during the measurement year (MY) from 47.57% to 62.17%.	Module 1	3	Completed and Passed in SFY 2019
		Module 2	3	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
Meridian	⇨ Goal: 41.75% to 45.44% By 12/31/2020, increase the percentage of acute or nonacute discharges for which members 18 years of age and older had patient engagement follow-up with a PCP from Advocate's Physician Partners within 30 days of discharge from 41.75% to 45.44%.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins

MCO	MCO Documented SMART Aim Statement	Module Status	# of Resubmissions	Validation Status
Molina	⇨ Goal: 50.40% to 54.42% By 12/31/2020, increase the percentage of acute or nonacute discharges within Southern Illinois Healthcare Foundation's HealthChoice Illinois membership for which members 18 years of age and older had patient engagement (outpatient visit with or without telehealth, a telephone visit, or transitional care management services) follow-up within 30 days of discharge from 50.40% to 54.42%.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and two progress check-ins
NextLevel	⇨ Goal: 70% to 90% By 12/31/2020, increase the percentage of follow-up visits within 30 days after acute or nonacute inpatient discharge for all aged, blind, or disabled (ABD) ACCESS males ages 18 years and older who are continuously enrolled from the date of discharge through 30 days after discharge from 70.0% to 90.0%. Engagement for follow-up includes outpatient visits with or without telehealth, a telephone visit, or transitional care management.	Module 1	2	Completed and Passed in SFY 2019
		Module 2	2	Completed and Passed in SFY 2019
		Module 3	1	Completed and Passed in SFY 2020
		Module 4	Not Applicable	Pre-validation review of the intervention plan and one progress check-in

The validation results show that the MCOs successfully completed Module 3 and progressed to Module 4, intervention testing for each PIP. The MCOs were successful in completing a process map and failure modes effects analysis (FMEA) at the level of their selected narrowed focus to identify gaps or opportunities for improvement. Based on the completed quality improvement tools, the MCOs identified potential interventions to test for the PIPs. In Module 4, MCOs started by submitting an intervention plan for pre-validation review and feedback. Following receipt of HSAG's recommendations, the MCOs began intervention testing. During intervention testing, HSAG conducted Module 4 intervention check-ins with the MCOs to review progress and provide feedback. The MCOs test interventions for the PIPs until December 31, 2020. In February 2021, the MCOs will submit completed Module 4s and Module 5s (PIP Conclusions) for validation.

Interventions

Table 4-3 and Table 4-4 summarize the MCOs' interventions for each PIP topic validated during SFY 2020. The tables include failure modes and interventions that the MCOs reported in the module submissions and whether interventions were selected for testing as reported by the MCOs in the Module 4 progress updates.

Follow-Up After Hospitalization for Mental Illness PIP

Table 4-3—Plan-Specific Interventions

MCO	Failure Mode	Potential Intervention	Selected for Testing
BCBSIL	Member discharges without a proper discharge plan and/or follow-up appointment.	MCO Utilization Management (UM) and Care Coordination (CC) teams identify, track, and analyze trending communication and discharge planning issues at Hartgrove Hospital. UM, CC, Network, and Quality teams meet monthly to review tracking log and schedule quarterly meetings, at minimum, with Hartgrove Hospital to resolve communication barriers, provide education, and improve transition of care (TOC) collaboration efforts that will provide increased support to members and improve post-discharge follow-up. MCO CC team will work collaboratively with pharmacy to obtain reporting and make targeted outreach attempts to members post-discharge to assess barriers to taking/filling medication, provide education, and assist with resolving barriers.	Yes
	Facility not returning MCO calls and/or not calling in discharge information timely.	MCO UM and CC teams identify, track, and analyze trending communication and discharge planning issues at Hartgrove Hospital. UM, CC, Network, and Quality teams meet monthly to review tracking log and schedule quarterly meetings, at minimum, with Hartgrove Hospital to resolve communication barriers, provide education, and improve TOC collaboration efforts to increase the frequency that CC can meet with members face-to-face during hospitalization.	Yes

MCO	Failure Mode	Potential Intervention	Selected for Testing
	Incorrect or untimely reporting notification of an admission.	CC and UM leadership teams work with reporting and systems teams to address daily UM census and system reporting. UM, CC, Network, and Quality teams meet monthly to review tracking log and schedule quarterly meetings, at minimum, with Hartgrove Hospital to resolve communication barriers and provide education on importance of timely reporting.	No
CountyCare	Care manager not notified of member's hospital admission.	Optimize resources available to the health plan and care management entity (CME) by sending the prior authorization information for mental health hospital admissions on a daily basis to the CME.	No
	TOC documents not completed.	Improve the work flow of completing the TOC documents by creating a standardized discharge document/template for the care manager to complete and share with the member, provider, and upload to the CME documentation system.	No
	No follow-up appointment scheduled prior to discharge.	CME will outreach member within two days of discharge to schedule follow-up after hospitalization appointment with mental health practitioner and will document scheduled appointment date and time.	No
	TOC documentation of the member's condition, needs, and the plan for follow-up care is incomplete or omitted.	TOC coordinators see every member admitted for mental illness for a face-to-face visit while inpatient.*	Yes
IlliniCare	Hospital schedules appointment that does not meet member preference. Follow-up appointment scheduled at discharge does not meet member preference. Behavioral health (BH) providers identified by hospital are not offering convenient hours.	(On-site) MCO CC to assist in discharge planning process and appointment scheduling prior to member's discharge.	Yes
	Hospital schedules appointment that does not meet member preference. Follow-up appointment scheduled at discharge does not meet member preference. BH providers identified by hospital are not offering convenient hours.	(Off-site) MCO CC that includes follow-up appointment tracker tool.	Yes

MCO	Failure Mode	Potential Intervention	Selected for Testing
	Member does not have transportation to keep the appointment.	MCO reminder calls at which time MCO offers CC including transportation assistance.	No
	Hospital schedules appointment that does not meet member preference.	Behavioral Health Appointment Request (BAR) form completed before discharge.**	Yes
	Timely identification of missed appointment and member re-engagement in order to reschedule a follow-up appointment within 30 days after discharge.	Confirmation of follow-up appointment attendance and member re-engagement.*	No
Meridian	CC unable to reach member after discharge.	Ensure appropriate training of Behavioral Health Transitions of Care (BH TOC) team for discharge processes and timelines. Track follow-ups within 72 hours of member discharge and streamline additional outreach attempts to determine most clinically effective timeline that ensures members can be reached and have opportunity to schedule and attend appointment before 30 days post-discharge. Focus facilities will include Chicago Behavioral, Riveredge, and Touchette hospitals.	Yes
	BH TOC team member does not meet with the discharge planner while the member is inpatient.	BH TOC team member will collaborate with the hospital discharge planner to help address barriers for the member with the goal of increasing the number of complete discharge plans received. Focus facilities will include Chicago Behavioral, Riveredge, and Touchette hospitals.	No
	Discharge facility does not submit discharge paperwork to MCO UM on the day of discharge.	BH TOC team member identifies members' admissions in the bi-weekly census of inpatient Meridian members provided by the hospital. BH TOC team member will also work with the hospital discharge planner to ensure that discharge paperwork is submitted to MCO in a timely manner with all needed information. Focus facilities will include Chicago Behavioral, Riveredge, and Touchette hospitals.	No
Molina	Member was unable to be contacted after missed follow-up appointment.	Update work flow for TOC team process for handling transient/homeless members prior to discharge. Add processes to obtain more information about the member and their routines to make contacting the member easier.	No

MCO	Failure Mode	Potential Intervention	Selected for Testing
	Appointment availability issues after missing follow-up appointment.	Develop a decision map to step TOC or care management through the levels of providers to attempt to get the member into a mental health practitioner during the 30-day window. Example: if a psychiatrist is not available, the next attempt should be with a masters-level practitioner, etc.	No
	Unable to contact member or hospital, or member declines assistance.	Work with discharge planner to ensure TOC contact information is included with the discharge plan.	Yes
NextLevel¥	Facility does not answer phone or return voice message.	Embedded staff at Holy Cross and Mt Sinai for face-to-face facility staff engagement.	No
	Facility does not call back after message left.	Embedded staff at Holy Cross and Mount Sinai for face-to-face facility staff engagement.	No
	Facility does not submit clinical information.	Electronic medical record (EMR) access (Epic-CareLink).	No
	MCO not aware of member's admission.	• EMR access (Epic-CareLink). • Facility census made available.	No
	Member does not obtain coordinated discharge plan between MCO and facility.	• Face-to-face facility and MCO staff engagement. • Face-to-face member engagement. • Coordinated discharge planning, MCO and facility staff.	No
	Member does not receive education about disease process, medications, and follow-up plan.	• Face-to-face member education coordinated with facility and MCO staff through embedded case managers. • Appointment made for follow-up prior to discharge. Communicated directly to member. • Medication and disease process education coordinated by MCO and facility staff.	No
	MCO does not engage member while inpatient.	• Access to EMR. • Collaboration with facility staff in discharge planning. • Census for Holy Cross and Mount Sinai.	No

MCO	Failure Mode	Potential Intervention	Selected for Testing
	MCO staff do not collaborate with facility on discharge planning.	• Access to EMR. • Collaboration with facility staff in discharge planning. • Census for Holy Cross and Mount Sinai.	No

* Intervention not included in Module 3; however, it was approved through the Module 4 pre-validation process.
** Intervention not included in Module 3 or Module 4; however, it was included in the intervention progress update.
¥ As of July 1, 2020, NextLevel ceased operations of its MCO in Illinois.

Transitions of Care–Patient Engagement After Inpatient Discharge PIP

Table 4-4—Plan-Specific Interventions

MCO	Failure Mode	Potential Intervention	Selected for Testing
BCBSIL	CC unable to reach member with pre/post-discharge planning needs.	CC will develop a notification system in collaboration with Christ Advocate Hospital that will provide real-time notification of member admission. Members are reached by CC while still inpatient for accurate member contact update and initiation of discharge planning.	Yes
	Member unable to get provider appointment within 30 days of discharge.	CC will contact member's provider to assist in securing an appointment within 30 days post-discharge.	No
	Member does not attend scheduled 30-day post discharge follow-up appointment.	CC will contact member to confirm that the member attended the scheduled appointment. Assess for barriers and services not addressed during pre/post-discharge planning that caused member to not attend the appointment.	No

MCO	Failure Mode	Potential Intervention	Selected for Testing
CountyCare	Care manager not notified of member's hospital admission.	Optimize resources available to the health plan and CME by sending the prior authorization information for hospital admissions on a daily basis to the CME.	No
	TOC documents not completed.	Improve the work flow of completing the TOC documents by creating a standardized discharge document/template for the care manager to complete and share with the member, provider, and upload to the CME documentation system.	Yes
	No follow-up appointment scheduled prior to discharge.	CME will outreach member within two days of discharge to schedule follow-up after hospitalization appointment and will document scheduled appointment date and time.	No
IlliniCare	MCO does not ensure member has follow-up visit scheduled. Hospital does not schedule follow-up visit. Barriers to discharge plan adherence not addressed prior to discharge. Member does not have transportation to follow-up visit. Member was not provided with opportunity to review discharge plan with the physician/nurse prior to discharge.	On-site CC to assist in discharge planning and appointment scheduling prior to member's discharge.	Yes
	MCO does not ensure member has follow-up visit scheduled. Hospital does not schedule follow-up visit. Barriers to discharge plan adherence not addressed prior to discharge. Member does not have transportation to follow-up visit.	MCO coordinates discharge planning meetings with hospital coordinators, member, and outpatient provider to ensure discharge plan is understood by all parties and any barriers to discharge plan adherence are addressed.	Yes
	Member does not have transportation to follow-up visit. Member forgets about follow-up visit. No follow-up with provider or member to re-engage member, address reason for no show and rescheduling.	MCO reminder calls at which time MCO offers CC including transportation assistance. MCO follow-up with provider and member to confirm attendance and rescheduling if member did not complete appointment.	Yes

MCO	Failure Mode	Potential Intervention	Selected for Testing
Meridian	CC is unable to contact member after discharge.	CC must complete three additional outreach attempts at seven days, 14 days, and 30 days after discharge, utilizing a best practice checklist for unable-to-reach members and document at least five separate sources to identify the most up-to-date member contact information. CC should reference the discharge paperwork and Advocate Physician Partners (APP) records. CC will provide targeted member assessments including medication reconciliations, appointment confirmation, evaluation of clinical status, and understanding of discharge plan to members assigned to APP as a Physician Hospital Organization (PHO).	Yes
	Discharge facility does not submit discharge paperwork to MCO UM.	Include due date for hospital to submit discharge paperwork to ensure timely notification to Meridian UM and oversight monitoring.	No
	Hospital discharge planner does not schedule a follow-up appointment for the member prior to discharge or create a comprehensive discharge plan.	CC provides oversight monitoring of discharge plan. CC sends email template to APP Advocate discharge hospital highlighting information that should be provided to Meridian upon discharge.	No
Molina	Member was unable to be contacted after missed follow-up appointment.	Update work flow for TOC team process for handling transient/homeless members prior to discharge. Obtain more information about members and their routines to make contacting the member easier.	No
	Member was unable to be contacted after missed follow-up appointment.	Work with discharge planner to ensure TOC contact information is included with the discharge plan.	Yes
	Member does not want to attend follow-up appointment.	Create a decision map of best practices for motivational interviewing members to step the TOC or CM through discussion with members that need encouragement to be more engaged in their healthcare and attend the follow-up appointment.	No
	Member may be high-risk (not identified) or highly engaged and helped in arranging the follow-up appointment and for other needs.	Outreach to members that are not high-risk/do not have one of the high-risk admitting diagnoses. Assist in setting up follow-up appointment.	No

MCO	Failure Mode	Potential Intervention	Selected for Testing
NextLevel[¥]	Facility does not answer phone or return voice message.	Embedded staff at Holy Cross and Mount Sinai for face-to-face facility staff engagement.	No
	Facility does not call back after message left.	Embedded staff at Holy Cross and Mount Sinai for face-to-face facility staff engagement.	No
	Facility does not submit clinical information.	EMR access (Epic-CareLink).	No
	MCO not aware of member's admission.	• EMR access (Epic-CareLink). • Facility census made available.	No
	Member does not obtain coordinated discharge plan between MCO and facility.	• Face-to-face facility and MCO staff engagement. • Face-to-face member engagement. • Coordinated discharge planning, MCO and facility staff.	No
	Member does not receive education about disease process, medications and follow-up plan.	• Face-to-face member education coordinated with facility and MCO staff through embedded case managers. • Appointment made for follow-up prior to discharge. Communicated directly to member. • Medication and disease process education coordinated by MCO and facility staff.	No
	MCO does not engage member while inpatient.	• Access to EMR. • Collaboration with facility staff in discharge planning. • Census for Holy Cross and Mount Sinai.	No
	MCO staff do not collaborate with facility on discharge planning.	• Access to EMR. • Collaboration with facility staff in discharge planning. • Census for Holy Cross and Mount Sinai.	No

[¥] As of July 1, 2020, NextLevel ceased operations of its MCO in Illinois.

Next Steps

The MCOs will progress to the next stage of the rapid-cycle PIP process, concluding the PIPs and completing Module 4 and Module 5. The SMART Aim measure outcomes and the Module 4 and Module 5 validation results will be reported in the next annual External Quality Review Annual Report.

5. Network Adequacy Validation

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

Section Contents

Network Adequacy Monitoring

HealthChoice Illinois Network Monitoring

Introduction

During SFY 2020, health plans were required to submit quarterly provider network data files for required provider types outlined in the *Provider Network Data Submission Instruction Manual* provided by HSAG. The data files were used to conduct analysis and monitoring of the provider network to ensure compliance with the Medicaid Model contract and federal requirements.

Health plans must notify HFS of provider terminations for network providers serving 100 or more active enrollees. HSAG was required to conduct analysis of the impact of the provider termination(s) to the health plan network. Based on the results of the termination analysis, health plans were required to develop contingency plans to transition enrollees to other network providers, and if necessary, contract with available providers within the affected service area to remediate network gaps. Results of the impact analyses conducted during SFY 2020 are available upon request.

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

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

Results

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

Analysis and monitoring of the HealthChoice Illinois provider network throughout SFY 2020 verified that the health plans contracted with a sufficient number of required providers types within each service region. SFY 2020 biannual provider network reports are available upon request.

For more detailed results, see the regional comparison in Appendix E2.

Recommendations

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

- Continue monitoring health plans' contracting efforts and network development through a review of the provider data.

- Continue to enhance the accuracy of reporting for all adult and pediatric providers serving appropriate age groups.
- Evaluate health plan resources and systems to more efficiently complete the loading process for newly contracted providers.
- Continue to improve the accuracy of reporting individual providers within provider/physician groups, hospitals, CMHCs, FQHCs, and RHCs.
  - Work with contracted providers to receive accurate and updated provider rosters.
- Evaluate the frequency of online and paper provider directories audits for compliance with directory requirements.
  - Examine the process and timeliness of completing updates to the provider directory.
  - Include audits of the delegated online directories for compliance with directory requirements; for example, dental and vision provider directories.
- Pursue contracts with any available provider(s) within rural areas.
- Continue to pursue single-case agreements with out-of-network providers until a qualified in-network provider is contracted/available.
- Explore contracting opportunities with providers available in counties bordering Illinois (e.g., St. Louis County, Missouri).

MLTSS Network Monitoring

Introduction

HFS directed its EQRO to establish a process for health plans to submit provider network data quarterly for each of their service areas, including MLTSS. The network analysis allows HFS to evaluate provider network capacity across the health plans using a multifaceted, iterative, and standardized approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy.

The EQRO also conducted a statewide analysis to evaluate the contracting of nursing facilities and, based on the results of this analysis, HFS estimated the number of assigned enrollees within the noncontracted nursing facilities and required all health plans to begin contracting efforts with these facilities to ensure a seamless transition for enrollees residing in these nursing facilities. Health plans are required to update the nursing facility contracting workbook to document the status of contracting efforts.

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

During this reporting period, health plans submitted MLTSS provider network data on May 15, 2020. The analysis showed that all statewide health plans were in compliance with the requirement to contract with at least two providers for each of the required service categories across all regions. See Appendix E3 for detailed results.

The health plans also submitted updated nursing facility contracting workbooks on May 15, 2020. From these data, the EQRO prepared a quarterly report that HFS used to monitor health plan progress toward executing contracts with noncontracted nursing facilities.

Results

The contracting summary results for nursing facilities as of May 2020 are summarized below:

- IlliniCare, Meridian, and Molina contracted with 21 of the 32 facilities.
- BCBSIL contracted with 15 of the 32 facilities.
- CountyCare contracted with three of the four facilities in its service region, while NextLevel contracted with all four facilities in its region.

Time/Distance Analysis

Introduction

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

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

Methodology

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

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

HFS and the health plans provided Medicaid enrollee demographic information and provider network files to HSAG for use in the time/distance analysis. The health plans submitted the provider data as part of their regular, ongoing submissions to HSAG. HSAG cleaned, processed, and used the provided data to define unique lists of providers, provider locations, and enrollees for inclusion in the analysis. Then, HSAG standardized and geocoded all Medicaid enrollee and provider addresses and conducted analyses by region to illustrate differences by Illinois region. Additional details about the methodology for the time/distance analysis are in the SFY 2020 Provider Network Time/Distance Analysis Report in Appendix E4.

Findings

This report presents the percentage of enrollees with each health plan who have access to providers within the time/distance standards statewide and for each region and the percentage of counties per region meeting the contract requirements defined in the HealthChoice Illinois Medicaid model contract. HSAG validated the time/distance requirements for 22 provider categories within each service region.

Overall time/distance results for all five regions are summarized as follows:

- BCBSIL was compliant with contract standards for 19 provider categories across all service regions.
- IlliniCare, Meridian, and Molina were compliant with contract standards for 20 provider categories across all service regions.
- CountyCare was compliant with contract standards for 21 provider categories in the Cook County service region.
- NextLevel was compliant with contract standards for all provider categories in the Cook County service region.

Table 5-1 displays overall health plan compliance with the time/distance standards for all provider categories included in the study.

Table 5-1–Regional Summary for Enrollees Residing Within Time/Distance-Based Access Standards and Non-Complaint Provider Categories by Health Plan*

	Statewide Health Plans				Cook County Only Health Plans	
Health Plans	**BCBSIL**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Provider Categories						
Adult PCPs	✓	✓	✓	✓	✓	✓
Pediatric PCPs	✓	✓	✓	✓	✓	✓
Adult Behavioral Health Service Providers	✓	✓	✓	✓	✓	✓
Pediatric Behavioral Health Service Providers	✓	✓	✓	✓	✓	✓
Obstetrician/Gynecologist (OB/GYN) Providers	✓	✓	✓	✓	✓	✓
Dentistry, Adult	✓	✓	✓	✓	✓	✓
Pediatric Dentist	✓	✓	✓	✓	✓	✓
Hospitals	✓	✓	✓	✓	✓	✓
Pharmacies	1, 2, 5	2	2	1, 2	✓	✓
Specialists						
Allergy and Immunology	✓	✓	✓	✓	✓	✓
Cardiology	✓	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓	✓
ENT/Otolaryngology	✓	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓	✓
General Surgery	✓	✓	✓	✓	✓	✓
Infectious Disease	✓	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓	✓
Neurosurgery	1,3	✓	✓	✓	✓	✓
Oncology	✓	✓	✓	✓	✓	✓
Oral Surgery	1, 2, 3	1, 2, 3	1, 2, 3	3	✓	✓
Psychiatry	✓	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	4**	✓

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except pharmacy providers, for which the contract standard requires that 100 percent of enrollees have access to providers within the access standard. Check marks (✓) indicate that the health plan met the time/distance requirements in all regions for the identified provider category. Numeric values in red font indicate the region number for which the health plan was noncompliant.

** No urology providers were present in the data HSAG received from CountyCare, which may indicate a data issue rather than a network gap.

Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- While most health plans are meeting the contract standards for most provider categories, HFS should collaborate with the health plans to continue to monitor the status of time/distance standards for all provider categories. Additionally, HFS and the health plans should continue to improve provider data collection to indicate populations served by the providers, especially regarding pediatric providers. Future time/distance analyses should be stratified for pediatric providers to ensure that these providers are accurately represented in the health plans' networks so that the unique needs of the pediatric population can be met.
- HFS should continue to collaborate with those health plans that do not meet the time/distance standards in specific regions to contract with additional providers, if available. Provider categories of concern include pharmacies, neurosurgery, and oral surgery.
- HFS should conduct an in-depth review of provider categories for which no health plans met the time/distance standards, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories for which providers may not be available or willing to contract with the health plans.
- As time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should continue using appointment availability surveys to evaluate providers' availability. HSAG also recommends incorporating encounter data to assess enrollees' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- HFS should continue to develop requirements for long-term services and supports (LTSS) providers that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule.

Provider Network Access and Availability Survey

Introduction

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

HFS directed HSAG to conduct two secret shopper telephone surveys. The results of the first survey of PCPs and OB/GYN providers are summarized in this report. A subsequent report will summarize the results of a survey of dental and specialty providers. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential biases introduced by knowing the identity of the surveyor.

The goal of the Access and Availability PCP and OB/GYN Secret Shopper Survey was to evaluate appointment availability among the health plans' networks of primary care and OB/GYN providers.

Findings

Results of the secret shopper survey of primary care and OB/GYN providers on access and availability of provider offices indicate an overall response rate of 50.3 percent, which exceeds a typical provider response rate of approximately 15 percent to 20 percent for similar studies. By health plan, providers' response rates ranged from 39.8 percent to 69.2 percent.

HSAG found that 10.5 percent of the providers did not accept the health plan, and only 0.8 percent did not accept Medicaid. Moreover, 3.9 percent of the providers indicated that they were specialists, and 5.8 percent of all health plans did not accept new patients, ranging from 1.9 percent to 12.5 percent.

Ninety percent of the providers accepting the health plan and Medicaid confirmed being a PCP or OB/GYN provider as listed in the provider data. Of these, 83.4 percent reported accepting new patients, but limitations to scheduling appointments were observed across health plans. Appointment availability without a noted limitation was reported in 36.5 percent of all survey calls where the provider accepted the health plan, Medicaid, and new patients, with a range from 16.2 percent to 60.0 percent across the health plans.

Despite the limited number of cases with appointment availability, PCP offices that could be reached and that offered appointments for new Medicaid patients requesting sick visits were in compliance with the contract standards for 82.4 percent of the offered appointments. For new Medicaid patients requesting routine well-checks, these offices were in compliance with the contract standards for 88.7 percent of the offered appointments. The average time to appointment was similar for both routine and sick PCP visit types. The all health plan median time to appointment for well-checks was 12 days, slightly longer than for sick visits (i.e., 10 days).

The OB/GYN appointments complied with contract standards in 68.1 percent of cases for first trimester visits. For second trimester visits, 25.0 percent of these appointments complied with contract standards, ranging from 0.0 percent (NextLevel) to 46.2 percent (IlliniCare and Meridian). As expected, the mean time to appointment for the first trimester (13.1 days) was shorter than for the second trimester (18.2 days). The same was true for the median days to appointment (12 versus 14 days).

Recommendations

Based on the survey results presented in this report, HSAG identified several opportunities for improvement related to accurate provider information, enrollees' ability to successfully schedule an appointment, and the timeliness of available appointments relative to enrollees' needs. HSAG offers the following recommendations to address potential opportunities to improve access among enrollees covered by HealthChoice Illinois managed care plans:

- HSAG was unable to reach more than 30 percent of sampled cases for each health plan, and a key nonresponse reason involved call attempts in which the provider was no longer at the location listed in the provider data.
  - As the health plans are required to conduct annual provider directory audits and confirm provider information for providers who have not submitted a claim within six months, HFS should continue conducting oversight of the health plans' provider directory reviews and require the health plans to review the findings. Additionally, HFS should follow up with the health plans regarding deficiencies noted in the reviews and collaborate with the health plans to ensure that deficiencies are resolved for the subsequent year's review.
  - HFS should consider collaborating with its EQRO to conduct an independent provider directory review to validate the information provided to enrollees in the online provider directory and to validate the findings from the health plans' annual provider directory audits.
- HSAG was only able to obtain an appointment date with 43.6 percent of the sampled providers who accepted the health plan, Medicaid, and new patients. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, designation with the PCP through insurance prior to appointment scheduling, and medical record review. While some barriers pose unique limitations to a secret shopper survey where caller information cannot be provided to the office (e.g., pre-registration or requiring personal information to schedule), other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments. HFS and the health plans should consider

conducting a review of the provider offices' requirements to ensure that the barriers are not unduly burdening enrollees' ability to schedule an appointment.

- In coordination with ongoing outreach and network management activities, the health plans should review physician office procedures for ensuring that appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials. In particular, HFS and the health plans should work with OB/GYN providers to ensure (1) that providers are aware of the different appointment availability standards based on a woman's trimester and (2) that barriers to scheduling appointments are identified and corrected.
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with specific geographic areas. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with standards.
- HFS should continue to monitor the health plans' compliance with existing State standards for appointment availability and audits to assess the accuracy of their online provider directories to ensure enrollees' access to services. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.

More details are available in the SFY 2020 Provider Network Access and Availability Survey: Primary Care Providers (PCPs) and Obstetrician/Gynecologist (OB/GYN) Providers Report (February 2020) in Appendix E5.

Provider Network Readiness Reviews

YouthCare Network Readiness Review

Children in the care of the DCFS, including those formerly in care who have been adopted or who entered a guardianship (DCFS Youth), were incorporated into HealthChoice Illinois. IlliniCare was contracted as the DCFS Youth Managed Care Specialty Plan (YouthCare) to provide managed care services for DCFS Youth. HSAG conducted a readiness review process throughout SFY 2020 specific to the DCFS population, which included an ongoing review of network adequacy.

Network Analysis Activities

The following activities were conducted to evaluate, validate, and monitor network capacity prior to program implementation:

1. Match analysis—HSAG completed an analysis of the CY 2019 DCFS utilization file to review the services billed by DCFS providers and categorized DCFS providers as "high spend" or "low spend" based on paid claims in CY 2019. HSAG conducted a match analysis of the tax identifications (IDs) and/or National Provider Identifiers (NPIs) within the DCFS utilization file against the YouthCare provider network data to determine the number of matched and nonmatched DCFS providers. Hospitals were matched by tax ID, and all other providers were matched by NPI.
2. Supplemental DCFS utilization data—HSAG completed a supplemental match analysis for a subset of DCFS providers who provided services to approximately 400 children with complex needs for CY 2018 and CY 2019. A "percent spend" was calculated to reflect the spend (claims payments) represented by matched DCFS providers.
3. HFS also requested that HSAG conduct a match analysis for providers who provided services to children with complex needs that were in the physician category. Providers were matched by tax ID and count of unique tax IDs as well as by NPI and count of unique NPIs.
4. Nonmatched provider list—HSAG sent YouthCare and HFS a full list of DCFS providers who were not matched based on NPI and tax ID. YouthCare was required to review the list of DCFS providers who were not matched and verify that the provider network data included all contracted providers.
5. YouthCare enhanced provider network review—HSAG conducted a provider network review that included all contracted providers by region, county, and provider/specialty type.
6. HealthWorks agencies contracting—HSAG verified that YouthCare contracted with all HealthWorks lead agencies.
7. Identified contracting priorities for noncontracted providers—YouthCare was required to continue to pursue contracts with the high-volume priority providers identified in the DCFS contracting workbook and continue submission of the provider network data files and contracting workbook to demonstrate compliance with the DCFS provider network requirements and to address any network gaps identified during development of the DCFS provider network.

8. Continued monitoring and evaluation of provider network adequacy—HFS required HSAG to conduct ongoing review of the YouthCare provider network capacity and adequacy and identify any gaps in services.

Results

DCFS worked with YouthCare to ensure a smooth transition that allowed youth in care to continue to see any healthcare provider, even those not in the YouthCare network. YouthCare executed contracts with noncontracted providers and used single case agreements with noncontracted providers. More details are available upon request.

DCFS Time/Distance Analysis

HFS requested that HSAG conduct a time/distance analysis of the YouthCare DCFS network as part of the DCFS readiness review. The purpose of this time/distance analysis was to evaluate the degree to which the health plan complies with network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7. HSAG validated the time/distance-based access standards for 24 provider categories within each service region across the state, including six provider categories (pediatric PCPs, pediatric behavioral health providers, OB/GYNs, pediatric dentists, hospitals, and pharmacies) and 18 types of pediatric specialists. A series of four different time and distance studies was conducted, the final using the provider network data file submitted on July 1, 2020.

Results

YouthCare was compliant with access standards for pediatric PCPs, pediatric behavioral health providers, OB/GYNs, pediatric dentists, and hospitals across all service regions in the state. YouthCare was also compliant with 12 pediatric specialty provider categories across all service regions in the state. More details are available upon request.

Special Needs Children (SNC) Readiness Review

HFS' statewide managed care expansion also included SNC. HFS obtained a 1915(b) waiver to include populations of children with complex health and social service needs in the State's comprehensive mandatory Medicaid managed care program, HealthChoice Illinois. One health plan (YouthCare) was selected to provide services to DCFS Youth; however, all of the HealthChoice Illinois health plans were contracted to provide services for the remainder of the SNC population. Prior to implementation, HFS contracted HSAG to conduct an SNC readiness review. Two network adequacy activities were conducted to evaluate and report on the capacity of the health plans' provider networks to serve the SNC population.

SNC Network Analysis Activities

During the SNC network readiness review prior to SNC Waiver implementation in February 2020, HSAG maintained ongoing communication with the health plans and HFS regarding any findings and recommendations. Health plans were required to address and correct any identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps. HSAG monitored and reported to HFS the health plans' compliance with establishing an adequate provider network in preparation for the SNC expansion.

At the request of HFS, HSAG established a process for health plans to submit provider network data quarterly for each of their service areas, including SNC. HSAG worked extensively with HFS and the health plans to standardize the format that the health plans use to report on the providers in their networks. The standardized format includes standardized provider categories, a protocol to detect and minimize duplications of providers, and expanded provider network reporting, including counts of providers by counties within the health plan. Health plans submit a standardized Provider File Layout (PFL) that includes a range of provider types specific to SNC services, including pediatric providers such as PCPs, specialists, FQHCs, LTSS, pediatric hospitals (including hospitals with pediatric wings), and transportation providers. Following submission, HSAG conducts a validation process and produces health plan-specific and comparative network reports to identify the number of provider types within each county and region across the state. The network analysis allows HFS to evaluate provider network capacity across the health plans, using a multifaceted, iterative, and standardized approach. These data are used to support ongoing monitoring, assessment, and reporting activities to evaluate provider network adequacy.

DSCC Core Population Network Readiness Review

As of May 20, 2020, HFS changed the methodology for review and validation of the health plans' provider network based on updated DSCC utilization data. The updated DSCC utilization file included all DSCC FFS utilization for CY 2018 and CY 2019, which included additional providers compared to the original DSCC utilization data for CY 2018.

HSAG completed an analysis of the DSCC utilization file to review the types and amount of services billed by DSCC providers. HSAG categorized DSCC providers as "high spend" or "low spend" based on paid claims in CY 2018 and CY 2019. "High spend" providers were paid claims greater than $50,000 and "low spend" providers were paid claims between $10,000 and $49,999. This analysis allowed the health plans to focus contracting efforts on the high-cost/high-spend network providers.

HSAG categorized all the provider types included within the DSCC utilization files into provider categories as directed by HFS. HSAG shared the categorization with the health plans to inform them which provider types were grouped under each provider category for the network analysis.

DSCC Utilization Network Analysis

The following DSCC activities were conducted to evaluate, validate, and monitor network capacity prior to program implementation.

1. **DSCC utilization data.** DSCC providers who provided services to more than 2,000 children (CORE population) during CY 2018 and CY 2019.
2. **DSCC utilization data—match analysis.** HSAG completed a match analysis by matching the tax IDs and NPIs included in the DSCC utilization data against the health plans' provider network data submitted. This allowed HSAG to approximate the number of DSCC providers contracted by the health plans.
3. **Nonmatched provider list.** HSAG sent the health plans and HFS a full list of DSCC providers who were not matched based on NPI and tax ID. Health plans were required to review the list of DSCC providers who were not matched and verify that the provider network data included all contracted providers. HSAG maintained ongoing communication with the health plans regarding any data discrepancies identified during the match analysis process.
4. **Pediatric provider network review.** HSAG conducted a pediatric provider network review that included a summary of contracted pediatric providers by region and provider category.
5. **Pediatric hospital network review.** HSAG conducted data validation between the health plan provider data and the HFS list for pediatric hospitals to determine the number and percentage of contracted pediatric hospitals (including pediatric units) by health plan.
6. **Identified contracting priorities for noncontracted providers.** Health plans were required to continue to pursue contracts with the high-volume priority providers identified in the DSCC contracting workbook. Health plans are required to continue submission of the provider network data files and contracting workbook to demonstrate compliance with the DSCC provider network requirements and to address any network gaps identified during development of the DSCC provider network.
7. **Continued monitoring and evaluation of provider network adequacy.** HFS requires HSAG to conduct a biannual review of the health plans' provider network capacity and adequacy and identify any gaps in services.

Ad Hoc Provider Network Reporting

HSAG produces ad hoc network reports at the request of HFS. The reports are completed in a specified format to comply with HFS' requirements and the information in these reports may include specific provider types for particular enrollee populations, freedom of information act (FOIA) requests, specific zip code analysis and county-specific analysis for individual provider types. HSAG also prepares network reports to CMS in order to provide information prior to implementation of programs that are jointly administered by CMS.

The reports listed below were produced in SFY 2020 in response to HFS provider network requests:

- Tertiary Hospital Review—health plan-specific review of contracted transplant centers within hospitals
- DCFS Utilization Data Review—prior to DCFS program implementation
- DCFS Specialty Provider Review—focused analysis of the availability of pediatric specialty providers in regions/counties that were identified as noncompliant with time/distance standards
- Primary Care Physicians Validation Review—verification of PCP counts self-reported by the health plans prior to HFS approval for distribution of health plans' enrollment packets
- Provider Network Impact Analysis by Provider Type and Region—plan-specific provider termination(s)

6. Beneficiary Experience With Care

Overview

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

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

Health plans are required to independently administer surveys which provide HFS with important feedback on performance and are used to initiate changes to improve members' experiences with the managed care programs. Additional details about CAHPS methodology are presented in Appendix F1 and detailed results are included in Appendix F2 of this report.

CAHPS Measures

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

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

HFS contracted with six health plans to provide healthcare services to HealthChoice Illinois beneficiaries. Four of the HealthChoice Illinois health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. Table 6-1 displays the health plans that reported CAHPS data for SFY 2020.

Table 6-1—HealthChoice Illinois Health Plans for 2020 CAHPS

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

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

To evaluate trends in member experience, HSAG performed a trend analysis that compared the 2020 top-box scores to the corresponding 2019 top-box scores. Top-box score results that were statistically significantly higher in 2020 than in 2019 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2020 than in 2019 are noted with downward (▼) triangles. Top-box

scores in 2020 that were not statistically significantly higher or lower than scores in 2019 are not noted with triangles.

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

Table 6-2—Star Ratings

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

Summary of Performance

Adult CAHPS Medicaid Surveys

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

Table 6-3—Adult Aggregate Results

	2019	2020	Trending Results (2019–2020)
Composite Measures			
Getting Needed Care	82.1% ★★	81.0% ★★	—
Getting Care Quickly	82.0% ★★	81.0% ★★	—
How Well Doctors Communicate	92.9% ★★★	93.2% ★★★	—
Customer Service	89.8% ★★★	89.8% ★★★	—
Global Ratings			
Rating of All Health Care	54.6% ★★	56.7% ★★★	—
Rating of Personal Doctor	69.0% ★★★	69.4% ★★★	—
Rating of Specialist Seen Most Often	68.1% ★★★	67.0% ★★	—
Rating of Health Plan	59.3% ★★	59.9% ★★	—

— Indicates the 2020 score is not statistically significantly higher or lower than the 2019 score.

Notable

- The star rating improved from 2019 to 2020 for *Rating of All Health Care*.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that adult members reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*.
- The star rating declined from 2019 to 2020 for *Rating of Specialist Seen Most Often*.
- Overall, no statistically significant trends were observed.

Child CAHPS Medicaid Results

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

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

	2019	2020	Trending Results (2019–2020)
Composite Measures			
Getting Needed Care	79.7% ★	81.0% ★	—
Getting Care Quickly	85.6% ★	88.2% ★★	—
How Well Doctors Communicate	93.6% ★★	94.2% ★★★	—
Customer Service	87.1% ★	86.2% ★	—
Global Ratings			
Rating of All Health Care	70.6% ★★★	73.6% ★★★	—
Rating of Personal Doctor	77.1% ★★★	78.1% ★★★	—
Rating of Specialist Seen Most Often	72.9% ★★	74.4% ★★★	—
Rating of Health Plan	69.7% ★★	68.3% ★	—

— Indicates the 2020 score is not statistically significantly higher or lower than the 2019 score.

Notable

- Star ratings improved from 2019 to 2020 for *Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often*.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Rating of Health Plan*.
- The star rating declined from 2019 to 2020 for *Rating of Health Plan*.
- Overall, no statistically significant trends were observed.

Statewide Survey Results

HSAG administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. These child CAHPS surveys include questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines, access to specialized services). Results are calculated for the population of children identified as having a chronic condition and for the general child population. HFS does not require the health plans to administer the CAHPS 5.0 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

General Population

The Illinois statewide program aggregate (i.e., Illinois Medicaid and All Kids combined) CAHPS results for the general child population are displayed in Table 6-5.[6-1,6-2]

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

	2019	2020	Trending Results (2019–2020)
Composite Measures			
Getting Needed Care	85.2% ★★★	84.2% ★★	—
Getting Care Quickly	87.0% ★★	88.3% ★★	—
How Well Doctors Communicate	94.0% ★★	94.2% ★★★	—
Customer Service	87.3% ★★	79.1% ★	▼
Global Ratings			
Rating of All Health Care	71.5% ★★★	70.2% ★★	—
Rating of Personal Doctor	77.8% ★★★	76.3% ★★	—
Rating of Specialist Seen Most Often	81.2% ★★★★★	75.9% ★★★	—

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

6-2 Due to significant differences between the total eligible populations of the All Kids and Illinois Medicaid programs, the 2020 Illinois statewide program aggregate was not weighted. For consistency, HSAG recalculated the 2019 Illinois statewide program aggregate results, so the results were not weighted. Therefore, these results are different from the 2019 weighted aggregate in the 2019 External Quality Review Annual Report.

	2019	2020	Trending Results (2019–2020)
Rating of Health Plan	63.9% ★	61.3% ★	—

▼ Indicates the 2020 score is statistically significantly lower than the 2019 score.
— Indicates the 2020 score is not statistically significantly higher or lower than the 2019 score.

Notable

- The star rating improved from 2019 to 2020 for *How Well Doctors Communicate*.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the general child population for the Illinois statewide program aggregate reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*.
- Star ratings declined from 2019 to 2020 for *Getting Needed Care*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*.
- The 2020 score was statistically significantly lower than the 2019 score for *Customer Service*.

CCC Population

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

Table 6-6—Statewide Survey CCC Population Aggregate Results

	2019	2020	Trending Results (2019–2020)
Composite Measures			
Getting Needed Care	83.1% ★	85.5% ★★	—
Getting Care Quickly	88.7% ★	90.7% ★	—
How Well Doctors Communicate	93.7% ★★	95.0% ★★★	—
Customer Service	83.8% ★	84.7% ★	—
Global Ratings			
Rating of All Health Care	62.2% ★	67.6% ★★	—
Rating of Personal Doctor	75.0% ★★	75.5% ★★	—
Rating of Specialist Seen Most Often	74.8% ★★★	76.3% ★★★	—
Rating of Health Plan	56.0% ★	57.9% ★	—
CCC Composites and Items			
Access to Specialized Services	68.9% ★	70.5%+ ★+	—
FCC: Personal Doctor Who Knows Child	91.1% ★★	89.9% ★	—
Coordination of Care for Children with Chronic Conditions	77.7% ★★★	81.9%+ ★★★★★+	—
Access to Prescription Medicines	88.2% ★	90.3% ★★	—
FCC: Getting Needed Information	90.1% ★	92.4% ★★★	—

— Indicates the 2020 score is not statistically significantly higher or lower than the 2019 score.

Notable

- Compared to national Medicaid percentiles, 2020 experience survey results indicated that parents/caretakers of child members from the CCC population for the Illinois statewide program aggregate were generally satisfied with *Coordination of Care for Children with Chronic Conditions*.
- Star ratings improved from 2019 to 2020 for *Getting Needed Care*, *How Well Doctors Communicate*, *Rating of All Health Care*, *Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the CCC population for the Illinois statewide program aggregate reported top-box scores below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines*.
- The star rating declined from 2019 to 2020 for *FCC: Personal Doctor Who Knows Child*.
- Overall, no statistically significant trends were observed.

Overall Findings and Conclusions

Although none of the 2020 adult aggregate scores for all HealthChoice Illinois health plans combined were statistically significantly higher than the 2019 scores for any measure, the star rating of *Rating of All Health Care* increased from below the 50th percentile to at or between the 50th and 74th percentile compared to national Medicaid benchmarks between 2019 and 2020. However, the 2020 scores fell below the 50th percentiles compared to national Medicaid benchmarks for four measures (*Getting Needed Care*, *Getting Care Quickly*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*).

Although the child aggregate results of all health plans combined showed that there were no statistically significant differences between the 2020 and 2019 scores, the star ratings of three measures (*Getting Care Quickly*, *How Well Doctors Communicate*, and *Rating of Specialist Seen Most Often*) increased between 2019 and 2020 compared to national Medicaid benchmarks. However, the star rating of one measure, *Rating of Health Plan*, decreased between 2019 and 2020.

When the 2020 scores for the general child population for the Illinois statewide program aggregate were compared to national benchmarks, one measure, *How Well Doctors Communicate*, increased from below the 50th percentile to at or between the 50th and 74th percentile compared to national Medicaid benchmarks between 2019 and 2020; however, two measures (*Customer Service* and *Rating of Health Plan*) performed poorly, falling below the 25th percentile compared to national Medicaid benchmarks. In addition, *Customer Service* scored statistically significantly lower in 2020 than in 2019.

Although there were no statistically significant differences between the 2020 and 2019 scores for the CCC population for the Illinois statewide program aggregate, the star ratings of two composite measures (*Getting Needed Care* and *How Well Doctors Communicate*), one global rating (*Rating of All Health Care*), and three CCC composites and items (*Coordination of Care for Children with Chronic Conditions*, *Access to Prescription Medicines*, and *FCC: Getting Needed Information*) increased between 2019 and 2020 compared to national Medicaid benchmarks. Of these, one measure, *Coordination of Care for Children with Chronic Conditions*, scored at or above the 90th percentile. However, the star rating of *Family-Centered Care: Personal Doctor Who Knows Child* decreased between 2019 and 2020.

Recommendations

Based on these results for both the adult and child populations, HealthChoice Illinois health plans and the Illinois statewide program aggregate have opportunities for improvement regarding customer service skills and the timeliness and accessibility to care. Improvements in these areas may increase members' overall rating of their health plan.

HFS should also consider advising the health plans to increase their oversample to assist with response rates as response rates likely plummeted due to COVID 19.

7. Additional EQR Activities

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

Section Contents

Quality Rating System

Overview

Federal regulation 42 CFR §438.334 requires the development of a Medicaid managed care quality rating system. In SFY 2020, HFS updated its consumer quality comparison tool, called the HealthChoice Illinois Plan Report Card (report card), to reflect the performance of the HealthChoice Illinois health plans.

HSAG was tasked with developing a report card to evaluate the performance of health plans serving HealthChoice Illinois beneficiaries. The report card was targeted toward a consumer audience; therefore, it was user-friendly, easy to read, and addressed areas of interest for consumers. As part of the EQRO contract, HSAG analyzed 2020 HEDIS results, including 2020 CAHPS data from the health plans.

HSAG created two report cards. The Cook County report card included an analysis of the plans that are available to Medicaid beneficiaries in Cook County. The statewide report card included an analysis of the plans that are available statewide to Medicaid beneficiaries. The report card analyses helped support HFS' public reporting of MCO performance information.

The report card is published online at https://www.illinois.gov/hfs/healthchoice/reportcard/Pages/statewide_sc20.aspx.

The report card is posted for public review during open enrollment so beneficiaries can use it to make health plan choices.

Reporting Measures and Categories

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

- **Doctors' Communication and Patient Engagement:** Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate, shared decision making, and overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.

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

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

Measures Used in Analysis

HFS, in collaboration with HSAG, chose measures for the report card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; the available data; and nationally recognized, standardized measures of Medicaid and/or managed care. Thirty-nine measures were chosen: 11 CAHPS and 28 HEDIS, along with their associated weights. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the final results.

Comparing Plan/Plan Category Performance to National Benchmarks

HSAG presented measure-level ratings on the selected HEDIS and CAHPS measures based on comparisons to national Medicaid benchmarks. A five-level rating scale was used to report how HEDIS and CAHPS measures compare to the 2019 Quality Compass national Medicaid benchmarks. In addition, HSAG provides consumers with category-level trending information for the selected categories (Doctor's Communication, Access to Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy) to indicate whether the MCOs' average rating in each category improved, declined, or stayed the same from 2019 to 2020 based on comparisons to national Medicaid benchmarks. HSAG computed six reporting category summary scores for each MCO, compared each measure to national benchmarks, and assigned star ratings for each measure.

Responding to Illinois Legislation

Illinois Public Act 099-0725 sets forth requirements for the Medicaid quality rating system. HSAG and HFS worked together to tailor the report card to meet the requirements of the legislation, and HFS has designed the online version of the report card.

Evaluation of Quality Strategy

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

On January 1, 2018, HFS rebooted the Illinois Medicaid managed care program, launching HealthChoice Illinois; therefore, HFS published a fully revised and restructured Quality Strategy in 2018. However, due to additional program changes, such as incorporating SNC populations in HealthChoice Illinois and the statewide expansion of MLTSS, HFS worked throughout SFY 2020 to revise its Quality Strategy, which will be republished in the first quarter of 2021.

HSAG stays abreast of CMS requirements for states' Quality Strategy and advised HFS on the development of its Quality Strategy in accordance with CMS' *Quality Strategy Toolkit for States*.[7-2]

[7-2] Centers for Medicare & Medicaid Services. *Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care-quality/state-quality-strategies/index.html.

Quality of Life Surveys

Overview

The Quality of Life (QoL) Survey was administered to adult members covered under the statewide HealthChoice Illinois MLTSS program, and the Pediatric Quality of Life Inventory (PedsQL™) 4.0 Parent Report for Children Survey (PedsQL Survey) was administered to parents or caretakers of child members covered under the statewide HealthChoice Illinois program to evaluate these members' health-related QoL.[7-3,7-4] HFS contracted with six health plans to provide healthcare services to adult and child members. Four of the health plans serve enrollees statewide, and two health plans serve enrollees in Cook County only. Table 7-1 displays the health plans that participated in the QoL and PedsQL surveys for SFY 2020.

Table 7-1—HealthChoice Illinois Health Plans for 2020 QoL and PedsQL Surveys

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

Reporting Measures and Categories

The QoL Survey included measures from the Veterans RAND 12-Item Health Survey (VR-12) and the Centers for Disease Control and Preventions' (CDC's) Behavioral Risk Factor Surveillance System

[7-3] Although the (PedsQL 4.0 Parent Report for Children survey instrument selected is designed for children ages 8–12, the survey instrument can be used for children ages 5–18. HSAG limited the survey eligibility to children who are 5–17 since the PedsQL Survey questions are not appropriate for child members younger than 5 years of age.

[7-4] The PedsQL Survey was developed by James W Varni, PhD. Copyright © 1998 JW Varni, PhD. All rights reserved.

(BRFSS) survey.[7-5,7-6,7-7] VR-12 survey response items were used to assess eight health domains (physical functioning, role-physical, role-emotional, bodily pain, social functioning, mental health, vitality, and general health), which were summarized into estimates of physical health (PCS scores) and mental health (MCS scores). The CDC's Healthy Days measures are aimed at identifying health disparities, tracking health trends, and measuring health-related QoL.[7-8]

The PedsQL Survey is composed of 23 items comprising the following four domains: (1) physical functioning, (2) emotional functioning, (3) social functioning, and (4) school functioning. The measures were scored into two summary component scores (i.e., psychosocial health summary and physical health summary).

QoL Survey Analyses

HSAG performed three separate analyses on the survey results: PCS and MCS comparative analysis, mean number of unhealthy days, and Healthy Days measures comparative analysis. The analysis of the VR-12 results was performed using the VR-12 Norm90 Imputation analysis program.[7-9] Case-mix-adjusted PCS and MCS scores were reported. Case-mix refers to the characteristics used in adjusting the results for comparability. Case-mix adjusted PCS and MCS scores are based on a scale of 0 to 100; a higher score indicates better health. MCO-level, case-mix adjusted PCS and MCS scores were compared to the program average scores to determine whether there were statistically significant differences between the scores for each MCO and the program average scores.

The mean number of days for each Healthy Days measure was calculated. If respondents indicated zero physically and mentally unhealthy days, then days with activity limitations were recoded to zero days. Also, responses to the Healthy Days measures were classified into three response categories: "None," "1–13," and "14–30." Proportions were calculated for each Healthy Days measure response category. Responses that fell into a response category were assigned a 1, while all others were assigned a 0. These values were summed to determine a response category score. Chi-square (χ^2) tests were performed for

7-5 Iqbal SU, et al. *The Veterans Rand 12 Item Health Survey (VR-12): What It Is And How It Is Used*. Boston, MD: Boston University School of Public Health. Available at: http://www.hosonline.org/globalassets/hos-online/publications/veterans_rand_12_item_health_survey_vr-12_2007.pdf. Accessed on: October 6, 2020.

7-6 Centers for Disease Control and Prevention. *Behavioral Risk Factor Surveillance System Survey Questionnaire*. Atlanta, Georgia: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2019.

7-7 The Veterans RAND 12 Item Health Survey (VR-12) was developed from the Veterans RAND 36 Item Health Survey version 1.0 (also known as the MOS SF-36). HSAG received written permission to use the survey from the developers of the VR-12 in October 2019. Permission is not required for the CDC BRFSS components of the survey.

7-8 Centers for Disease Control and Prevention. *Health-Related Quality of Life—Methods and Measures*. Available at: http://www.cdc.gov/hrqol/methods.htm. Updated on October 31, 2018. Accessed on: October 6, 2020.

7-9 Spiro A, Rogers WH, Qian S, and Kazis LE. *Imputing Physical and Mental Summary Scores (PCS and MCS) for the Veterans SF-12 Health Survey in the Context of Missing Data*. The Health Outcomes Technologies Program, Health Services Department, Boston University School of Public Health, Boston, MA and The Institute for Health Outcomes and Policy, Center for Health Quality, Outcomes and Economic Research, Veterans Affairs Medical Center, Bedford, MA. Available at: https://hosonline.org/globalassets/hos-online/publications/hos_veterans_12_imputation.pdf. Accessed on: October 6, 2020.

each Healthy Days measure response category score (i.e., "None," "1–13 days," and "14–30 days") to determine if statistically significant differences existed between the MCOs.

Arrows were assigned to each MCO's PCS and MCS score and Healthy Days measures response category proportion to indicate whether there were statistically significant differences. An MCO's score or response category proportion that was statistically significantly higher than the MLTSS program (all health plans combined) is noted with an upward (↑) arrow. An MCO's score or response category proportion that was statistically significantly lower than the MLTSS program is noted with a downward (↓) arrow. An MCO's score or response category proportion that was not statistically significantly different than the MLTSS program is not noted with arrows.

PedsQL Survey Analyses

HSAG performed a psychosocial and physical health summary scores comparative analysis on the survey results. The analysis of results was conducted using the Scaling and Scoring of the PedsQL, which is officially distributed by Mapi Research Trust.[7-10] Health summary scores were calculated using a 5-point Likert scale, and items in each domain were reverse scored and linearly transformed to a 0–100 scale. The psychosocial health summary score was calculated using the sum of the items over the number of items answered in the emotional, social, and school functioning domains. The physical health summary score was calculated using the sum of the items over the number of items answered in the physical functioning domain (i.e., Question 1). A psychosocial and physical health summary score was only calculated if no less than 50 percent of items within the domain were completed. Higher scores indicate better health.

MCO-level scores were compared to the program average scores (all health plans combined) to determine whether there were statistically significant differences between the scores for each MCO and the program. MCO-level results that were statistically significantly higher than the program are noted with an upward (↑) arrow. MCO-level results that were statistically significantly lower than the program are noted with a downward (↓) arrow. MCO-level results that were not statistically significantly different from the program are not noted with arrows.

[7-10] Varni, JW. *Scaling and Scoring of the Pediatric Quality of Life Inventory™ PedsQL™*. College Station, Texas: Mapi Research Trust, May 2017. Available at: https://www.pedsql.org/PedsQL-Scoring.pdf. Accessed on: October 6, 2020.

Summary of Performance: QoL Survey

PCS and MCS Scores

Table 7-2 shows the PCS and MCS scores for each MCO and the MLTSS program.

Table 7-2—PCS and MCS Scores Summary

Measure	MLTSS Program	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel
PCS	**27.5**	27.6	27.7	26.7	26.5 ↓	27.6	29.6 ↑
MCS	**41.4**	42.1	40.3	41.3	40.2	42.4	41.7

↑ Statistically significantly higher than the program.
↓ Statistically significantly lower than the program.

Healthy Days Measures

Table 7-3 shows a summary of the statistically significant differences when the MCO response category proportions were compared to the MLTSS program for the Healthy Days measures.

Table 7-3—Healthy Days Measures Comparisons

BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel
			↓ Mentally Unhealthy Days: None		↑ Physically Unhealthy Days: None

↑ Statistically significantly higher than the program.
↓ Statistically significantly lower than the program.

Table 7-4 presents the mean number of unhealthy days in the last 30 days for each of the Healthy Days measures for the MLTSS program and each MCO. Respondents experienced, on average, slightly less than half of a month with unhealthy days. In addition, respondents experienced substantially fewer mentally unhealthy days than physically unhealthy days or days with activity limitations.

Table 7-4—Mean Number of Unhealthy Days

Program/MCO Name	Physically Unhealthy Days	Mentally Unhealthy Days	Days with Activity Limitations
MLTSS Program	**15**	**10**	**13**
BCBSIL	15	9	14
CountyCare	16	11	14
IlliniCare	14	10	13

Program/MCO Name	Physically Unhealthy Days	Mentally Unhealthy Days	Days with Activity Limitations
Meridian	16	11	14
Molina	15	10	13
NextLevel	13	10	12

Summary of Performance: PedsQL Survey

Health Summary Results

Table 7-5 shows a summary of statistically significant differences (indicated by the assignment of arrows) when the MCO-level psychosocial and physical health summary scores were compared to the program average.

Table 7-5—Psychosocial and Physical Health Summary Scores

Measure	HealthChoice Illinois Program	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel
Psychosocial Health Summary	**82.4**	86.1 ↑	81.6	81.2 +	82.5	81.8	78.9 +
Physical Health Summary	**86.7**	88.2	86.9	88.2 +	86.0	87.0	82.6 +

\+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.
↑ Statistically significantly higher than the HealthChoice Illinois program.

Case Management (CM) Staffing and Training Reviews

Introduction

HSAG is contracted by HFS to conduct a biannual calendar year review of the health plans' compliance with case management staffing and training requirements. The 2020 review included an assessment of internal health plan staff members as well as any delegated entities performing case management services. For those delegated entities serving more than one health plan, an additional analysis was completed to determine compliance with case management requirements when the delegated case manager's caseload was assessed across all health plans served.

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

HSAG analyzed 17 contractually required elements of case management staffing and training, which were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

Findings

HealthChoice Illinois

The first biannual staffing review of calendar year 2020, completed in May 2020, identified the following findings:

- Five of the six health plans met requirements for weighted, high-risk, and moderate-risk caseloads. One health plan, Meridian, did not meet requirements.
- All six health plans met requirements for low-risk caseloads.

- Completion of cultural competency training ranged from 0 percent to 57 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- None of the six health plans met brain injury (BI) waiver case manager qualification/education requirements.
- Four of the six health plans met BI waiver caseload requirements. Two health plans, Meridian and Molina, did not meet requirements.
- One of the six health plans, NextLevel, had evidence of completed BI waiver-specific training for all its BI waiver case managers. The remaining five health plans did not have training completed for all BI waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- All six health plans met elderly (ELD) waiver qualification/education requirements.
- One of the six health plans, NextLevel, had evidence of completed ELD waiver-specific training for all its ELD waiver case managers. The remaining five health plans did not have training completed for all ELD waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Three of the six health plans met HIV waiver qualification/education requirements.
- Three of the six health plans met HIV waiver-related experience requirements.
- Four of the six health plans met HIV waiver caseload requirements. Two health plans, Meridian and Molina, did not meet requirements.
- One of the six health plans, NextLevel, had evidence of completed HIV waiver-specific training for all its HIV waiver case managers. The remaining five health plans did not have training completed for all HIV waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- None of the six health plans met physical disabilities (PD) waiver case manager qualification/education requirements.
- None of the six health plans had evidence of completed Supportive Living Program (SLP) waiver-specific training for all SLP case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review
- Completion of 20 hours of annual waiver training ranged from 0 percent to 6 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.

MMAI

The first biannual staffing review of calendar year 2020, completed in May 2020, identified the following findings:

- All six health plans met requirements for weighted, high-risk, moderate-risk, and low-risk caseloads.

- Completion of cultural competency training ranged from 0 percent to 96 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Four of the six health plans met BI waiver case manager qualification/education requirements. Two health plans, Humana and Molina, did not meet requirements.
- Five of the six health plans met BI waiver caseload requirements. One health plan, Molina, did not meet requirements.
- None of the six health plans had evidence of completed BI waiver-specific training for all their BI waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- All six health plans met ELD waiver qualification/education requirements.
- None of the six health plans had evidence of completed ELD waiver-specific training for all their ELD waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Five of the six health plans met HIV waiver qualification/education requirements. One health plan, Molina, did not meet requirements.
- Three of the six health plans met HIV waiver-related experience requirements.
- Five of the six health plans met HIV waiver caseload requirements. One health plan, Molina, did not meet requirements.
- None of the six health plans had evidence of completed HIV waiver-specific training for all their HIV waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Two of the six health plans met PD waiver case manager qualification/education requirements. The remaining four health plans did not meet requirements.
- None of the six health plans had evidence of completed SLP waiver-specific training for all SLP case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review
- Completion of 20 hours of annual waiver training ranged from 0 percent to 33 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.

Recommendations

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

- HFS should require that Meridian provide a plan to comply with weighted caseload and caseload volume requirements and redistribute cases to ensure the requirement is met.
- HFS should review the qualification/education requirements for the BI, HIV, and PD waivers to determine if further clarity and guidance related to interpretation of the contract language can be

provided to the health plans. HFS may also consider identification of qualification/education requirements not specifically dictated in contract language that HSAG may consider compliant in future assessments.

- HFS should provide guidance related to interpretation of the contract language related to HIV and BI waiver caseload maximums to Meridian and Molina.
- HFS should consider providing guidance to health plans related to expectations for caseloads for those case managers with combined lines of business (LOB) caseloads.
- HFS should consider providing guidance to health plans and their delegates related to expectations for caseloads for those case managers serving more than one health plan.

Population specific results and additional details can be found in Appendix G1.

Critical Incident Monitoring Review

Introduction

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

Methodology

HSAG conducts quarterly record reviews and system effectiveness assessments to determine health plan compliance with the HealthChoice Illinois and MMAI contract measures and MLTSS waiver requirements. A detailed description of the sampling methodology and data collection processes is provided in Appendices G2 and G3. File review elements were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

File Review Findings

Eight health plans were included in the FY 2020 review. File review of the sampled CI cases demonstrated the following performance:

- For the Reporting of Incident domain, which captures compliance with assuring the health, safety, and welfare of the enrollee after the CI occurred, the health plans performed at a rate of 96 percent for HealthChoice Illinois and 98 percent for MMAI.
- For the Compliance With Investigating Authority Decisions domain, which captures whether health plans respond to the investigating authority within 15 days of receipt of a Report of Substantiation form, the health plans performed at a rate of 72 percent for HealthChoice Illinois and 71 percent for MMAI.
- For the Case Management Activities domain, which captures whether health plans complete care/service plan updates when there is an identified change in condition and/or need, the health plans performed at a rate of 84 percent for HealthChoice Illinois and 92 percent for MMAI.

System Effectiveness Findings

HSAG evaluated the health plans' system effectiveness as related to CI intake and processing, CI data reporting, and CI reporting to investigating authorities. HSAG did not identify any critical concerns related to items assessed via the systems effectiveness review.

Recommendations

Based on the findings of the CI file review and system effectiveness assessment, HSAG identified the following conclusions and recommendations for HFS.

- HFS should consider providing guidance to the health plans on processes that must be documented to consider an incident closed/resolved, including specific actions if the enrollee is unable to reach. HFS may consider approving the health plans' processes for unable to reach enrollees related to CI resolution.
- HFS should consider further refining CI definitions in order to ensure consistent reporting by the health plans.
- HFS should consider revising policy MCO-002. Specifically, HFS should consider communicating with investigating authorities regarding expectations for health plan responses to Report of Substantiation forms, as file review identified that current Adult Protective Services/Illinois Department of Aging (APS/IDoA) forms no longer have a response section. HFS should also review the policy with the health plans to ensure correct information related to dedicated email addresses is communicated between the investigating authorities and the health plans.
- HFS should provide direction to MMAI health plans related to abuse, neglect, and exploitation (ANE) education for nonwaiver enrollees and those enrollees not engaged in care coordination. HFS may consider revising member handbook template language to ensure that education is provided to all enrollees.

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

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

Introduction

As part of its continuous effort to evaluate quality improvement activities of the Illinois Medicaid managed care plans (health plans), HFS contracted HSAG to assess each health plan's FY 2020 Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) annual report.

Methodology

Annually, HFS provides the health plans with a QA/UR/PR report outline, which describes the expectations for the annual report. HSAG reviewed the report outline and the annual QA/UR/PR report requirements in the HealthChoice Illinois and MMAI contracts to develop an assessment tool. The methodology for assessing the QA/UR/PR reports can be found in Appendix G-4.

General Requirements

HSAG assessed each health plan's FY 2020 QA/UR/PR report for the following general requirements, which were prescribed by HFS in its annual outline document provided to the health plans:

- Does the report address all populations served by the health plan?
- Did the health plan submit all applicable appendices?
- Is the Executive Summary no more than five pages?
- Is the entire report (excluding appendices) no more than 75 pages?
- Does the report cover the correct time period (FY 2020, HEDIS calendar year 2019)?

Review of the health plans' annual reports identified full compliance with the general requirements.

Contract Requirements

HSAG's assessment of annual QA/UR/PR report contract requirements included 23 elements across HealthChoice Illinois and MMAI; some elements were applicable to only one contract.

Findings

Results of each health plan's findings can be found in the Assessment of Illinois Medicaid Managed Care Health Plans' FY 2020 QA/UR/PR Annual Reports, Appendix G-4. Table 7-6 summarizes the findings for all health plans.

Table 7-6—Summary Scoring Table

Scoring Summary – Contract Elements				
Health Plan	**Number Met**	**Number Not Met**	**Number N/A**	**Performance Score**
Aetna	17	2	4	89% (16/19)
BCBSIL	23	0	0	100% (23/23)
CountyCare	20	0	3	100% (20/20)
Humana	18	1	4	95% (18/19)
IlliniCare	20	0	3	100% (20/20)
Meridian	23	0	0	100% (23/23)
Molina	18	5	0	78% (18/23)
NextLevel	21	0	2	100% (21/21)

General Requirements

Review of the health plans' annual reports identified full compliance with the general requirements.

Contract Requirements

Three health plans, Aetna, Humana, and Molina, had findings related to contract requirements:

- Aetna's report did not include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year. The health plan should ensure that its FY 2021 report includes an analysis of the QI program, as well as information related to FY 2021 identified QI program restructuring or changes.
- Aetna included detailed information about its internal process for identification and investigation of fraud, waste, and abuse; however, the health plan has an opportunity to ensure that its FY 2021 report includes additional detail to describe the volume and types of cases reviewed, investigation outcomes, successes of the program, and any opportunities for improvement.
- Humana's report did not include a detailed analysis of chronic conditions, the effectiveness of the health plan's program, or the impact on the population served. The section related to chronic

conditions reported mainly on efforts related to unable to reach members and did not provide information regarding the health plan's management of members with chronic conditions. The health plan did not reference any appendices to direct the reader to additional information that would provide a more detailed analysis. In its FY 2021 report, the health plan should consider including additional information to further inform the reader of its management of chronic conditions, including but not limited to case management, the effectiveness of the program, and the impact on the population served. *This is a continued finding from FY 2019.*

- Molina detailed its FY 2020 successes; however, it did not provide an analysis of barriers or resulting FY 2021 QI goals. The health plan should ensure that its FY 2021 report includes a narrative description of barriers to accomplishing QI goals, as well as information related to FY 2021 goals and initiatives.
- Molina's report provided some information related to the QI program, but did not provide adequate detail on the program resources, the structure of the QI Committee, or level of practitioner participation and leadership involvement. Although some information was included in the work plan, the work plan did not include status of the elements of the QI work plans and did not provide specificity of the program structure. The health plan should ensure that its FY 2021 report reflects the organizational structure to support and accomplish its QI program, including any QI program restructuring or changes.
- Molina's report did not include an analysis of cultural competency. The health plan should include a detailed analysis of how the health plan includes cultural competency in services provided to enrollees and/or provide its culturally and linguistically appropriate services (CLAS) analysis in future reports.
- Molina's report included a QI work plan; however, the work plan did not include analysis or the status of the elements included. The health plan should include an analysis of the progress of its work plan, which would assist the health plan in identifying successes or opportunities for improvement.
- Molina provided detail of the structure of American Disabilities Act (ADA) compliance monitoring; however, the narrative did not include efforts to assess ADA compliance; for example, the number of site visits completed to assess ADA compliance and the results of those visits. The health plan should ensure that its annual report includes information regarding outcomes of the ADA site assessments. The health plan has an opportunity to not only report data but to report its analysis of data to inform Molina and HFS of any trends, patterns, and opportunities for improvement.

Report Observations

HFS instructed HSAG to include observations about the health plans' reports, including use of appendices, ability to expand on the outline provided, and success of "telling the story" of its population.

Health plan-specific observations are included in each health plan's individual report; however, HSAG noted the following similarities among health plans:

- Most health plans have an opportunity to more successfully use the data and information in their attached appendices by referencing the information in their narrative reports. For instance,

appendices related to population assessment would be appropriate to reference in the health plans' sections related to cultural competency and care management.

- Most health plans followed the HFS outline to establish headings and subheadings in their reports, some using the outline verbatim to report the year's activities. However, the health plans have an opportunity to use the outline more as a guide for information that must be included rather than following the outline for report setup. For instance, BH utilization and PIPs are both required on the outline in different areas but could be reported together to better draw conclusions about the success of PIP efforts on utilization, or to identify additional opportunities for improvement related to behavioral health utilization. Health plans should determine if the annual report would benefit from restructuring to "tell the story," which would allow the health plans to include all outline elements but in a different order.
- HSAG noted that the health plans' reports indicate different maturity and sophistication levels in terms of providing narrative information, drawing conclusions, or assessing data to determine the success of their QI programs. Some health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting.

Illinois Department of Healthcare and Family Services (HFS) Meetings

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

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

For health plan monthly quality meetings, HSAG was responsible for consulting with HFS in selecting meeting content, preparing the agenda and any necessary meeting materials, forwarding materials to participants in advance of the meeting, and facilitating the meeting. Following each meeting, HSAG prepared meeting minutes and, after HFS approval, forwarded them to all meeting participants. As part of this process, HSAG created an action item list and then followed up with the health plans and HFS to ensure timely completion of those items. HSAG provided status updates to HFS so it could track health plan progress on completing follow-up items.

Technical Assistance (TA) to HFS and Health Plans

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

HSAG understood the importance of providing ongoing and specific TA to each health plan, as needed, and provided consultation, expertise, suggestions, and advice to assist with decision making and strategic planning. HSAG worked in partnership and collaboration with HFS and health plans to ensure that it delivered effective technical support that facilitated the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG continued to provide technical guidance to the health plans to assist them in conducting the mandatory EQR activities—particularly, to establish scientifically sound PIPs and develop effective CAPs. In addition, the following TA activities were conducted in SFY 2020.

NCQA Accreditation Tracking

The 2010 federal ACA called for the use of accreditation to ensure quality in the managed healthcare sector. The ACA requires that, beginning in 2014, all health plans offered through state insurance exchanges "…must be accredited with respect to local performance on clinical quality measures … by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans…" The NCQA's Health Plan Accreditation is considered the industry's gold standard to provide a current, rigorous, and comprehensive framework for essential quality improvement and measurement. Illinois implemented legislation that requires all HealthChoice Illinois plans to achieve NCQA accreditation. HSAG designed several tools to assist HFS in monitoring plan accreditation status. The NCQA tracking spreadsheet displays each health plan's accreditation eligibility date, accreditation dates, date of final NCQA decision letter and summary report, accreditation expiration date, accreditation status, and NCQA health insurance plan ratings and accreditation star ratings.

In addition, HSAG developed the HealthChoice Illinois Managed Care Program NCQA Medicaid Healthcare Maintenance Organization Accreditation status sheet (status sheet), which succinctly displays each health plan's accreditation date and status, along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at https://www.illinois.gov/hfs/SiteCollectionDocuments/IL2019HFSWebsiteNCQAAccreditationDoc071119.pdf.

Throughout SFY 2021, HSAG will update the NCQA tracking spreadsheet for HFS' reference periodically and any time there is an update to a health plan's status. HSAG will also keep the status sheet updated through accessing the most recent accreditation information on NCQA's website.

Development of Program-Specific Performance Measures

Historically, HSAG has provided key support to assist HFS in developing performance measures that meet the unique demands of Illinois Medicaid programs. HSAG works collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently serve as part of the care coordination expansion. In SFY 2020, HSAG provided TA in the development and selection of performance measures.

HFS and Health Plan Training

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

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

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

Report and Data Collection Templates

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

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

Research

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

Presentations to the Illinois Legislature and HFS Administration

HFS is sometimes required to make presentations to the Illinois legislature for the purposes of providing education, reporting results, clarifying Medicaid processes, or assisting the legislature in making policy decisions. Likewise, sometimes the HFS director requests presentations on specific topics for internal use. HSAG consults with HFS to clarify the needs for an ad hoc presentation, conducts necessary research or data analysis, drafts and revises the presentation as necessary, and sometimes delivers the presentation via face-to-face meetings or webinars. Examples of presentations that HSAG has developed for HFS include annual quality results and proposed quality improvement initiatives.

Expansion Map

Given the significant expansion in Illinois, HFS requested HSAG to design a graphical depiction of expansion efforts that could be shared with stakeholders. As a result, HFS and HSAG created the Care Coordination Expansion Map, which demonstrates which health plans are operating across the State of Illinois, and in which programs those plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and it was displayed publicly on the HFS website. Throughout SFY 2020, HSAG provided ongoing TA to periodically update the map to reflect up-to-date expansion. HFS provides the most current map on its website, located at https://www.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlans.pdf.

Appendix A1. Executive Summary of Performance Measure Results

Performance Measures

Table A1-1 displays a snapshot of health plan performance for measures selected by the HFS in domains of care that it prioritizes for improvement. Performance for HEDIS 2020 measures is compared to the NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019, when available, which is an indicator of health plan performance on a national level. For most measures, two years of data (HEDIS 2019 and HEDIS 2020) are trended. Due to changes in the technical specifications for one measure in HEDIS 2020 (i.e., *Prenatal and Postpartum Care*), NCQA does not recommend trending between 2020 and prior years or comparisons to benchmarks; therefore, this measure is not displayed below. Additionally, *Ambulatory Care* and *Mental Health Utilization are* utilization measures and are provided for information only. A key and notes for Table A1-1 are listed in the table below.

Table A1-1—Summary of Performance Measures Results

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Access to Care								
Adults' Access to Preventive/Ambulatory Health Services								
Total	6	2	3	0	1	25th–49th ↑	5 of 6 plans	A
Adult BMI Assessment								
Adult BMI Assessment	6	3	2	1	0	<25th ↑	2 of 6 plans	Q
Ambulatory Care (per 1,000 Member Months)								
ED Visit—Total	6	1	3	2	0	25th–49th ↓	1 of 6 plans	Not Applicable (NA)
Outpatient Visit—Total	6	4	1	1	0	25th–49th ↑	6 of 6 plans	NA
Annual Dental Visits								
Annual Dental Visits	6	1	3	0	2	50th–74th ↓	1 of 5 plans[1]	A

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Keeping Kids Healthy								
Childhood Immunization Status								
Combination 2	6	3	1	1	1	25th–49th ↑	2 of 6 plans	Q
Combination 3	6	4	1	1	0	<25th ↑	2 of 6 plans	Q
Immunization for Adolescents								
Combination 1 (Meningococcal, Tdap)	6	1	0	3	2	>75th ↑	5 of 6 plans	Q
Combination 2 (Meningococcal, Tdap, HPV)	6	1	2	2	1	50th–74th ↑	5 of 6 plans	Q
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents								
BMI Percentile Documentation—Total	6	1	4	1	0	25th–49th ↓	0 of 6 plans	Q
Counseling for Nutrition—Total	6	1	4	0	1	25th–49th ↓	0 of 6 plans	Q
Counseling for Physical Activity—Total	6	1	3	1	1	25th–49th ↓	0 of 6 plans	Q
Well-Child Visits in the First 15 Months of Life								
Six or More Well-Child Visits	6	1	3	1	1	50th–74th ↑	4 of 6 plans	Q
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life								
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	6	1	2	2	1	50th–74th ↓	0 of 6 plans	Q
Women's Health								
Breast Cancer Screening								
Breast Cancer Screening	6	2	2	1	1	25th–49th ↑	6 of 6 plans	Q
Cervical Cancer Screening								
Cervical Cancer Screening	6	2	2	2	0	25th–49th ↑	2 of 6 plans	Q
Chlamydia Screening in Women								
Total	6	0	4	0	2	50th–74th ↓	3 of 6 plans	Q

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Living With Illness								
Comprehensive Diabetes Care								
HbA1c Testing	6	1	1	3	1	50th–74th ↑	3 of 6 plans	Q
Eye Exam (Retinal) Performed	6	1	4	1	0	25th–49th ↓	2 of 6 plans	Q
Medical Attention for Nephropathy	6	1	0	3	2	50th–74th ↑	3 of 6 plans	Q
Controlling High Blood Pressure								
Controlling High Blood Pressure	6	4	2	0	0	<25th ↓	1 of 6 plans	Q
Medication Management for People With Asthma								
Medication Compliance 50%—Total[1]	6	2	4	0	0	25th–49th ↑	5 of 6 plans	Q
Medication Compliance 75%—Total	6	2	4	0	0	25th–49th ↑	5 of 6 plans	Q
Statin Therapy for People With Diabetes								
Received Statin Therapy	6	1	0	0	5	≥75th ↑	5 of 6 plans	Q
Statin Adherence 80%	6	1	0	5	0	50th–74th ↑	6 of 6 plans	Q
Behavioral Health								
Follow-Up After Hospitalization for Mental Illness								
7-Day Follow-Up—Total	6	4	2	0	0	<25th ↑	3 of 6 plans	Q, T, A
30-Day Follow-Up—Total	6	4	2	0	0	<25th ↑	2 of 6 plans	Q, T, A
Initiation and Engagement of AOD Abuse or Dependence Treatment								
Initiation of AOD Treatment—Total	6	0	1	5	0	50th–74th ↓	3 of 6 plans	Q, T, A
Engagement of AOD Treatment—Total	6	0	3	3	0	50th–74th ↑	2 of 6 plans	Q, T, A
Mental Health Utilization								
Any Service—Total	6	1	5	0	0	25th–49th/NA	NA	NA
Inpatient—Total	6	0	0	1	5	≥75th /NA	NA	NA

Executive Summary of Performance Measure Results

Measure	# Plans Reporting 2020	Plan Performance 2020				Statewide Avg. 2020/Trended 2019-2020	Improved Performance 2019-2020	Quality (Q) Timeliness (T) Access (A)
		<25th	25th–49th	50th–74th	≥75th			
Intensive Outpatient or Partial Hospitalization—Total	6	0	0	6	0	50th–74th/NA	NA	NA
Outpatient—Total	6	1	5	0	0	25th–49th/NA	NA	NA
ED—Total	6	3	1	2	0	25th–49th/NA	NA	NA
Telehealth—Total	6	0	3	3	0	50th–74th/NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics								
Blood Glucose and Cholesterol Testing—Total	6	0	2	3	1	50th–74th ↑	4 of 6 plans	Q

↑ *indicates performance improved from HEDIS 2019 to HEDIS 2020.*
↓ *indicates performance declined from HEDIS 2019 to HEDIS 2020.*
[1] *Quality Compass benchmarks were not available; therefore, the Audit Means and Percentiles were used for comparative purposes.*

Appendix A2. Executive Summary Appendix

Federal Requirements for EQR Technical Report

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

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

As described in the CFR, the report also offers:

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

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

Scope of Report

Mandatory activities for SFY 2020 included:

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

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

Optional activities, as described in 42 CFR §438.356(c), for SFY 2020 included:

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

HealthChoice Illinois Health Plan Enrollment

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

Table A2-1—HealthChoice Illinois Health Plans and Enrollment

Health Plan Name	Counties	June 2020 Enrollment
BCBSIL	All Counties	526,882
CountyCare	Cook County	357,219
IlliniCare	All Counties	371,683
Meridian	All Counties	831,499
Molina	All Counties	252,665
NextLevel	All Counties	1
Total		**2,339,949**

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

Medicaid Managed Care Programs

MMAI

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

MLTSS

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

HCBS

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

DCFS Youth

Children in the care of the DCFS, including those formerly under this care who have been adopted or who entered into a guardianship, will be covered under statewide managed care Medicaid expansion. In SFY 2019, the transition of DCFS Youth to YouthCare Health Plan as part of HealthChoice Illinois began. As of November 1, 2019, YouthCare began limited care coordination activities for six priority populations identified by DCFS. Implementation for Former Youth in Care enrollees was February 1, 2020 and youth in the care of DCFS were transitioned to YouthCare program on September 1, 2020.

IHHs

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

the provider's ability to meet those needs. The IHH will be responsible for care coordination for members across their physical, behavioral, and social care needs. The development of IHHs and the payment model to sustainably support them is a significant but challenging step. HealthChoice Illinois recognizes that these IHHs will not materialize without considerable planning and appreciates that different providers are at different stages in their evolutions toward becoming IHHs, so HFS is allowing for a phased approach under which all providers are encouraged to make progress by creating greater incentives for those who can move more quickly toward a higher degree of integration.

Quality Strategy

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

Better Care

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

Healthy People/Healthy Communities

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

Affordable Care

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

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

Performance Domains

Quality

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

> Quality, as it pertains to external quality review, means the degree to which a managed care organization (MCO) or prepaid impatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement.[A2-3]

Access

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

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

Timeliness

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

Performance Measure Domains

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

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

[A2-4] Ibid.

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

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

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Adult BMI Assessment	✓		
Ambulatory Care (per 1,000 Member Months)—ED Visits—Total and *Outpatient Visits—Total*	NA	NA	NA
Annual Dental Visits			✓
Keeping Kids Healthy			
Childhood Immunization Status—Combination 2 and *Combination 3*	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total, and *Counseling for Physical Activity—Total*	✓		
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	✓		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓		
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs, Diuretics, and *Total*	✓		
Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed, and *Medical Attention for Nephropathy*	✓		
Controlling High Blood Pressure	✓		
Medication Management for People With Asthma—Medication Compliance 50%—Total and *Medication Compliance 75%—Total*	✓		
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		

Performance Measure	Quality	Timeliness	Access
Behavioral Health			
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and *30-Day Follow-Up—Total*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total and *Engagement of AOD Treatment—Total*	✓	✓	✓
Mental Health Utilization—Any Service—Total, Inpatient—Total, Intensive Outpatient or Partial Hospitalization—Total, Outpatient—Total, ED—Total, and *Telehealth—Total*	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	✓		

Appendix A3. Follow-Up on Prior Year EQR Recommendations

Section Contents

Prior Recommendations

The tables in this section identify recommendations for quality improvement made in the SFY 2019 EQR Technical Report and an assessment of the degree to which each health plan has addressed the recommendations effectively.

Table A3-1—Recommendations for Health Plans' Biggest Opportunities for Improvement from Prior EQR Report

Care Coordination and Transitions of Care (Physical and Behavioral Heath)
• Enhance timely communication with PCPs, including the sharing of care plans and coordination of services to meet enrollees' needs.
• Monitor case activity and provide regular feedback to care managers to ensure timely completion of assessments/reassessments, care plans, and PCP communication.
• Implement organization-wide strategies to identify difficult-to-locate beneficiaries with complex needs and connect them with care managers during each contact.
• Revamp children's BH CC/CM program to implement effective strategies for locating members, completing screenings, and crisis safety plans; enhance communication with PCPs; and ensure timely follow-up.
• Establish a monitoring process to monitor caseloads for high-risk or moderate-risk enrollees.
• Implement and/or strengthen the use of internal audit tools to address findings of the HCBS waiver record reviews and focus on remediation findings that result from the quarterly record reviews.
• Consider care management system enhancements to alert CC/CM of time frames to update waiver service plans and contact with beneficiaries.
• Establish a process to complete ongoing claims validation of the waiver service plan.
• Establish compliance with HCBS mandatory training requirements for CC/CM assigned to HCBS waiver enrollees by updating annual and waiver-specific training curriculum to comply with waiver-specific training requirements and establish methods to track completion of required training.
• Conduct ongoing review of staffing ratios to ensure case coordinators/care managers who manage HIV and BI waiver caseloads are not assigned caseloads greater than 30 enrollees.
• Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care from ED settings, discharge planning, and handoffs to community settings for members with BH needs.
• Evaluate the effectiveness of TOC programs to ensure timely follow-up with providers after hospital discharge and stabilization in the community.
Care Coordination Staffing
• Establish a process to confirm compliance with credentials/qualifications/experience prior to hiring/assigning staff to manage waiver caseloads, especially for the PD and BI waivers.
• Establish a process to monitor compliance with key leadership staffing requirements.
• Improve internal processes to notify HFS within two business days as required by contract for any staffing changes to key leadership positions.

Customer Service/Beneficiary and Provider Satisfaction with Services
• Require service recovery programs so health plan call center representatives have guidelines to follow for problem resolution.
• Track trends and use data to improve service processes, including service-level reporting for customer service.
• Train and empower front-line employees to resolve enrollee complaints and grievances quickly and effectively, including evaluation of data to identify failure points/root causes.
• Evaluate the effectiveness of grievance and appeals resolution process to address member dissatisfaction.
• Use health consumer advisory committees to determine opportunities to improve beneficiary satisfaction, including benefits or incentives.
• Implement a provider complaint resolution process to address provider dissatisfaction with timely resolution of provider complaints.
Prevention and Screenings
• Implement organization-wide strategies to contact members, such as flagging enrollees who need screenings in the system, and to train member services, nurse advice line staff, and care managers to address the reasons for flagging during contact with the member.
• Use the results of the annual access and availability survey to evaluate provider compliance with appointment availability and after-hours telephone access and to follow up with providers who are noncompliant with appointment standards.
• Use patient navigators for individualized assistance in scheduling and completing screenings.
• Evaluate care gap outreach programs by evaluating methods used to identify care gaps, evaluating engagement programs, and closure of care gaps through direct member and provider engagement.
• Evaluate structural barriers by assessing availability of after-hours and weekend appointments, mobile screenings, and community screening events.
Provider Network Adequacy
• Improve accuracy of network provider data submission by obtaining updated rosters from provider organizations that include all contracted providers within provider/physician groups, CMHCs, FQHCs, and RHCs.
• Improve accuracy of the Specialty Pediatric Provider Network through review of specialty provider contracts to validate the age groups served by network providers.
• Improve accuracy of the HCBS Provider Network through review of contracts and validation of the types of HCBS services provided.
• Improve accuracy of the online and hard copy provider directory by evaluating the frequency and effectiveness of completing directory audits and process for updating changes to the online and paper provider directory.
• Improve accuracy of delegated vendor online directories by conducting audits of the delegated dental and vision provider directories and holding delegated vendors accountable for remediation of audit findings.
• Evaluate methods used to monitor open and closed PCP panels and the process for updating the online directory for panel status changes.

Compliance Monitoring: Oversight of Delegated Vendors
• Improve oversight of delegated vendors through compliance with conducting monthly joint operations meetings and quarterly review of vendor performance by the delegation oversight committee.
• Develop delegation agreement, conduct a pre-delegation audit, and implement oversight and monitoring of the 24-hour CARES crisis line.
• Improve oversight of delegated dental and vision vendors through regular audits of compliance with directory requirements and compliance with remediation of deficiencies identified as a result of directory audits.
• Improve monitoring and oversight of delegated CC/CM vendors for compliance with HCBS waiver caseload requirements for CC/CM assigned to waiver enrollees.
• Improve monitoring and oversight of delegated CC/CM vendors for compliance with waiver CC/CM training requirements, including ELD, BI, HIV, and SLF waiver-specific required training.
Compliance Monitoring: CI Reporting
• Develop internal processes and reeducate staff to improve compliance with reporting to the appropriate investigating authority.
• Develop and implement a consistent process and specific information required for closure of a CI event. The process should include evidence of outreach to the enrollee to ensure their HSW.
IHHs[A3-1]
• Promote understanding of the benefits of IHHs among consumers and families.
• Engage providers in understanding the role and responsibility of an IHH and the role of the health plans in coordinating care for beneficiaries assigned to the IHH.

[A3-1] Implementation of IHHs was delayed by HFS; therefore, health plan follow-up is not reported for these recommendations.

Health Plan Follow-Up

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

Focused Areas of Improvement	Health Plan Follow-Up
BCBSIL	
Care Coordination/Transitions of Care Including BH	Began working on interventions for the rapid-cycle *Follow-up Post-Hospitalization for Mental Illness* PIP and QIP. Established two programs: The CCM and the IESS programs. These programs provide support to BCBSIL's most frequently admitting, most acute adult members and tend to fall within the disabled adult populations. The goals of these two programs are to reduce the rates of unnecessary inpatient admissions, promote continuity of care, and meet member's SDoH through providing a more intensive level of care coordination support. The programs work with identified members through ongoing engagement efforts in treatment and stabilization of their living situations to promote improved health outcomes. The Behavioral Health Transition of Care program saw improvements in readmission rates within 30 days for the FHP age 20+ population by 7.3% for chemical dependency and 5.8% for mental health and for the ACA adult population by 14.5% for chemical dependency and 21% for mental health. Provided up-front payments to CMHCs to reserve/book BH appointments in advance and provided two million dollars of grant funding for telemedicine funding to CMHCs to support new or improve existing telemedicine capabilities.
Customer Service	The customer service vendor, TMG/Cognizant, successfully remediated their CAP from SFY 2019 and the CAP was closed May 2020. The member customer service department implemented a post-call satisfaction survey, which allowed members to rate calls out of 5 possible points. The call center strives to achieve a score of greater than 4 points each month. From July 1, 2019, through June 30, 2020, the call center had an average of 4.4 points out of 5 points. All months in the time-period were above 4 points.
Prevention and Screenings	Conducted a causal analysis to evaluate opportunities for improvement of member health outcomes, including evaluating the member, provider, and system barriers that limit the success of members receiving the care they need and potentially limit the success of interventions. Initiatives implemented to focus on identified barriers included but were not limited to: revision of the member incentive program so that members receive the incentive quarterly instead of annually, working with Blue Door Centers to educate members and the community, clinical practice consultants using care gap reports for provider education

Focused Areas of Improvement	Health Plan Follow-Up
BCBSIL	
	and working on focused initiatives with providers, a monthly HEDIS workgroup led by the quality department with participation from various business areas, and a new 30-Day BH Facility Incentive program with a select set of facilities. Changed the provider incentive payment methodology and the timeline for the incentive payments; 2020 incentive payments were paid out quarterly instead of annually. The incentive is paid to providers for each compliant member, for each measure that is eligible for the incentive program. Measures that are eligible include *Breast Cancer Screening*, *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*, and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*.
Appropriate Care—Chronic Conditions	The Guided Health program for providers continued, where quarterly provider communications are sent alerting providers of patients with less than 80% medication adherence in the following categories: cholesterol, diabetes, and hypertension. The PAVE program continued, in which the pharmacist has a one-on-one conversation with nonadherent patients about their medication adherence and provides counseling. Continued to work with Davis Vision to conduct outreach calls to educate members on the importance of getting a dilated eye exam.
Compliance Monitoring—Oversight of Delegated Vendors	Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers. Reports received from Chrysalis are used to identify enrollees who require care coordination. To streamline oversight of the crisis line, the HCI health plans are currently working with HFS to establish a joint oversight process. Implemented MCR dashboard reporting to monitor compliance with contractual requirements for MCR services. This process has allowed BCBSIL to track and trend compliance and address identified concerns with MCR providers.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting. Developed an internal process to comply with the requirements for CI reporting. Improved consistency in use of the unable-to-reach process and updating the care plan/service plan when a change in condition or need is identified.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Care Coordination/Transitions of Care Including BH	Began the Advancing Health Equity Learning Collaborative to support payment innovations to address health disparities. CountyCare's Clinical Services Department assumed the lead in developing an investment in the Flexible Housing Pool as an innovation to achieve improved health outcomes for members experiencing homelessness. The P4P reinvestment program will allow the initiative to launch at a larger scale. Developed a CM strategy to improve the care management program and streamline operations by providing direct care management for the population receiving LTSS and members who are not otherwise empaneled to a medical home-based care management entity. As part of the CM strategy, invested extensive resources in supporting CountyCare's other CMEs to build capacity to serve children through CountyCare's gold standard model, provider-based care coordination. Launched the fourth year of the Behavioral Health-Primary Care-Learning Collaborative, which averaged 80 participants representing 15 medical homes, 12 BH entities, and three CMEs. A BH dashboard with BH HEDIS metrics was presented at each event to educate and update partners on the progress of CountyCare's performance. Developed a new BH Facility Dashboard that includes information about members with admission for both mental health and substance abuse services and a companion Census and Authorization Dashboard of daily inpatient statistics across the network. These dashboards were used to monitor quality and outcomes by facility and develop quality improvement interventions.
Customer Service	Implemented an overall retention and growth strategy that achieved an average redetermination rate of 80% each month. The retention and growth team continued to make outbound calls to members who were up for redetermination and assist them with the redetermination process, and also hosted bimonthly redetermination events throughout Cook County. Continued the Customer Quality Management Committee (CQMC), a multidisciplinary committee responsible for the comprehensive assessment and oversight of customer service programs at CountyCare to ensure the "voice of the customer" is integrated into all program planning and monitoring activities. Expanded the use of eConsult, a platform for PCPs to communicate with specialists, to additional PCPs at FQHCs. The Provider Reconciliation and PCP Engagement Project completed final testing of the newly developed application to store all Medicaid provider data and is currently testing the process to export this data to Evolent. In addition, efforts continued to obtain and upload complete, up-to-date provider rosters to the provider portal.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Prevention and Screenings	Onboarded a new HEDIS vendor, Vital Data Technology (VDT). VDT's Affinity Quality platform provides customizable monthly care gap reports to monitor HEDIS compliance and share reports with providers. Phase 2, VDT's ProviderLink platform, will go live in FY 2021. It will support provider access to member-level detail specific to individual providers so they can monitor their own care gaps and close them using more timely, actionable data. Developed and provided education to the CMEs on HEDIS measure specifications and how to educate and activate members on gaps in care. Also provided each CME with quarterly HEDIS progress reports with member-level data for each measure, which CMEs used to prioritize outreach to close care gaps. In response to COVID-19, CountyCare launched the first clinical component of the Brighter Beginnings program by partnering with four durable medical equipment providers to establish an easy, one-step process for clinicians to order at-home blood pressure monitors and educational materials for pregnant and postpartum members. This equipment allows pregnant and postpartum members to routinely monitor their blood pressure, participate in telehealth visits with their provider, and alert their provider if concerns are identified. Continued the P4P provider incentive program and member incentive program, CountyCare Rewards, with members earning rewards for preventive screenings, medication adherence, and follow-up care provided to close care gaps.
Appropriate Care—Chronic Conditions	Continued partnership with Canary Telehealth to implement the Member Self-Management program for low- to moderate-risk members with a diagnosis of asthma, diabetes, hypertension, and/or obesity. Members use the Canary Telehealth phone application to record and track biometric data and receive education about their chronic illness. During the first survey of members enrolled for at least three months in Spring 2020, 86% of members thought getting the equipment, tracking readings, and health education was very valuable; 86% of members also reported using the app every day with 79% of members reporting a change in their health habits. Continued partnership with Canary Telehealth to offer in-home diabetic retinal exams to members to remove transportation and access to care barriers, resulting in over 3,000 exams completed.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Compliance Monitoring—Oversight of Delegated Vendors	Management of vision and dental benefits was de-delegated from DentaQuest/EyeQuest to Guardia/Avesis and care coordination was also de-delegated from La Rabida Children's Hospital to MHN ACO. Prioritized its engagement with provider groups to gather EMR supplemental data and received EMR data from two provider groups covering 15% of the CountyCare membership. The report describes investments in expanded dashboards, provider data, and pharmacy benefit management data including quarterly Medicaid Business Review retreats to advance pharmacy program goals. Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers. Improved collaboration with the nine Cook County MCR providers by working on process improvements, hiring a BH manager, and implementing a process for MCR providers to upload assessments to CommunityCare Connect (the case management software platform). Implemented monthly community stabilization audits for each delegated CME and CountyCare internal CM staff.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting. Completed revisions to the Care Management Program Manual to include the expectations for timely reporting to the IA, and specified the minimum number of attempts to follow up with the IA. Completed revision of the CI Investigation Resolution Form to comply with requirements. Improved oversight and monitoring completion of the internal CI reporting form.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
IlliniCare	
Care Coordination/Transitions of Care Including BH	Continued the Accountable Care Communities program, providing multiple levels of outreach and engagement to meet members and providers where they are and facilitate meaningful care coordination when members are most in need. A strategy shift was necessary due to COVID-19 to move to a telemedicine model for physical and BH services for the second half of SFY 2020. The health plan continued with the embedded model with staff in 15 provider offices and 26 medical and behavioral facilities statewide until the onset of COVID-19, which necessitated the need to move to a virtual model. Continued to leverage digital solutions technologies for immediate notification to the care team when members are admitted to network hospitals and EDs (PatientPing) and remote care management programs to improve early member participation in prenatal care, drive better birth outcomes, and increase engagement in postpartum and well-child infant care through education and member incentives (Pacify).
Customer Service	The Provider Performance business unit developed key innovations to support network provider performance. These reporting tools include substantive analytics at the practitioner level by drilling down on aspects of practice management, such as utilization and cost, that are critical to improving member engagement, effective delivery of preventive care, and better management of outcomes.
Prevention and Screenings	Continued to use innovative member outreach strategies (including text messaging and auto-dialed proactive outreach management [POM] calls), which improved the collection of health risk screening [HRS] data and HEDIS gap closure.
Appropriate Care—Chronic Conditions	A robust action was implemented across the organization in the first quarter of SFY 2019 to achieve significant improvement in HEDIS percentile performance for a range of measures. Interventions were led by leaders and staff across departments; they analyzed data and workflows, and implemented rapid-cycle improvement strategies. This comprehensive plan was shared in detail with HFS leadership and year-to-date results of these efforts demonstrate favorable progress toward goals. Continued to use and enhance its chronic condition and disease management programs, including a self-management texting program for members diagnosed with diabetes, asthma, hypertension, or obesity, and support of large provider-based initiatives such as the Diabetes Prevention Program and the Depression Collaborative Care Model. CountyCare launched a telepsychiatry program during the COVID-19 public health emergency to provide telehealth counseling and psychiatry services for any CountyCare member. Other efforts included the use of community-based workers who act as trusted resources in the community for outreach to members, education, informal counseling, referrals, and social supports.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
IlliniCare	
Compliance Monitoring—Oversight of Delegated Vendors	Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers and implemented an oversight and monitoring process for MCR providers to ensure receipt of the Illinois Medicaid Crisis Assessment Tool (IM-CAT) and crisis safety plans. Leadership and staff outreached to 25 of IlliniCare's top MCR agencies, met face-to-face with many of them to discuss partnership opportunities, and established regularly scheduled case consultations to discuss members with recent crisis evaluation. Completed 27 consultations and reviewed 332 members in 2019 and reviewed 178 members during 20 consultations in 2020. Identified five top providers and provided grants of $20,000 to be used for IlliniCare members post-crisis intervention with the goal of preventing further crisis events.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting and enhanced training for new hires to include pre- and post-testing to verify understanding of CI reporting. Revised the CI policy and procedure as well as training materials to include requirements. Developed a monitoring process to track compliance with CI reporting requirements, communication with the IA, and enrollee follow-up for closure of CIs. Implemented staff huddles to provide a forum for coaching and feedback on CI reporting, improve communication and oversight, and improve documentation on steps taken for resolution and closure of CIs.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
Care Coordination/Transitions of Care Including BH	Used field outreach coordinators (FOCs) to increase outreach to new and existing enrollees to increase contractual compliance. Outbound campaigns were conducted for initial/overdue health risk assessment/health risk screening (HRA/HRS), welcome calls, maternity prenatal and postnatal assessments and trimester education, enrollees with coverage gaps, and other ad-hoc initiatives such as flu and COVID-19 outreach, satisfaction surveys, and attempts to contact enrollees who are unable to be reached (UTR). In total, FOC teams completed 111,920 outreach calls for CM activities and initiatives during quarters three and four of SFY 2020. Implemented interventions to remedy staffing challenges, contractual modifications, and population growth that impeded meeting the health plan's goal of a 75% completion rate for initial assessments and care plans across all programs. Interventions to improve program performance included collaboration with talent acquisition to hire staff through job fairs, interviews and implementation of weekly monitoring and compliance reports that track assessment and care plan completion rates by the team in real time, and streamlining HRS.
Customer Service	Though delayed, Meridian still plans to implement member feedback from Member Advisory Committees and reestablish an interdepartmental CAHPS workgroup designed to identify key drivers for member satisfaction and implement initiatives. Established a Member and Provider Satisfaction Workgroup in February 2020 that includes the Appeals, Care Coordination, Customer Experience, Grievances, and Quality Improvement departments. The purpose of the workgroup is to review annual CAHPS results; identify barriers to low scores; and create collaborative, interdepartmental, multifaceted solutions to improve ratings for future surveys.
Prevention and Screenings	Partnered with a third-party vendor, NovuHealth, to conduct outreach to Medicaid members due for P4P-related appointments and offer incentives for completing services. In SFY 2020, the partnership resulted in 80,520 unique members receiving outreach who had one or more open care gaps across all HEDIS measures. Of those members, 1,604 (2%) activated an account with NovuHealth. A total of 630 gift card redemptions were completed for members who attested to completing services.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
Appropriate Care—Chronic Conditions	Partnered with a third-party vendor, HealPros, to schedule appointments in high noncompliant areas for *Comprehensive Diabetes Care—Eye Exam.* HealPros was able to complete mobile eye exams in member residences and address identified gaps in care for diabetic members. In SFY 2020, the partnership resulted in outreach to 9,406 Medicaid members and 916 scheduled appointments; 751 (82%) appointments were successfully completed. Created a catastrophic flag (C-Flag) program to identify enrollees who may benefit from more intensive clinical CM. A majority of enrollees with a C-Flag are currently receiving palliative or hospice services; however, many members are not appropriate for palliative or hospice services but have high-cost medical needs and are at a higher risk for poor outcomes due to life threatening illnesses and/ or mismanagement of chronic disease. Enrollees that are appropriate for C-Flag are assigned to a CM nurse clinician so that care plan goals and more frequent outreach can be medically tailored to meet the increased clinical needs of the enrollee. As of June 30, 2020, there were 32 C-Flag cases enrolled in CM. Continued the Progeny First Year of Life program to provided intensive CM services for members who have babies admitted into a neonatal intensive care unit (NICU) or special care nursery up to their first birthday.
Compliance Monitoring—Oversight of Delegated Vendors	Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers and increased collaboration and communication with MCR providers for enrollees who are community stabilized or hospitalized through several program improvements. Partnered with five MCR providers to pilot the changes to create a provider-centric model and facilitated monthly meetings with MCR providers to continue to evaluate the program changes.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting and developed an on-demand webinar resource on how to complete a CI reporting form in its entirety. Revised policy to increase to unable to reach outreach attempts to external agencies and demonstrated increased communication with the IA after the initial CI report was made. Improved compliance with consistent utilization of the unable to reach process, including using a variety of sources to obtain contact with enrollees.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
Care Coordination/Transitions of Care Including BH	Continued to support the Embedded Transition of Care Program, which aligns a TOC coach to every in-network hospital across the state to increase collaboration and improve discharge planning. Created the Telepsychiatry Grant program that offered $100,000 each to five BH providers to support capacity for telepsychiatry services. Since its launch last year, Molina's Behavioral Health Excellence Program has realized improved engagement from provider discharge planners in scheduling specific follow-up appointments with members in place of general walk-in clinic referrals that had become common. Molina's CM department participated in dedicated engagement meetings with larger providers to discuss clinical opportunities and best practices. The program offers an incentive for facilities to achieve follow-up and readmission goals while collaborating with Molina quality staff and provides quarterly scorecard reporting to facilities.
Customer Service	Secured key contracts with providers that address the needs of members in Southern Illinois and refocused contracting efforts to engage ancillary providers to support and meet the needs within the community that are not hospital-based services. This refocus allowed the provider network team to engage in contracts with specialty providers such as Prentke Romich, Tobii Dynavox, and others to ensure that members are able to access the providers that they need.
Prevention and Screenings	Continued the use of Community Connectors, a team of dedicated care coordination field staff dedicated to member outreach, education, and advocacy. Community Connectors are geographically focused and can connect face-to-face with members in their regions. They leverage claims and authorization data for leads in finding Molina's UTR members. Community Connectors work with members to secure updated contact information and develop a relationship to engage the member in completing health assessments and connect the member with local supports. Continued the HEDIS medical project to which Molina partly attributes its rate improvements in hybrid measure rates. Molina actively pursued over 9,000 medical records for the project and achieved 93.6% project completion, exceeding the goal of 85% and last year's 90% completion. Molina's complete compliant chart review percentage was 34.9%, which was an improvement of nearly four percentage points from the 2019 project.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
Appropriate Care—Chronic Conditions	Developed a disease-specific case management program to lend dedicated expertise to management of members with prevalent chronic conditions, including diabetes, asthma, COPD, sickle cell, HIV/AIDS, and congestive heart failure (CHF). Molina assigned one or more case management subject matter experts for each disease state, and those experts helped develop checklists, guides, trainings, and other materials for their fellow case managers to help them achieve best practices for managing the disease states. The subject matter experts offered consultations to case managers and took on a caseload of members who had high risk in their disease states. Since respiratory illness was a key driver of utilization and ED use, Molina enlisted a respiratory specialist to join the new disease-specific case management program.
Compliance Monitoring—Oversight of Delegated Vendors	Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers and revised internal processes to ensure MCR providers, inpatient hospitalization staff, and health plan staff roles are clearly defined. Implemented a potential quality of care process to monitor MCR providers not meeting the 90-minute IM-CAT time frame and created and distributed provider memorandums to outline the expectations for MCR providers and facilities. Added eviCore as a new delegated vendor in 2020 to provide utilization management reviews for select laboratory, radiology, radiation oncology, sleep study, and genetic testing. Bolstered Molina's delegation oversight activities by expanding joint oversight committee meetings to include encounter data staff to ensure compliance with encounter utilization monitoring expectations and a robust presentation and discussion regarding member grievances and appeals to address any trends to identify quality of care concerns and improvement opportunities.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting, changed the internal procedure for improved CI supervisory oversight, and conducted staff trainings to address CI policy and procedure changes. Implemented utilization of consistent criteria to determine closure of a CI. Demonstrated improved documentation of UTR attempts for enrollees who cannot be located following identification/report of CI and improved communication with IA after initial CI report.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
NextLevel	
Care Coordination/Transitions of Care Including BH	TOC team continued to engage with hospital discharge planners and social workers, including embedding case managers at partnering facilities and utilizing a daily census report that pulls all notifications of a hospital admission into one report which allows the TOC team to identify and engage with members and discharge planners while they are in the hospital. Partnered with PatientPing to receive real-time notifications from facilities within the PatientPing network when a member presents to the ED or is otherwise admitted, allowing the TOC team to identify high-risk members in real-time and monitor specific member populations to allow for immediate course correction. Initiated a housing pilot with Trilogy, a community BH provider partner, for enrollees with serious mental illness with a history of high inpatient utilization. Instituted daily, integrated provider rounds on BH readmissions. Strategically relaxed prior authorization (PA) requirements for outpatient behavior and substance use disorder to remove barriers to members availing themselves of outpatient care and tightened PA requirements for inpatient opioid care as evidence supports outpatient care over inpatient.
Customer Service	Acquired multiple licenses with Quest Analytics, a network management solution tool, to track network adequacy requirements. NextLevel reported a 100% network adequacy rating in FY 2020. Implemented an appointment availability audit program (measuring wait times for various appointment types). Engaged an FQHC partner that covers 75% of the health plan's geographic area and 40% of its membership.
Prevention and Screenings	Created the Complete Health Advisory Council, which is aimed at tackling SDoH and reaching members in their communities. Members of the 30-person group range from BH providers to substance abuse counselors to leaders of FQHCs. Launched a grassroots approach to create specific service areas in the diverse neighborhoods of Cook County by creating eight Community Wellness Zones with the goal of facilitating access to locally curated, tailored, culturally competent physical and BH services, including prevention services, social services, education, and wellness programs. Continued the NextLittle Steps program, which provides wrap-around care for pregnant members, extends coverage to one year for this population, and provides a greater opportunity to address SDoH and preventive measures that directly impact fetal and maternal mortality.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
NextLevel	
Appropriate Care—Chronic Conditions	Developed a disease/condition-specific member registry (e.g., asthma, cancer, transplant) to focus CM and specialty care before conditions progress to more severe stages. Continued to collaborate with the Metropolitan Chicago Breast Cancer Task Force to outreach to and engage members. Continued to enhance the health information exchange partnership that allows the health plan to get real-time clinical notification when members presented to selected providers to receive care.
Compliance Monitoring—Oversight of Delegated Vendors	Implemented Chrysalis crisis line call center reporting to monitor timely referral to MCR providers.
Compliance Monitoring—CI Reporting	Conducted a variety of staff trainings related to CI reporting. Revised internal CI policies and procedures to include contractual requirements and HFS policy related to CI reporting, IA follow-up, care plan updates, and tracking of CIs.

Appendix B1. 2019–2020 Performance Measure Methodology

NCQA HEDIS Compliance Audit

Objectives

This section describes the evaluation of the health plans' ability to collect and report on the performance measures accurately. The HEDIS performance measures are a nationally recognized set of performance measures developed by the NCQA. Healthcare purchasers use these measures to assess the quality and timeliness of care and service delivery to members of managed care delivery systems.

A key element of improving healthcare services is the ability to provide easily understood, comparable information on the performance of the health plans. Systematically measuring performance provides a common language based on numeric values and allows the establishment of benchmarks, or points of reference, for performance. Performance measure results allow the health plans to make informed judgments about the effectiveness of existing processes and procedures, identify opportunities for improvement, and determine if interventions or redesigned processes are meeting objectives. HFS requires the health plans to monitor and evaluate the quality of care using HEDIS and HFS-defined performance measures. The health plans must establish methods to determine if the administrative data are accurate for each measure. In addition, the health plans are required by contract to track and monitor each performance measure and applicable performance goal on an ongoing basis, and to implement a quality improvement initiative addressing compliance until the health plans meet the performance goal.

NCQA licenses organizations and certifies selected employees of licensed organizations to conduct HEDIS Compliance Audits using NCQA's standardized audit methodology. The NCQA HEDIS Compliance Audit indicates the extent to which health plans have adequate and sound capabilities for processing medical, member, and provider information for accurate and automated performance measurement, including HEDIS reporting. The validation addresses the technical aspects of producing HEDIS data, including information system practices and control procedures, sampling methods and procedures, data integrity, compliance with HEDIS specifications, and analytic file production.

Technical Methods of Data Collection and Analysis

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's MY 2019 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS 2020, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*, which outlines the accepted approach for auditors to use when conducting an Information Systems (IS) capabilities assessment and an evaluation of compliance with HEDIS specifications for a plan. All of HSAG's lead auditors were Certified HEDIS Compliance Auditors (CHCAs). The audit involved three phases: off-site, on-site, and post-on-site.[B-1] The following provides a summary of HSAG's activities with the health plans, as applicable, within each of the validation phases:

[B-1] Due to the impact of the COVID-19 virus, some of the health plans' HEDIS audits were conducted virtually instead of on-site. However, the on-site validation phase remained unchanged if the audit was conducted virtually.

Off-Site Validation Phase (October 2019 through May 2020)

- Forwarded HEDIS 2020 Record of Administration, Data Management, and Processes (Roadmap) upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled on-site visit dates.
- Conducted kick-off calls to introduce the audit team, discussed the on-site agenda, provided guidance on HEDIS audit processes, and ensured that health plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the IS standard tracking report that listed outstanding items and areas that required additional clarification.
- Reviewed source code used for calculating the HEDIS performance measure rates to ensure compliance with the technical specifications, unless the health plan used a vendor whose measures were certified by NCQA.
- Reviewed source code used for calculating the HFS-defined performance measure rates to ensure compliance with the specifications required by the State.
- Conducted validation for all supplemental data sources (SDS) intended for reporting and provided a final supplemental data validation report that listed the types of supplemental data reviewed and the validation results.
- Conducted preliminary rate review to assess data completeness and accuracy early in the audit process to allow time for making corrections, if needed, prior to final rate submission.
- Conducted medical record review validation (MRRV) to ensure the integrity of medical record review (MRR) processes for performance measures that required medical record data for HEDIS reporting.

On-Site Validation Phase (January 2020 through April 2020)

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

Post-On-Site Validation Phase (May 2020 through July 2020)

- Worked collaboratively to resolve any outstanding items and corrective actions, if applicable, and provided a final IS standard tracking report that documented the resolution of each item.
- Conducted final rate review and provided a rate analysis report that included a comparison to the preliminary rate submission and prior two years' rates (if available) and showed how the rates compared to the NCQA HEDIS 2019 Audit Means, Percentiles, and Ratios. The report also included requests for clarification on any notable changes in rates, eligible populations, or measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result for each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the performance measure validation. These included:

- HEDIS Roadmap.
- Source code, computer programming, and query language (if applicable) used to calculate the selected measures.
- Supporting documentation, such as file layouts, system flow diagrams, system log files, and policies and procedures.
- Reabstraction of a sample of medical records selected by HSAG auditors.

HSAG also obtained information through interaction, discussion, and formal interviews with key health plan staff members and by observing system demonstrations and data processing.

A specific set of performance measures was selected by HFS for validation by HSAG based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. The measures selected for validation through the NCQA HEDIS Compliance Audits are listed in the table below. For measures that had an administrative and hybrid methodology, HFS allowed the health plans to choose the methodology (i.e., admin or hybrid) that worked best for its health plan.

Table B1-1—Measures Selected for Validation

HEDIS 2020 Performance Measures Selected by HFS			
	Performance Measure Name	**Acronym**	**Methodology**
1	*Ambulatory Care*	*AMB*	Admin
2	*Childhood Immunization Status*	*CIS*	Hybrid
3	*Follow-Up After Hospitalization for Mental Illness*	*FUH*	Admin
4	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	*IET*	Admin
5	*Medication Management for People With Asthma*	*MMA*	Admin
6	*Metabolic Monitoring for Children and Adolescents on Antipsychotics*	*APM*	Admin
7	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*	*WCC*	Hybrid
8	*Movement of Members Within Service Populations (HFS-defined measure)*	*IL 3.6*	Admin

HSAG used several different methods and information sources to conduct the audits, including:

- Teleconference calls with health plan personnel and vendor representatives, as necessary.
- Detailed review of each health plan's completed responses to the HEDIS 2020 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS 2020, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*, and updated information communicated by NCQA to the audit team directly.

- On-site meetings in the health plans' offices, which included staff interviews, live system and procedure demonstrations, documentation review and requests for additional information, primary source verification (PSV) for a selection of measures, programming logic review and inspection of dated job logs, computer database and file structure review, and discussion and feedback sessions.
- Detailed evaluation of computer programming used to access administrative data sets and calculate HEDIS measures.
- If the hybrid method was used, an abstraction of a sample of medical records selected by the auditors was compared to the results of the health plan's review determinations for the same records.
- If nonstandard supplemental data were used, PSV was conducted on a sample of records, which involved review of proof-of-service (POS) documentation for each selected case.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates submitted by the health plans.
- A variety of interviews with individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, the IS director, the quality management director, the enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that calculated HEDIS 2020 (and earlier) performance measure data may also have been interviewed and asked to provide documentation of their work.

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the NCQA categories listed below in Table B1-2.

Table B1-2—Performance Measure Audit Results and Definitions

Rate/Result	Definition
R	*Reportable.* A reportable rate was submitted for the measure.
NR	*Not Reported.* The health plan chose not to report the measure.
NA	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate. a. For Effectiveness of Care (EOC) and EOC-like measures, when the denominator is <30. b. For utilization measures that count member months, when the denominator is <360 member months. c. For all risk-adjusted utilization measures, when the denominator is <150. d. For electronic clinical data systems measures, when the denominator is <30.
NB	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.
NQ	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Unaudited.* The health plan chose to report a measure that is not required to be audited. This result applies only to a limited set of measures (i.e., Board Certification).

For measures reported as percentages, NCQA has defined significant bias as a deviation of more than five percentage points from the true percentage. (For certain measures, a deviation of more than 10 percentage points in the number of reported events determines a significant bias.)

For some measures, more than one rate is required for HEDIS reporting (e.g., *Medication Management for People with Asthma* and *Initiation* and *Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*). It is possible that the health plan prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the health plan would receive a *Reportable (R)* result for the measure as a whole, but significantly biased rates within the measure would receive a *Biased Rate (BR)* result, where appropriate.

Upon completion of the audit, HSAG submitted a final audit report to HFS and each health plan that included a completed and signed final audit statement.

For the MRRV portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) review the MRR processes employed by the health plan, including MRR staff qualifications, training, data collection instruments/tools, accuracy of data collection, vendor oversight, and the method used for combining MRR data with administrative data; and (2) complete MRRV, which involves the validation of the health plan's abstraction accuracy for a sample of cases across the NCQA-designated measure groups and a comparison of HSAG's validation results to the health plan's abstraction results.

HSAG reviewed the processes in place at each health plan for MRR performance for all measures reported using the hybrid method. HSAG reviewed data collection tools and training materials to verify that all key HEDIS data elements were captured. Feedback was provided to each health plan if the data collection tools appeared to be missing necessary data elements.

HSAG completed the MRRV process and reabstracted sample records across the appropriate measure groups and compared the results to each health plan's findings for the same medical records. This process provided an assessment of actual reviewer accuracy. HSAG randomly selected 16 cases from the MRR numerator positives as identified by each health plan. If fewer than 16 medical records were found to meet numerator compliance, all records were reviewed or additional records from another measure within the same group were added to equal 16 cases. If an abstraction discrepancy was noted, only critical errors were considered errors. A critical error is defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa). If one critical error was noted, HSAG was required to retest a second sample of 16 records that did not include the original sampled records. If the second sample was free of errors, the measure and measure group passed. If one or more errors were detected, the measure and measure group did not pass validation and could not be reported until all errors were corrected and reviewed by the auditor. If there was not enough time to correct all errors, the health plan was not allowed to report the measure via the hybrid methodology.

Plan-Specific Findings for HealthChoice Illinois Health Plans

NCQA HEDIS Compliance Audit Results for BCBSIL

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for BCBSIL's HealthChoice Illinois population. The audit indicated that BCBSIL was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B1-3—BCBSIL 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

BCBSIL used Cognizant (formerly TMG) as a third-party administrator to process medical services data. Cognizant used Facets to process claims. Cognizant received approximately 90 percent of claims in standard 837 format and the remaining 10 percent on paper. Cognizant only accepted standard claims forms, diagnosis codes, and procedure codes. Cognizant converted paper claims to 837 format by scanning and using optical character recognition (OCR) technology. All 837 files received through the clearinghouse via Cognizant's scanning process were loaded into Facets through the applications translator. Standard validations and business rules were applied. For 2019, 87 percent of claims were auto-adjudicated.

Cognizant's Quality Team conducted audits on a random sample of claims to monitor processor proficiency and accuracy. BCBSIL met with Cognizant weekly to discuss operations and targeted audit results. The audits assessed timeliness, compliance with State processing requirements, potential fraud and abuse, technical accuracy, and financial accuracy. In addition, BCBSIL conducts annual delegation audits of Cognizant. BCBSIL reimbursed providers on a fee-for-service (FFS) basis for all services. The plan reinforced this point during the on-site visit. During the on-site visit, Cognizant provided a system walk-through to demonstrate the ability of the Facets system to capture data elements required to support HEDIS reporting. The walk-through confirmed that Facets had processes to validate procedure codes, diagnosis codes, eligibility, and provider affiliation. The capture of rendering provider identifiers was also confirmed.

BCBSIL had a very close relationship (financial stake) with Prime Therapeutics. Oversight included weekly and biweekly meetings. Reports and dashboards presenting performance on key indicators of operational and quality metrics were reviewed during meetings.

BCBSIL provided data for the Query 2—Data Loading Checks request, documenting the monthly medical and pharmacy claim counts for 2019. Monthly medical claim counts provided demonstrated a reasonable, consistent volume and trend over the year, with a slight decrease in the last two months of the year. Monthly pharmacy claim counts were consistent across all of 2019.

BCBSIL was fully compliant with IS Standard 1.0.

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

BCBSIL's membership did not change significantly during 2019. Monthly membership counts remained very consistent for the first half of the year, with small increases each month over the last half of the year.

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

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

During June 2019, BCBSIL identified a problem with missing member enrollment segments on the eligibility files provided by the State. The issue was corrected by the State, and a small increase in the volume of retroactive enrollment segments occurred for a short period. BCBSIL provided monthly enrollment counts by gender for 2019 (Query 1—Overall Demographics). Query results showed a modest increase during the second quarter of 2019, with a slow decreasing trend throughout the rest of the 2019. A small but consistent increase in enrollment was observed over the last six months of the year.

BCBSIL was fully compliant with IS Standard 2.0.

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

BCBSIL maintained practitioner data in Premier Provider and Facets. Credentialing and contracting data were maintained in the Premier Provider system. Daily files were exported and transferred to Cognizant via a file transfer protocol (FTP) site. Weekly reports (Control 77 Premier—Facets Error Report) were produced and reviewed to ensure concordance between the two systems. The report compared the full set of practitioner data in each system. The concordance rate between the two systems was consistently over 95 percent. During the on-site, system demonstrations were conducted for both the Premier Provider and Facets provider systems. Two behavioral health providers were reviewed in both systems to verify the concordance of the data in the systems. A walkthrough of the configuration of providers within one contracted federally qualified health center (FQHC) was conducted. The demonstration confirmed that all individual practitioners within the contracted FQHC were loaded in the Premier and Facets systems. All data elements, including specialty and active contract segments, matched across the two systems.

BCBSIL was fully compliant with IS Standard 3.0.

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

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

BCBSIL used internal staff to conduct MRRs and quality assurance (QA). Staff members were sufficiently qualified and trained on the HEDIS Technical Specifications and the use of Inovalon's Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for the measures under review. BCBSIL conducted appropriate post-training assessment of staff and required a 95 percent score for staff to begin working on the project. Ongoing overreads of records were also conducted.

BCBSIL was determined to be exempt from convenience sample validation. Both the *CIS* and *WCC* measures were selected for the final statistical MRR validation process. Documentation for selected members was provided by BCBSIL and reviewed. BCBSIL successfully passed the final MRRV.

BCBSIL was fully compliant with IS Standard 4.0.

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

BCBSIL submitted documentation for two standard SDS for HEDIS 2020 reporting: Quest Diagnostics (Quest) and Boncura Health Solutions (Boncura). BCBSIL received Quest data twice monthly in a standard format. Quest data were loaded into the BCBSIL Enterprise Data Warehouse (EDW). Boncura data were received in a standard proprietary file layout that has been used by the provider group for many years. Boncura data required mapping of the lab test name to a standard code.

BCBSIL provided a demonstration of the data in the EDW. The demonstration included data discussion about validations and visual inspection to confirm required data fields.

All SDS were reviewed and approved for HEDIS 2020 reporting prior to the on-site visit.

BCBSIL was fully compliant with IS Standard 5.0.

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

BCBSIL had a sound process for updating and monitoring the accuracy and completeness of the HEDIS data repository. Standard data sources, including enrollment, provider, claims, pharmacy, and supplemental data, were updated monthly. Routine data checks, including record counts and data integrity checks, were performed and documented in the Data Quality Report (DQR). BCBSIL's process included monthly calculation and reporting of HEDIS measures to support internal quality improvement activities and to provide ongoing monitoring and comparison for the production of HEDIS performance measure calculations.

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

BCBSIL was fully compliant with IS Standard 6.0.

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

BCBSIL used Inovalon's QSI software to generate its performance measure rates. BCBSIL had a sound process for monitoring data integrity and the accuracy of calculations. BCBSIL conducted parallel calculation and reporting processes that provided monthly updated reporting and the annual production for HEDIS reporting. During the on-site visit, PSV for Query Group 3 was conducted for five members in each of the following measures: *FUH*, *WCC*, and *IL 3.6*. For each member, enrollment, administrative, and practitioner data in the QSI repository and source systems were reviewed to confirm compliance with measure specifications and system concordance. All five members for each of the selected measures were found to be compliant with the measure specification requirements.

In addition to the on-site query review, data for additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers, and loads into the QSI repository. Membership and enrollment data were assessed through Query Group 1—Overall Demographics query for which BCBSIL provided monthly membership counts for 2019 by product and stratified by gender.

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

BCBSIL was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for CountyCare

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for CountyCare's HealthChoice Illinois population. The audit indicated that CountyCare was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS measures received an *R* designation.

Table B1-4—CountyCare 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

In 2019, CountyCare continued to delegate most health plan operations to Evolent, including claims processing. Evolent used Aldera as its claims transactional system. For 2019, approximately 90 percent of claims were received electronically in the standard 837 format. The remaining 10 percent of claims were received as paper claims and then scanned and converted to the standard 837 format for loading. Evolent only accepted standard claim forms, diagnosis codes, and procedure codes. Electronic claims files were loaded into the Aldera system, and industry-standard edits were applied. Evolent had appropriate edits in place at the clearinghouse level for formatting as well as member validation, code edit checks, and required field checks within the Aldera system. CountyCare conducted weekly meetings with Evolent, and Evolent provided daily reports to CountyCare for oversight. Claims audits were conducted on claims that failed the initial validation and required manual processing. Biweekly oversight meetings were conducted by CountyCare.

CountyCare reimbursed providers through an FFS delivery system, with few exceptions for individual providers. A small number of providers were reimbursed through a capitation model for behavioral health services. These providers were required to submit claims for all services. CountyCare closely monitored received claims and compared the claims with capitation payments. Evolent provided a system demonstration during which original claims were compared with data in the Aldera system, and all HEDIS-related fields were traced through into the Aldera system.

CountyCare contracted with OptumRx for January through March of 2019 and MedImpact for the rest of 2019. OptumRx provided daily encounter files along with monthly reconciliation files. Routine

oversight and monitoring of pharmacy data for completeness and accuracy was appropriate for HEDIS reporting. Similarly, MedImpact provided daily encounter files along with monthly reconciliation files. Pharmacy encounter files were received by Evolent and loaded into the data warehouse. Routine validation reports were produced during the process of being loaded into the warehouse.

CountyCare provided data for the Query Group 2—Data Loading Checks request, documenting the monthly medical and pharmacy claim counts for 2019. Monthly medical claim counts provided demonstrated a reasonable modest volume and trend over the year, with a slight decrease in the last two months of the year. Monthly pharmacy claim counts were consistent across all of 2019.

CountyCare was fully compliant with IS Standard 1.0.

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

CountyCare experienced a very small (3 percent) decrease in enrollment during 2019. CountyCare delegated enrollment processing to Evolent. Daily and weekly 834 files were received through an automated process and loaded into Aldera. Daily and weekly files contained member additions, terminations, and changes. The 834 files provided by HFS were clean, with a very low volume of rows that were rejected during the load process. The most common reason for rows being rejected included overlapping segments, date of birth inconsistencies, and name inconsistencies.

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

CountyCare provided monthly enrollments counts by sex for 2019 (Query Group 1—Overall Demographics). Query results showed a consistent member count throughout the rest of 2019.

CountyCare was fully compliant with IS Standard 2.0.

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

CountyCare submitted daily provider files to Evolent, which were loaded into the Aldera system. In addition, Evolent routinely identified providers who submitted claims for CountyCare members but were not included in the files provided by CountyCare. These providers were researched through the State provider database and entered into the Aldera system; data elements included provider specialty.

Evolent provided a demonstration of the Aldera provider system, and no issues were identified. The Aldera system contained all HEDIS-relevant data elements.

CountyCare was fully compliant with IS Standard 3.0.

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

CountyCare continued to contract with Change Healthcare as its medical record project vendor. HSAG reviewed the Change Healthcare tools and participated in a live demonstration of the MRR application

to determine compliance with HEDIS audit standards. HSAG approved the medical record tools for HEDIS 2020 production prior to the virtual on-site audit. Change Healthcare had appropriate training and conducted routine evaluation of abstractor accuracy. Abstractor oversight included overreads of 5 percent of each abstractor's charts and a minimum of 95 percent accuracy must be maintained. CountyCare conducted close oversight along with weekly oversight meetings to ensure complete and accurate data collection.

CountyCare sampled for the *WCC* and *CIS* measures according to the HEDIS sampling guidelines and assigned measure-specific oversamples. The MRR project configuration and data were reviewed through a walkthrough of the MRR application.

Based on the State's allowance to rotate hybrid measures due to COVID-19 related issues, CountyCare elected to rotate the *CIS* and *WCC* measures using HEDIS 2019 (MY 2018) hybrid rates. As a result, final MRR was not required.

CountyCare was fully compliant with IS Standard 4.0.

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

CountyCare presented several standard SDS' for HEDIS 2020 reporting including:

- Care Coordination Claims Data (CCCD) State Encounter File
- HFS Immunization Registry
- LabCorp
- Cook County electronic health record (EHR)
- Mount Sanai Lab Data
- Quest Diagnostics
- Stroger Lab
- Lawndale Clinic EHR

These SDS were determined to be standard supplemental data and were exempt from PSV.

CountyCare hosted a Webex meeting on February 21, 2020, to review supplemental data sources. CountyCare provided process overviews describing data procurement, warehousing, and validations. Eight standard data sources were reviewed and found to be compliant with NCQA's supplemental data guidelines.

All standard SDS were approved to use for HEDIS 2020 reporting on March 31, 2020.

CountyCare was fully compliant with IS Standard 5.0.

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

Evolent built monthly data warehouses from the Aldera tables, including claims, enrollment, and provider data. Change Healthcare loaded the text files into the repository and conducted valuations that included repository-to-source record count reconciliation, integrity checks, and field-level validations. Validations were documented through the Pre-data Assessment Report (PDAR), which Evolent provided to CountyCare for review. The PDAR documented validation results that included detailed information at the file and field level. Evolent did not accept nonstandard coding schemes; therefore, no crosswalks were used or reviewed.

CountyCare provided a walk-through of the process for its data extraction claims system and the Change Healthcare load and validation process. The load and validation process had appropriate controls in place, including logs and field-level validations.

The change in pharmacy vendors from OptumRx to MedImpact in March 2019 had no negative impact. The transfer of files from the Evolent monthly data warehouses into the Change Healthcare repository continued to have the same level of record count reconciliation, integrity checks, and data validation.

CountyCare was fully compliant with IS Standard 6.0.

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

CountyCare maintained its relationship with Change Healthcare for HEDIS 2020 performance measure production. All HEDIS measures within the scope of the audit were included in Change Healthcare's measure certification. The process for calculating the *IL 3.6* measure was reviewed during the on-site visit, and CountyCare asked for clarification on the requirements for identifying MLTSS members. Source code for this measure was submitted for review after the clarification was provided.

During the on-site visit, PSV for Query Group 3 was conducted for five members for each of the following measures: *FUH* and *WCC*. Enrollment, administrative, and practitioner data in the QSI repository and source systems were reviewed for each member to confirm compliance with measure specifications and system concordance. All five members for each of the selected measures were found to be compliant with the measure specification requirements.

During the on-site visit, CountyCare provided a walkthrough of the *IL 3.6* calculation. Source code review was performed and found that the underlying calculations met the measure specifications.

In addition to the on-site query review, data for additional queries were reviewed to assess the accuracy and completeness of data extracts, transfers, and loads into the Change Healthcare repository. Membership and enrollment data were assessed through the Group 1—Overall Demographics query for which CountyCare provided monthly membership counts for 2019 by product and stratified by gender.

CountyCare was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for IlliniCare

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for IlliniCare's HealthChoice Illinois population. The audit indicated that IlliniCare was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B1-5—IlliniCare 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

Centene Corporation (Centene) processed IlliniCare's claims during MY 2019 using the AMISYS Advance (AMISYS) system in several locations, including Missouri, Montana, Arizona, and California. The majority of IlliniCare's claims were processed in Great Falls, Montana.

Approximately 97 percent of claims were received electronically. The auto-adjudication rate for IlliniCare was 90.5 percent.

Claims audits conducted by Centene included high dollar audits for hospital and medical claims, as well as a random sample of claims reviewed and reported monthly. Overall internal audit scores for 2019 were greater than 99 percent for financial accuracy and 98 percent for payment accuracy. These results met the health plan's goals.

Electronic claims transmissions had requirements in place to ensure HIPAA compliance. The electronic claims also went through several business rule validations including field edits, member eligibility, provider eligibility, authorization, benefits, and pricing. The claims were then loaded to AMISYS.

The majority of IlliniCare providers under capitated payment arrangements were part of primary care practices. Encounters submitted by capitated providers were processed in AMISYS the same as claims. The providers were required by the State to submit all encounters to IlliniCare.

IlliniCare's contracted ancillary vendors included Envolve Pharmacy, Envolve Vision, and Envolve Dental. CVS was the pharmacy benefit manager (PBM) until October 1, 2019. Starting on October 1,

2019, IlliniCare contracted with RxAdvance to serve as its PBM. Pharmacy data files were sent directly from the PBMs to IlliniCare daily. Envolve was responsible for managing the relationships with the pharmacy vendors and performing vendor oversight. There were no issues with receiving the files after the transition to the new PBM; files were sent in the same format, and reversals followed the same process.

Envolve submitted data files for dental and vision services to IlliniCare weekly. Files were submitted securely and loaded to the data warehouse. Vendor file submission counts were monitored monthly. Files were validated for HIPAA compliance, valid field formatting, and valid data types. There were some load failures of the dental files during 2019; however, additional attempts were made, and the files were able to be loaded.

IlliniCare was fully compliant with IS Standard 1.0.

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

HFS submitted enrollment files to IlliniCare daily and monthly during 2019. These files were initially loaded to the electronic data interchange and then to Unified Member View (UMV) and AMISYS.

Following each transmission, record counts were matched to the State file. The Queued Error Report identified any membership information that could not be loaded. These cases were researched and resolved daily. Records that were flagged as "fatal" and records with error messages had to be resolved prior to processing.

Error reports were run to identify errors such as invalid effective date, PCP affiliation errors, and effective date occurring prior to date of birth. Daily error reports were reviewed and researched within the same day.

In addition, internal audits were conducted after the monthly files were received. The audit compared the State eligibility information to the information in AMISYS. All discrepancies were researched and corrected, if needed.

There were no significant issues receiving or processing the State's enrollment files during 2019.

There were no member benefits carved out by the State in 2019.

IlliniCare was fully compliant with IS Standard 2.0.

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

Portico was the system IlliniCare used to maintain credentialing data in 2019 and was the main database used to house all practitioner data. The practitioner data automatically flowed from Portico to AMISYS and the data warehouse. Data feeds to AMISYS were continuous.

CenProv was the module used to load data to Portico. Practitioner data rosters were updated in CenProv, validated, and then loaded to Portico. Procedures were in place to monitor the provider roster

transmissions. Once the data were loaded to Portico, additional checks were performed to ensure accuracy. The practitioner data in AMISYS were also validated to ensure accuracy and completeness.

FQHCs and rural health clinics (RHCs) were confirmed using the State roster of providers; this was known as the State Impact File. The State Impact File had a provider type field that identified if the facility was an FQHC or RHC. The servicing provider information was captured if included on the claim.

IlliniCare was fully compliant with IS Standard 3.0.

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

IlliniCare confirmed there were no changes to its MRR processes since the prior year.

IlliniCare used internal staff to conduct the MRRs using Inovalon's QSHR abstraction tools. IlliniCare had 10 staff members (five employees and five temporary staff members) involved in the MRR process for reporting year 2020. Six of the reviewers were new to IlliniCare. MRR training was held in January 2020, and all staff members involved attended the training. IlliniCare administered a test, and all MRR staff members passed.

IlliniCare performed 100 percent overread of the MRRs during the first two weeks of the project, with 95 percent accuracy required. Retraining was provided if needed. After the first two weeks, overreads were conducted biweekly on a sample of completed charts that were compliant and partially compliant. End of season results were compiled.

The retrieval process involved direct EHR access, faxes to provider offices, and on-site visits. If the practice contracted with Ciox, records were uploaded to the Ciox portal.

There were no changes to the chase logic; however, some rule orders were changed in QSHR. The number of chases for the current year was comparable to the count for the previous year. The auditor reviewed and approved the sample sizes. IlliniCare did not reduce sample sizes.

For the *CIS* and *WCC* measures, the primary chase was at primary care offices. IlliniCare had login access to the State Immunization Registry and this was used for chart reviews.

IlliniCare ran samples in mid-February. Outreach was completed and abstraction began according to schedule. IlliniCare monitored reviewer progress using QSHR.

The auditor determined that IlliniCare met the criteria to waive the convenience sample requirement.

Based on the State's allowance to rotate hybrid measures due to COVID-19 related issues, IlliniCare elected to rotate the *WCC* measure using HEDIS 2019 (MY 2018) hybrid rates. IlliniCare passed the MRRV for the *CIS—Combo 10* measure with no issues.

IlliniCare was fully compliant with IS Standard 4.0.

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

IlliniCare developed supplemental databases from several provider EHR systems. Roadmap sections were submitted for Access Community Health Network, Christopher Rural Health, Cook County Health, Crusader Community Health, Lawndale Christian Health Center, Mercy Health, Southern Illinois Healthcare, and Swedish Covenant Hospital. Prior to setting up the data feed, the health plan defined the intent of the data source and worked with the source provider to ensure that all data elements were captured to meet intent and close gaps. The data source was then developed, tested, and deployed using standard validation practices and logic to ensure that valid data were stored in the data repository. File submissions were tracked monthly. Impact was monitored using supplemental data impact reports. Standard formats were used for submission. Mapping of nonstandard codes was not applicable. IlliniCare did not experience any issues receiving the EHR data files.

IlliniCare developed an HL7 Lab database comprised of lab results data received from LabCorp, Quest, and Medical Diagnostics Laboratories. Files were submitted using standard formats. Claim counts for each lab vendor were reviewed and tracked each month to ensure that files were received, loaded properly, and volume remained consistent. IlliniCare did not experience any issues receiving the lab data files.

The HEDIS User Interface (HUI) database is a nonstandard database that was populated from internally conducted MRRs. Corporate trainers held quarterly live training sessions, and ad hoc training was provided on demand. A test following training was administered, and 95 percent accuracy was required. Ongoing overreads of the MRRs were conducted; 95 percent accuracy was required. The auditor conducted primary source validation of a sample of the database and did not identify any issues.

IlliniCare clarified that the i2i data included data from a single FQHC; i2i extracted data from the FQHC's EHR and reformatted the file for submission to IlliniCare. IlliniCare validated the data prior to loading to the data warehouse. There was no mapping of nonstandard coding schemes.

The USMM database included data collected from in-home assessments. A provider entered the patients' data into an EHR system at the time of the visit. Of the measures listed in the Roadmap, only *WCC* is applicable to the scope of this audit. IlliniCare initially indicated that this database would not have any numerator hits for HEDIS 2020; however, on March 4, 2020 IlliniCare reported the need to make a correction, as it determined there were four hits from the USMM feed for the *WCC* measure. The auditor instructed IlliniCare to update the file with a date stamp for each record to confirm that the records were created prior to the March 2, 2020 deadline for supplemental data completion. IlliniCare posted an updated file with this information. The database included only four cases with *WCC—Body Mass Index (BMI)* percentiles. The auditor conducted primary source verification of all four cases and did not identify any issues.

IlliniCare submitted several Roadmaps for supplemental data sources that did not impact any measures under the scope of the audit and therefore were withdrawn. These included Optum, Exact Sciences, Envolve, and TruCare. Centene presented the supplemental database validation processes during the on-site audit. Row counts, file layouts, and data values were validated as part of the process. File validations were performed prior to loading to the data warehouse. Error flags were set on records

that failed the validation. Only records that were validated and not flagged as errors were loaded to the data warehouse.

All standard and nonstandard data sources were approved to use for HEDIS 2020 reporting.

IlliniCare was fully compliant with IS Standard 5.0.

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

IlliniCare has used Inovalon's Quality Spectrum Insight (QSI-XL) certified measures for generating its HEDIS performance measure rates for three years. The QSI-XL data extract began with the eligibility crosswalk. The eligibility crosswalk was populated with all of the existing combinations for eligibility information for the plan within the last three years. The plan's role was to complete the product and benefit information for each combination, which QSI-XL used to assign product and benefits for HEDIS reporting.

The data warehouse sources for the data load to QSI-XL included member/eligibility, claims, provider, and other sources (e.g., supplemental, ancillary data). Validation checks were in place to ensure data accuracy. Business intelligence and advanced analytics capabilities were in place. No significant data completeness issues were identified.

The auditor reviewed the provider specialty mapping document. Centene and IlliniCare clarified that the code mapping of clinic to PCP was done based on analyses confirming the claims were coming from PCP clinics.

The auditor confirmed that all necessary data sources were included in the data load to QSI-XL. Data loads to QSI-XL were completed monthly throughout the year. For HEDIS 2020, loads were completed in January, February, April, and May. Claims from the past three and a half years were loaded with additional historical data for specific exclusions. Record counts were validated at each stage of the load process to ensure data completeness.

QSHR MRR data were loaded to QSI-XL weekly. QSHR was also updated from QSI-XL when this occurred.

IlliniCare received data validation reports from Centene following each month's load. A dashboard was created to compare eligible populations, denominators, and rates for each measure.

For Query 2, the auditor reviewed the data load report and did not identify any issues. The most frequent rejections were for lab claims and providers. The error counts represented less than 0.1 percent of lines loaded.

IlliniCare was fully compliant with IS Standard 6.0.

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

The auditor reviewed preliminary rates for the *AMB*, *MMA*, *APM*, *FUH*, and *WCC* measures. The denominators and rates were comparable to the prior year's final denominators and rates. The *CIS* eligible population was comparable to last year; however, the *CIS* administrative rates increased due to additional supplemental data from the HUI database, which included data from the State immunization registry.

The auditor conducted Query Group 3 on-site. The auditor selected five compliant cases each from QSI-XL for *CIS—MRR*, *WCC—Counseling for Nutrition*, and *FUH—7 Day*. For all five *WCC—Counseling for Nutrition* and *FUH—7 Day* cases, IlliniCare demonstrated the proof of service in AMISYS. IlliniCare was not able to determine the proof of service for one *CIS—MMR* case selected; the service was not found in AMISYS or the supplemental data. It appeared that the record may have come from prior year MRR. IlliniCare provided the appropriate documentation post-on-site and the auditor approved it.

For Query 6, the auditor confirmed that the provider specialty in AMISYS for all five *FUH—7 Day* cases met the specification requirements for the measure.

For Query 1, the auditor reviewed IlliniCare's membership counts for each month during 2019. The report provided by IlliniCare categorized the membership by plan type. The report did not identify any significant changes in membership by month; therefore, there were no apparent data completeness issues for the membership data.

The auditor did not identify any measures at risk at the time of the audit or during rate review.

The auditor confirmed that the certified version of the software was used to produce final rates for each measure by reviewing the IDSS warnings during final rate review.

The auditor reviewed all IDSS Tier 2 warnings for the health plan's performance reports. The auditor requested further explanation as needed and signed off on all warnings.

The audit team reviewed and approved the source code for the *IL3.6* measure. The auditor reviewed the measure rates and did not identify any issues.

IlliniCare was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Meridian

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Meridian's HealthChoice Illinois population. The audit indicated that Meridian was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. Further, all selected HEDIS performance measures received an *R* designation.

Table B1-6—Meridian 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

Meridian continued to use its internally developed claims system, Managed Care Systems (MCS). MCS is more robust than many external industry standard systems. MCS was able to capture and manage attachments for claims using its graphical user interface buttons. Additionally, claims that were scanned in-house were accessible from MCS from its desktop application.

Meridian monitored its aging reports daily and used industry-standard incurred but not received (IBNR)/claims triangle reports to determine paid and pending claims. HSAG requested that an IBNR report be provided in April 2020 for the claims paid through March 2020. The April 2020 IBNR report was provided and showed that over 94 percent of all services were paid by March 2020. Additionally, Meridian continually refreshed the HEDIS data, so that amount continued to grow through May 2020. HSAG had no concerns with Meridian's data completeness for claims.

No vendors, other than electronic claims clearinghouses, were involved with processing claims. All clearinghouses provided HIPAA edit checks prior to supplying the electronic claims to Meridian. Meridian's claims process was very clean, with more than 92 percent of all claims submitted electronically. Meridian continued to receive some paper claims, which were scanned and vertexed by internal staff members. The time to process a claim was within Meridian's standard of 30 days.

Meridian indicated that there were no backlogs of claims during the measurement year, even with the acquisition of Harmony Health Plan of Illinois, Inc. (Harmony) members. This was confirmed through Meridian's IBNR submission in April 2020.

Meridian was fully compliant with IS Standard 1.0.

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

Meridian's enrollment data were staged in MCS. Data were updated daily and confirmed monthly from the State's enrollment files. Meridian experienced significant growth in enrollment due to acquiring Harmony's members in January 2019. The acquisition resulted in more than 200,000 new members enrolling in the HealthChoice Illinois Medicaid program. Meridian did not have any issues providing member services due to the acquisition of the additional membership from Harmony. Harmony members were terminated on December 31, 2018, and enrolled in Meridian on January 1, 2019. Most of the Harmony members acquired by Meridian will not meet continuous enrollment criteria for some of the measures under review. Eligible populations were consistent with the previous year for many measures; however, some were increased due to the acquisition of Harmony's members.

As with past reviews, Meridian did not manually enter any enrollment information, with the exception of special circumstances. Special circumstances arose only when the State provided a request to enroll a member following the final submission of the enrollment file.

Meridian did not have any changes to its enrollment processes from the previous year's review and did not experience any difficulties in processing enrollment data for the measurement year.

Meridian relied on HFS to supply accurate information in the monthly enrollment files. There were no manual steps or vendors involved with the enrollment process.

Meridian received an enrollment file daily from HFS, which was loaded into its MCS claims/encounter processing system. This file contained all enrollment information required for Medicaid. On a monthly basis, Meridian also verified enrollment using the State's full roster. The full roster provided Meridian with additions, changes, or deletions that were previously reported on the daily files. MCS contained all applicable fields relevant for HEDIS reporting. MCS maintained a unique identifier for each member and captured the Illinois Medicaid HealthChoice identifiers.

HSAG conducted specific enrollment verification reviews that looked at enrollment by month during the virtual on-site audit. The review identified when Harmony members were incorporated in Meridian. There were no concerns with the data review.

Meridian was fully compliant with IS Standard 2.0.

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

There were no significant changes to the provider systems and processes used during the measurement year. MCS captured all credentialing information from Meridian's providers and was able to capture primary and secondary specialties. During the virtual on-site audit, plan staff members confirmed that neurology was a valid mental health specialty for Meridian. Meridian's MCS captured all fields required for HEDIS reporting, as outlined in Roadmap Section 3, Table 3B.A.

The provider specialty mapping for FQHCs that were mapped to primary care providers was approved by the auditor for HEDIS 2020 reporting. FQHCs were allowed to provide both primary care and mental health services to Medicaid members in Illinois. To meet the qualifications for being an FQHC, certain

criteria must be met per the NCQA guidelines. HSAG conducted a drill-down of the *FUH* measure during the virtual on-site audit to determine if any providers were associated with and billed by an FQHC. None of the examples that were randomly selected had any association with an FQHC. Based on the HEDIS Roadmap review of attachment 3.2, Meridian followed the CMS guidelines for certifying FQHCs and RHCs.

There were no concerns with MCS' ability to capture provider taxonomy, National Provider Identifier (NPI), U.S. Drug Enforcement Administration (DEA) numbers, or tax identifiers.

MCS is a fully integrated health information system and is very robust. There were no transfers of data from one system to another, and therefore no opportunity for loss of data along the way. All specialties were fully documented. All provider specialties were reviewed and approved for use for HEDIS 2020. HSAG had no concerns with Meridian's provider capabilities.

Meridian was fully compliant with IS Standard 3.0.

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

HSAG reviewed Meridian's IS 4 Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS 4.0 requirements.

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

Medical record pursuit and data collection were conducted by Meridian staff members using proprietary data abstraction tools. HSAG participated in a live demonstration of the hybrid tools. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2020, Volume 2: Technical Specifications for Health Plans*. HSAG reviewed and approved Meridian's hybrid tools and had no concerns.

Staff members were sufficiently qualified and trained in the current year's HEDIS Technical Specifications. Meridian maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in numerator positives or exclusions, and a random sample of numerator negatives.

Based on HFS' allowance to rotate hybrid measures due to COVID-19 related issues, Meridian elected to rotate the two hybrid measures under the scope of the audit using HEDIS 2019 (MY 2018) hybrid rates; therefore, final MRRV was not required. HSAG reviewed and validated the reported rates from the previous year and found them to be accurate.

Meridian was fully compliant with IS Standard 4.0.

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

Meridian submitted four supplemental data sources for HEDIS 2020 reporting. The four supplemental data sources included lab results, EHR data, Illinois historical claims, and internal health plan data. The internal data source was determined to be nonstandard data, and the remaining three data sources were determined to be standard data. The internal database was based on providers submitting EHR data to Meridian in Meridian's file layout. Providers were required to use a mapping document provided by Meridian to map their services to Meridian service type codes. HSAG's examination of the file layout and mappings did not reveal any concerns. The internal database required a sample of 50 records for proof-of-service (POS) verification. Meridian successfully passed the proof of service requirement for using the nonstandard internal database which was approved to use for HEDIS 2020 reporting.

All standard and nonstandard supplemental data sources were approved to use for HEDIS 2020 reporting.

Meridian was fully compliant with IS Standard 5.0.

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

Meridian reported all measures using internally developed programs. HSAG reviewed and approved the source code for the measures under the scope of the audit. Programs resided in MCS and were referred to as the "HEDIS engine." The programs accessed tables in MCS that were populated directly without manipulation from underlying tables in MCS. These tables were updated as changes were made in source data and therefore reflected current data at the time the HEDIS engine was run.

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

HSAG conducted several queries to review enrollment, provider specialty, and pharmacy impacts on reporting. HSAG also conducted Query Group 3 for two measures to ensure numerator compliance with the specifications. HSAG did not have any concerns with the data review during the virtual on-site audit; however, due to time constraints, Meridian provided additional selected cases for review as a follow-up item. HSAG had no concerns with the cases and verified provider specialty compliance with the *FUH* measure.

Meridian was fully compliant with IS Standard 6.0.

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

Meridian's HEDIS repository structure contained all relevant fields for reporting. The HEDIS repository pulled data directly from MCS, maintaining all of the same data. There was no manual manipulation of the data.

All measures under the scope of the audit were calculated by Meridian using internally developed programs that resided within MCS. Programs were reviewed and updated to reflect any changes in the reporting requirements from the previous HEDIS season. This update included code sets from CPT-4, IDC-10, and NCQA. Quality checks were done by using internal peer review on source code as well as validating numerators in comparison with benchmarks and historical performance. User acceptance testing was performed on all changes to ensure accuracy of updates. HSAG had no concerns with Meridian's ability to produce the measures under the scope of the audit.

Meridian was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Molina

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for Molina's HealthChoice Illinois population. The audit indicated that Molina was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. All selected HEDIS measures received an *R* designation.

Table B1-7—Molina 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

There were no changes to Molina's claims and encounter processes for 2019. Molina continued to use QNXT, an industry-standard claims adjudication system, to process FFS claims during 2019. The QNXT system captured only standard codes and only used standard claims forms. Molina received some nonstandard codes during the measurement year that were ultimately mapped to standard immunization and well-care visit codes. HSAG reviewed and approved the mapping during the on-site visit. The nonstandard codes represented less than 1 percent of all claims submitted and had little impact overall on total claim volume.

HSAG verified that QNXT had appropriate claim edits in place during the measurement year to ensure that only standard codes were accepted. Additional edits were in place to reject claims if they were missing critical information, such as patient and provider identifiers as well as primary diagnosis and procedure codes. HSAG also verified that QNXT captured a sufficient number of diagnosis and procedure codes to meet HEDIS reporting requirements. Molina received encounter data from several vendors and capitated providers during 2019. Molina continued to monitor and track independent practice association (IPA) encounter submissions monthly to ensure that complete encounters were captured.

All encounter data were directly fed into the corporate Operational Data Store (ODS) for use with HEDIS data integration. The ODS encounter data were in a standard 837 format. Molina had sufficient processes in place to capture and validate encounter data submissions. Molina validated data submissions against financial reports with the State to ensure accuracy of reporting.

Molina was fully compliant with IS Standard 1.0.

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

There were no updates or changes to Molina's enrollment process for HEDIS 2020. Eligibility files were received from the State in an 834 file format. Pre-processing of eligibility files was performed in the Molina Eligibility Gateway (MEG) module. With the exception of newborns, all records were loaded into QNXT. Newborns required manual processing and were linked to the mother's record until Molina received identification numbers for the newborns. This process of linking newborns to mothers was only conducted if the State did not submit the Medicaid number for the baby. In most instances, claims were not processed until Molina received an update on the enrollment files from the State. All enrollment processes were conducted in the QNXT system. QNXT had appropriate fields to capture all vital information required for claims processing and HEDIS reporting. QNXT allowed for several identification numbers in order for families to be linked together. Molina received daily files from the State and reconciled those records with the final monthly file. The amount of time to process enrollment files was less than three days. There were no concerns with the enrollment process following HSAG's review.

All downstream vendors received daily and monthly enrollment files after they were processed in the QNXT system. This ensured that all vendors had the most current member information for processing claims/services.

There were no concerns with Molina's enrollment process for HEDIS 2020.

Molina was fully compliant with IS Standard 2.0.

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

There were no changes to Molina's provider processing systems during the measurement year. HSAG reviewed the provider mapping documents provided in the Roadmap and found no issues during the on-site review. There were several newly added PCPs during the measurement year, mainly to accommodate a growing membership.

Molina maintained all providers in the QNXT system and contracted with individual doctors and physician groups; data exchanged between all entities were complete and accurate. All required fields for HEDIS processing were present. QNXT had the ability to capture multiple identification numbers. A unique identifier links the records with multiple identification numbers together. There were no issues encountered with this practice of maintaining multiple identifiers.

Molina audited the provider data in QNXT monthly to ensure completion of specialties, license type, and professional degrees. This internal audit included review of provider locations and ZIP Codes. Molina used several delegated entities to process provider information. The delegated entities were monitored annually, and no significant issues were found. Delegated entities audited were within 95 percent accuracy thresholds for 2019.

Molina was fully compliant with IS Standard 3.0.

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

Molina sampled according to the HEDIS sampling guidelines and assigned an appropriate measure-specific oversample. HSAG reviewed and approved the sample sizes during the on-site audit. Molina did not reduce any samples for hybrid measures and did not need approval from NCQA for any sample increases.

Medical record pursuit and data collection were conducted by Molina staff using Inovalon's QSHR hybrid tools. HSAG reviewed and approved the hybrid tools. Provider chase logic was reviewed and determined to be appropriate across the hybrid measures. Reviewer qualifications, training, and oversight were appropriate. Inter-rater reliability for training and final abstraction was submitted to HSAG prior to final approval of the hybrid abstraction.

Due to changes to the measure specifications, a convenience sample was required for the *WCC* and *CIS* measures. All cases successfully passed the validation process.

The final statistical MRRV was conducted for the *WCC* measure, and all records passed the validation process. Based on the State's allowance to rotate hybrid measures due to COVID-19 related issues, Molina elected to rotate the *CIS* measure using HEDIS 2019 (MY 2018) hybrid rates.

Molina was fully compliant with the IS Standard 4.0.

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

Molina originally submitted several supplemental data sources for review with its Roadmap submission. However, 14 were withdrawn for MY 2019 reporting. Molina requested that the PMRR nonstandard data source be withdrawn. For the 13 other databases that were removed from consideration, it was determined that the data did not contribute to any of the measures under the scope of the audit. The 14 supplemental databases that were withdrawn included Christopher Rural Health, Heartland, Shawnee Health Services, Quest, PMRR, MMG, Minute Clinic, March Vision, LabCorp, Inovalon Pseudo Claim, Healow Insights, CMS Historical, BioReference, and Costas.

The SDCT database was determined to be nonstandard supplemental data. PSV was conducted according to NCQA's guidelines, and all selected cases passed the validation process.

There were four standard data sources that were approved for MY 2019 reporting: lab results, EHR from IPAs, and historical claims and immunization records from the State.

HSAG reviewed and approved all standard and nonstandard data sources. There were no concerns with data capture, file layouts, or code mapping.

All standard and nonstandard data sources were approved to use for HEDIS 2020 reporting.

Molina was fully compliant with IS Standard 5.0.

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

Data transfers and mappings were managed appropriately, as demonstrated during the on-site audit. Molina monitored data transfers through matching data loads to its data extracts from ODS into Inovalon's system. Data that fell out due to issues were quickly identified to ensure that critical errors were corrected. During the on-site audit, the examination of the data transfer and consolidation did not reveal any issues. HSAG conducted PSV for the *FUH* and *AMB* measures, and no issues were identified. Nonstandard coding was mapped appropriately for a select number of State-required codes.

Molina did not use any nonstandard coding, and no mapping to industry standard codes for HEDIS reporting was necessary.

Molina was fully compliant with IS Standard 6.0.

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

Molina continued to use Inovalon's software for the HEDIS 2020 rate calculation. Molina's Illinois staff worked with Molina Corporate for the management of the Inovalon product. Corporate processes were reviewed during the on-site visit and were found to be sufficient for HEDIS 2020 processing. Molina's staff were proficient in data warehousing and demonstrated during the on-site visit that record counts and volumes were monitored. Molina continued to meet with Inovalon on a regular basis to discuss file loading and processing. There was significant improvement from last year with Molina's oversight of vendor file submissions. Molina began monitoring provider submissions and tracked the volume for each submission over time. These volumes were compared to expected per member per month (PMPM) counts to determine if data were missing. Molina will continue to monitor its oversight of external entities.

HSAG conducted PSV for the *FUH* and *AMB* measures for Query Group 3, and all selected cases passed the validation process.

Molina was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for NextLevel

HSAG conducted a 2020 NCQA HEDIS Compliance Audit of the data collection and reporting processes for NextLevel's HealthChoice Illinois population. The audit indicated that NextLevel was fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, and measure calculations resulted in rates that were not significantly biased. All selected HEDIS measures received an *R* designation.

Table B1-8—NextLevel 2020 NCQA HEDIS Compliance Audit Results

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

The rationale for full compliance with the HEDIS IS standards was based on the findings summarized below. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

IS 1.0—Medical Services Data—Sound Coding Methods and Data Capture, Transfer, and Entry

NextLevel contracted with Envolve, a subsidiary of Centene Corporation, to process claims. Claims were processed in the AMISYS system.

The auditor confirmed that all necessary fields were captured in AMISYS. There was no use of non-standard coding. Envolve had adequate policies in place that ensured the timeliness and accuracy of electronic claims transmissions, paper claims (using OCR technology), and data entry.

NextLevel demonstrated significant improvement in claims processing accuracy. The State accepted 97 percent of NextLevel's encounters for the last quarter of 2018 and the first three quarters of 2019. For the first two years of the plan's operations, the acceptance rate was in the low 80 percent range. State acceptance is based on claims being paid, coded, and processed correctly. NextLevel attributed the improvement to transitioning claims processing oversight in 2018 from the previous vendor to handling it internally.

NextLevel took additional steps to ensure that claims were paid with the correct taxonomy codes, National Drug Codes (NDCs), and transportation codes, as well as ensuring that procedure codes were appropriate for age and gender combinations.

There were no significant claims processing backlogs during 2019. Approximately 99 percent of claims were processed within 30 days.

NextLevel reported there were no issues receiving the claims data files from its ancillary vendors during 2019.

NextLevel was fully compliant with IS Standard 1.0.

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

Envolve delegated enrollment processing to Centene in 2019, which used the AMISYS system.

There were no issues receiving or processing the State enrollment files during the measurement year. Files were received from the State daily and monthly. NextLevel downloaded the files daily (Monday through Friday), and a copy was provided to Envolve the same day. Processes were in place to validate the files prior to and after loading to the UMV and AMISYS systems. Member counts were validated, and appropriate field values were confirmed. Envolve and NextLevel worked together to resolve discrepancies between information in the State files and information in AMISYS.

NextLevel membership increased gradually during 2019. There were no significant fluctuations in membership during the year. Overall membership increased from approximately 48,000 to 54,000 in 2019.

There were no significant backlogs or issues with timeliness for processing the enrollment files. Time to process standards were met.

NextLevel was fully compliant with IS Standard 2.0.

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

Envolve processed provider data using the Portico credentialing system and AMISYS.

The State was responsible for credentialing all providers in 2019. The State mandated that providers use a standard roster template beginning in 2018.

In July 2018, NextLevel developed processes to centralize how rosters were captured using the NextLevel website. NextLevel transmitted the provider data to Envolve securely to update Portico and AMISYS.

Envolve had data quality checks in place prior to loading the roster to the Portico system. Additional checks were completed to ensure transmissions to AMISYS were successful. In addition, NextLevel performed reconciliations of the originally received provider roster data to the information in Portico and AMISYS. There were no significant accuracy issues identified.

FQHCs and RHCs were determined by the State and identified in the State provider data rosters that were submitted to NextLevel. This information was loaded to Portico and AMISYS.

NextLevel was fully compliant with IS Standard 3.0.

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

NextLevel contracted with Inovalon to conduct medical record review for HEDIS 2020. HSAG reviewed the Roadmap pertaining to the policies and procedures for IS Standard 4.0. The Roadmap review found these policies and procedures to be consistent with the IS Standard 4.0 requirements.

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

HSAG participated in a live vendor demonstration of Inovalon's SAFHIRE medical record abstraction tool. All fields, edits, and drop-down boxes were reviewed for accuracy against NCQA's *HEDIS 2020, Volume 2, Technical Specifications for Health Plans*. HSAG approved Inovalon's hybrid tool for HEDIS 2020 production.

Reviewer qualifications, training, and oversight by Inovalon of its review staff were appropriate.

Since NextLevel used a new medical record vendor for HEDIS 2020, HSAG required a convenience sample for the *CIS—Combo 3*, *WCC—Counseling for Nutrition*, *WCC—Counseling for Physical Activity*, and *WCC—BMI Percentile Documentation* measures. The audit team reviewed the convenience sample charts and did not identify any issues.

Based on the State's allowance to rotate hybrid measures due to COVID-19 related issues, NextLevel elected to rotate the *WCC* measure using HEDIS 2019 (MY 2018) hybrid rates. MRRV was conducted for the *CIS—Combo 10* measure, and all cases passed the validation process.

NextLevel was fully compliant with IS Standard 4.0.

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

NextLevel did not use any nonstandard supplemental data for HEDIS 2020 reporting.

NextLevel received historical claims data from the State of Illinois. The auditor considered these data to be standard supplemental data. Standard coding was used, and no changes were made to the data when reformatting for upload to Inovalon's QSI-XL software. File transmissions were monitored by NextLevel. The auditor did not identify any issues with the State's data and approved the database for use in HEDIS 2020 reporting.

NextLevel received State immunization data monthly with the historical data provided by the State for this data set. These data were provided prior to 2019; however, this was the first year the data were loaded to QSI-XL for HEDIS reporting. The auditor determined the immunization data to be standard supplemental data. The State provided the CVX codes with the file and these were loaded to the data warehouse without any code mapping required. The immunization data were loaded to a table in the NextLevel data warehouse separate from the other data. The auditor approved this data source for use in HEDIS 2020 reporting.

NextLevel received lab results data from LabCorp, Quest, and Medical Diagnostics Lab. The auditor considered these data to be standard supplemental data. Standard coding was used, and no changes were made to the data when reformatting for upload to QSI-XL. File transmissions were monitored by Envolve. The auditor did not identify any issues with the data and approved the database for use in HEDIS 2020 reporting.

All standard supplemental data sources were approved to use for HEDIS 2020 reporting.

NextLevel was fully compliant with IS Standard 5.0.

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

For HEDIS 2020 reporting, NextLevel internally developed the mapping of data to the QSI-XL file formats. Last year, this was completed by Envolve. Testing was performed to ensure the accuracy of the new mapping.

NextLevel provided the files to Inovalon for loading to QSI-XL. The process included submission of a spreadsheet that identified the file names posted and the record counts for each file. Inovalon reconciled the file names and record counts with the actual data it received.

The initial data load was performed in January, and subsequent loads were completed in February, March, and April. The April load included claims processed through the day prior to the extract. NextLevel extracted paid, denied, and pended claims for the data loads.

Following each data load, Inovalon provided the data quality reports to NextLevel. The auditor reviewed the data quality reports during the virtual on-site audit and did not identify any significant issues.

NextLevel was fully compliant with IS Standard 6.0.

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

During the virtual on-site audit, the auditor reviewed preliminary rates for the HEDIS measures under the scope of the audit. No significant issues were identified. Administrative rates for the *CIS* measure increased due to the incorporation of the immunization supplemental data from the State. The auditor also noted rate increases for the *MMA* measure, which were attributed to NextLevel gaps-in-care reporting to providers for asthma medications, as well as asthma training that was offered for provider groups.

The auditor conducted Query Group 3 during the virtual on-site by selecting five compliant cases for each of the following measures: *WCC—Counseling for Physical Activity*, *CIS—Measles, Mumps, and Rubella (MMR)*, and *FUH—7 Day*. NextLevel demonstrated compliance in the source system for each case.

For Query Group 6, the auditor attempted to validate the servicing provider specialty in AMISYS for the five *FUH-7 Day* cases. For three of the cases, it was not clear if the servicing provider was a mental health provider. NextLevel provided the specialty information from the State provider roster for these providers.

The auditor completed Query Group 4 as a follow-up to the virtual on-site audit and did not identify any issues.

The auditor confirmed that the certified measure software was used for each measure by reviewing the IDSS warnings during final rate review.

The auditor reviewed all IDSS Tier 2 Warnings for the plan's performance reports. The auditor requested further explanation as needed and signed off on all warnings.

Based on the State's allowance to rotate hybrid measures due to COVID-19 related issues, NextLevel elected to rotate *WCC* using its HEDIS 2019 (MY 2018) hybrid rates.

The audit team reviewed and approved the source code for the *IL3.6* measure. The auditor reviewed the measure rates and did not identify any issues.

NextLevel was fully compliant with IS Standard 7.0.

Validation of State Performance Measures for CHIPRA

Introduction

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

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the CMS publication, *CMS External Quality Review (EQR) Protocols*, October 2019.[B1-2]

Conducting the Review

The primary objectives of the PMV process are to:

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

HFS identifies the performance measurement period for validation of the CHIPRA program for the reporting year. HFS selected NCQA HEDIS measures as well as CMS Adult Core Set and Child Core Set performance measures for the CHIPRA program. Most measures used the HEDIS 2020 Technical Specifications. For measures that were both HEDIS and Core Set measures, HSAG reviewed source code according to both the HEDIS 2020 Technical Specifications; the federal fiscal year (FFY) 2020 Adult Core Set, November 2019; and the FFY 2020 Child Core Set, November 2019. This was acceptable since the specifications for most, if not all, of the HEDIS measures were the same as the Core Set, except for the age breakouts. There were also measures that used the Maternal and Infant Health Initiative (MIHI) Contraceptive Care Measures technical specifications and the Data Definitions technical specifications produced by HFS. For a list of the validated measures and their corresponding rates, see Appendix B4 of this report.

Preaudit Activities

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

[B1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 9, 2021.

Data Collection and Analysis

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

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

Performance Measure Validation Findings

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

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the designations identified in the CMS PMV Protocol listed below in Table B1-9.

Table B1-9—Performance Measure Audit Results and Definitions

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

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

Appendix B2. 2019–2020 Encounter Data Completeness

Encounter Data Completeness

The tables below display the estimate of the administrative data completeness for the CY 2019 (HEDIS 2020) measure rate calculated using the hybrid methodology for each health plan. Health plans were not required to report using the hybrid method; therefore, the measures in the tables may differ between health plans. These measures use administrative encounter data and supplement the results with medical record data. The information provided in the tables below present the percentage of each HEDIS measure rate that was determined using administrative encounter data only.

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	68.08%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	19.64%
Combination 3	17.72%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	55.74%
Combination 2 (Meningococcal, Tdap, HPV)	51.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	58.50%
Counseling for Nutrition—Total	54.33%
Counseling for Physical Activity—Total	50.25%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	84.01%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	98.06%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	89.08%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.51%
Postpartum Care	96.41%

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	99.20%
Medical Attention for Nephropathy	100.00%
Controlling High Blood Pressure	
Controlling High Blood Pressure	50.31%

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

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	49.67%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	51.46%
Combination 3	49.17%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	99.71%
Combination 2 (Meningococcal, Tdap, HPV)	98.88%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	46.32%
Counseling for Nutrition—Total	34.10%
Counseling for Physical Activity—Total	25.90%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	89.59%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	96.88%

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.00%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.67%
Postpartum Care	92.59%
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	94.79%
Eye Exam (Retinal) Performed	88.26%
Medical Attention for Nephropathy	97.63%
Controlling High Blood Pressure	
Controlling High Blood Pressure	13.11%

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

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	57.85%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	87.17%
Combination 3	86.61%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	67.90%
Combination 2 (Meningococcal, Tdap, HPV)	57.26%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	60.19%

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Counseling for Nutrition—Total	42.11%
Counseling for Physical Activity—Total	32.73%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	90.48%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	97.94%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	93.87%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	99.44%
Postpartum Care	93.93%
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.63%
Eye Exam (Retinal) Performed	98.75%
Controlling High Blood Pressure	
Controlling High Blood Pressure	22.89%

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

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	55.37%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	97.95%
Combination 3	97.82%

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	100.00%
Combination 2 (Meningococcal, Tdap, HPV)	100.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	38.91%
Counseling for Nutrition—Total	23.81%
Counseling for Physical Activity—Total	23.11%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	99.68%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	97.63%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	99.48%
Postpartum Care	97.38%
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.64%
Eye Exam (Retinal) Performed	88.12%
Medical Attention for Nephropathy	100.00%
Controlling High Blood Pressure	
Controlling High Blood Pressure	12.66%

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

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	70.44%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	98.14%
Combination 3	98.25%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	97.17%
Combination 2 (Meningococcal, Tdap, HPV)	98.13%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	51.72%
Counseling for Nutrition—Total	39.51%
Counseling for Physical Activity—Total	34.23%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	89.68%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	98.26%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	93.94%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	98.76%
Postpartum Care	91.40%
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	97.00%
Eye Exam (Retinal) Performed	91.78%
Medical Attention for Nephropathy	99.47%
Controlling High Blood Pressure	
Controlling High Blood Pressure	17.08%

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

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

2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Access to Care	
Adult BMI Assessment	
Adult BMI Assessment	46.15%
Keeping Kids Healthy	
Childhood Immunization Status	
Combination 2	7.11%
Combination 3	7.22%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	27.97%
Combination 2 (Meningococcal, Tdap, HPV)	19.78%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	55.28%
Counseling for Nutrition—Total	37.41%
Counseling for Physical Activity—Total	30.89%
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	63.64%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	99.16%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.10%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	81.82%
Postpartum Care	94.38%
Living with Illness	
Comprehensive Diabetes Care	
HbA1c Testing	97.06%
Eye Exam (Retinal) Performed	79.74%
Medical Attention for Nephropathy	99.65%
Controlling High Blood Pressure	
Controlling High Blood Pressure	6.45%

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

Appendix B3. 2019–2020 PCCM/CHIPRA PMV Methodology

State PMV for PCCM/CHIPRA

Introduction

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

HSAG's role in the validation of performance measures is to ensure that the validation activities are conducted as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[B3-1]

Conducting the Review

The primary objectives of the PMV process are to:

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

HFS identifies the performance measurement period for validation for each program for the reporting year. HFS selected CMS Adult Core Set and Child Core Set performance measures for the PCCM and CHIPRA programs. HSAG reviewed source code according to the CMS Adult Core Set Technical Specifications (Adult Core Set) and CMS Child Core Set Technical Specifications (Child Core Set) March 2020.[B3-2,B3-3] For a list of the validated measures and their corresponding rates, see Appendix B4 of this report.

[B3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: November 20, 2020.

[B3-2] The Centers for Medicare & Medicaid Services. *Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set)*, March 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf. Accessed on: January 8, 2021.

[B3-3] The Centers for Medicare & Medicaid Services. *Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set)*, March 2020. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf. Accessed on: January 8, 2021.

Preaudit Activities

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

Data Collection and Analysis

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

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

Performance Measure Validation Findings

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

Each of the performance measures reviewed by HSAG were assigned a final audit result consistent with the designations identified in the CMS PMV Protocol 2, listed in Table B3-1.

Table B3-1—Performance Measure Audit Results and Definitions

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

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

Appendix B4. CHIPRA PMV Results

Overview

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

CY 2019 Performance Measures

CY 2019 performance measures selected by HFS were from CMS' Adult Core Set and Child Core Set measures. The measures were reviewed for compliance with the March 2020 Adult Core and Child Core Set specifications that were provided by HFS.

CY 2019 Results

Multiple data sources were validated by the auditor to make a determination as to the validity of the data collected by HFS. HSAG determined that the data supported the elements necessary for reporting, and measures were calculated appropriately according to the required measure specifications. As a result, all performance measures audited received an audit designation of *Reportable* (*R*). Table B4-1 displays the CY 2019 rates for the CHIPRA performance measures validated by HSAG.

Table B4-1—CY 2019 CHIPRA Performance Measures

Performance Measure	CHIPRA Rate
Adult BMI Assessment	
Ages 18 to 64 Years	32.69%
Ages 65 to 74 Years	31.73%
Total	32.66%
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	
Title 19	38.37%
Title 21	43.30%
Total	38.71%
Ambulatory Care—Emergency Department (ED) Visits (per 1,000 Member Months)	
*ED Visits**	43.30

Performance Measure	CHIPRA Rate
Antidepressant Medication Management	
Effective Acute Phase Treatment	45.97%
Effective Continuation Phase Treatment	26.55%
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	48.50%
Breast Cancer Screening	
Ages 50 to 64 Years	53.66%
Ages 65 to 74 Years	50.51%
Total	53.38%
Contraceptive Care—Postpartum Women Ages 15 to 44 Years	
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery (Ages 15 to 20 Years)	1.14%
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 3 Days of Delivery (Ages 21 to 44 Years)	7.85%
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery (Ages 15 to 20 Years)	24.32%
Were Provided a Most Effective or Moderately Effective Method of Contraception Within 60 Days of Delivery (Ages 21 to 44 Years)	26.50%
Were Provided a LARC Within 3 Days of Delivery (Ages 15 to 20 Years)	3.41%
Were Provided a LARC Within 3 Days of Delivery (Ages 21 to 44 Years)	2.59%
Were Provided a LARC Within 60 Days of Delivery (Ages 15 to 20 Years)	14.02%
Were Provided a LARC Within 60 Days of Delivery (Ages 21 to 44 Years)	12.24%
Cervical Cancer Screening	
Cervical Cancer Screening	54.09%
Contraceptive Care—All Women Ages 15 to 44 Years	
Were Provided a Most Effective or Moderately Effective Method of Contraception (Ages 15 to 20 Years)	9.80%
Were Provided a Most Effective or Moderately Effective Method of Contraception (Ages 21 to 44 Years)	11.10%
Were Provided a Most Effective or Moderately Effective Method of Contraception—Total (Ages 15 to 44 Years)	10.69%
Were Provided a Long-Acting Reversible Method of Contraception (LARC) (Ages 15 to 20 Years)	2.13%

Performance Measure	CHIPRA Rate
Were Provided a LARC (Ages 21 to 44 Years)	3.07%
Were Provided a LARC—Total (Ages 15 to 44 Years)	2.77%
Chlamydia Screening in Women	
Ages 16 to 20 Years	49.35%
Ages 21 to 24 Years	60.04%
Childhood Immunization Status	
Combination 2	64.49%
Combination 3	60.50%
Combination 4	57.59%
Combination 5	51.38%
Combination 6	31.87%
Combination 7	49.38%
Combination 8	31.11%
Combination 9	28.24%
Combination 10	27.66%
Developmental Screening in the First Three Years of Life	
1 Year Old	60.69%
2 Years Old	58.81%
3 Years Old	49.02%
Total	56.28%
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up—Ages 6 to 17 Years	30.41%
7-Day Follow-Up—Ages 18 to 64 Years	15.65%
7-Day Follow-Up—Ages 65 Years and Older	15.56%
30-Day Follow-Up—Ages 6 to 17 Years	54.29%
30-Day Follow-Up—Ages 18 to 64 Years	26.51%
30-Day Follow-Up—Ages 65 Years and Older	23.70%

Performance Measure	CHIPRA Rate
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment	
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Ages 18 to 64 Years	35.69%
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Ages 65 Years and Older	32.36%
Initiation of AOD Treatment—Alcohol Abuse or Dependence—Total	35.64%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Ages 18 to 64 Years	52.77%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Ages 65 Years and Older	47.50%
Initiation of AOD Treatment—Opioid Abuse or Dependence—Total	52.68%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Ages 18 to 64 Years	38.79%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Ages 65 Years and Older	40.85%
Initiation of AOD Treatment—Other Drug Abuse or Dependence—Total	38.81%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Ages 18 to 64 Years	12.02%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Ages 65 Years and Older	4.09%
Engagement of AOD Treatment—Alcohol Abuse or Dependence—Total	11.90%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Ages 18 to 64 Years	25.09%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Ages 65 Years and Older	16.07%
Engagement of AOD Treatment—Opioid Abuse or Dependence—Total	24.94%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Ages 18 to 64 Years	14.17%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Ages 65 Years and Older	6.86%
Engagement of AOD Treatment—Other Drug Abuse or Dependence—Total	14.11%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	85.64%
Combination 2 (Meningococcal, Tdap, HPV)	33.45%
Meningococcal	87.43%
Tdap	91.27%
HPV	36.48%
Live Births Weighing Less Than 2,500 Grams*	
Live Births Weighing Less Than 2,500 Grams	9.97%
Cesarean Section for Nulliparous Singleton Vertex*	
Cesarean Section for Nulliparous Singleton Vertex	19.48%

Performance Measure	CHIPRA Rate
Percentage of Eligibles Who Received Preventive Dental Services	
Percentage of Eligibles Who Received Preventive Dental Services	42.60%
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	63.41%
Postpartum Care	66.50%
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*	
Ages 18 to 64 Years	15.85
Ages 65 Years and Older	5.77
Total	15.60
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*	
Ages 18 to 64 Years	62.43
Ages 65 and Older Years	116.24
Total	65.70
Heart Failure Admission Rate (per 100,000 Member Months)*	
Ages 18 to 64 Years	26.83
Ages 65 Years and Older	161.11
Total	30.10
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)*	
Total	6.57
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.70%
Dental Sealants for 6–9-Year Old Children at Elevated Caries Risk	
Dental Sealants for 6–9-Year Old Children at Elevated Caries Risk	9.72%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications	
Glucose Test	84.47%
HbA1c Test	37.92%
Diabetes Screening	85.35%

Performance Measure	CHIPRA Rate
Well-Child Visits in the First 15 Months of Life	
*Zero Visits**	4.86%
One Visit	3.93%
Two Visits	5.05%
Three Visits	6.97%
Four Visits	9.77%
Five Visits	13.27%
Six or More Visits	56.14%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	70.04%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Ages 3 to 11 Years	28.06%
BMI Percentile—Ages 12 to 17 Years	29.64%
BMI Percentile—Total	28.67%
Counseling for Nutrition—Ages 3 to 11 Years	19.04%
Counseling for Nutrition—Ages 12 to 17 Years	19.02%
Counseling for Nutrition—Total	19.03%
Counseling for Physical Activity—Ages 3 to 11 Years	14.20%
Counseling for Physical Activity—Ages 12 to 17 Years	19.46%
Counseling for Physical Activity—Total	16.25%

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

Appendix B5. HCBS Record Reviews Methodology and Detailed Results

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

Home and Community-Based Service (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Review

of

HealthChoice Illinois Managed Care Plans

Summary of Findings and Recommendations

SFY20 Annual Report

October 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to discover/identify problems/issues within the Home and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG) conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This state fiscal year (SFY) 2020 HCBS Waivers CMS Performance Measures Record Reviews Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the HealthChoice Illinois Managed Care Program (HealthChoice), which includes the Managed Long-Term Services and Supports (MLTSS) 1915(b) waiver program.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2020 and across review years, and also contains a review of remediation activities conducted within the required timeframes and a summary of technical assistance provided to the health plans by HSAG.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to 15 CMS waiver performance measures, and additional HealthChoice contract measures. During SFY 2020, 2,117 HealthChoice and 1,357 MLTSS records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,727 HealthChoice and 1,294 MLTSS findings of non-compliance were identified.

A detailed description of the sampling methodology and data collection processes is provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1.1 displays the health plans that were reviewed during SFY 2020.

Table 1.1—SFY 2020 HealthChoice Health Plans

HealthChoice Health Plan Name
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare (CountyCare)
IlliniCare Health Plan (IlliniCare)
Meridian Health (Meridian)
Molina Healthcare of Illinois (Molina)
NextLevel Health (NextLevel)

Successes

SFY 2020 represented the third year of review for the HealthChoice population, and several successes were identified.

☑ Eleven of the 15 CMS performance measures averaged 90 percent or greater compliance in SFY 2020, an increase from SFY 2019.

☑ Eight of the 15 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2020 when compared to SFY 2019.

☑ Three of the six health plans averaged greater than 90 percent compliance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, IlliniCare realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance for 11 measures in SFY 2020.

☑ Compared to SFY 2019, CountyCare realized a statistically significant increase in performance for three measures in SFY 2020.

☑ Compared to SFY 2019, IlliniCare realized a statistically significant increase in performance for two measures in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in performance for seven measures in SFY 2020.

☑ Compared to SFY 2019, the BI waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for three measures.

☑ Compared to SFY 2019, the ELD waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for five measures.

☑ Compared to SFY 2019, the HIV waiver realized a statistically significant increase in performance in SFY 2020 and realized a statistically significant increase for one measure.

☑ Compared to SFY 2019, the PD waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for six measures.

☑ Compared to SFY 2019, the SLP waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for six measures.

Opportunities for Improvement

Review of SFY 2020 performance identified the following opportunities for improvement:

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 23 percent compliance in SFY 2019. All six health plans performed at a rate of less than 50 percent in SFY 2020. A detailed analysis related to 4A is provided in Section 3 of this report.

Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record,* averaged 52 percent and 44 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to 36D is provided in Section 3 of this report.

Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan*, averaged 78 percent compliance in SFY 2020. A detailed analysis related to 39D is provided in Section 3 of this report.

Analysis of SFY 2020 Performance on SFY 2019 Recommendations for Improvement

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2019 reviews, efforts to incorporate technical assistance received during onsite reviews, and efforts to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, Table 1.2 documents the results of some of the health plan improvement efforts.

Table 1.2—Health Plan Interventions and Results

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
Plan-Specific	
BCBSIL should focus efforts on measures 4A, 36D, 37D, and 39D. BCBSIL should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. BCBSIL should ensure consistent application of a process to validate the provision of waiver services for all members.	4A: BCBSIL demonstrated stable performance during SFY 2020 and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 36D: BCBSIL realized a statistically significant increase in performance in measure 36D, with a resulting increase of 15 percentage points. 37D: BCBSIL realized a statistically significant increase in performance in measure 37D, with a resulting increase of 14 percentage points. 39D: BCBSIL realized a statistically significant increase in performance in measure 39D, with a resulting increase of 24 percentage points. HSAG noted during reviews that BCBSIL had implemented the use of a standardized process to validate the provision of waiver services for all members.
CountyCare should focus efforts on measures 4A, 36D, and 39D. CountyCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. CountyCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. CountyCare should ensure consistent application of a process to validate the provision of waiver services for all members.	4A: CountyCare demonstrated a statistically significant decrease in performance in measure 4A, with a resulting decrease of 36 percentage points. 36D: CountyCare demonstrated stable performance during SFY 2020. 39D: CountyCare realized a statistically significant increase in performance in measure 39D, with a resulting increase of 14 percentage points.

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
IlliniCare should focus efforts on measures 4A, 36D, 37D, and 39D. IlliniCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. IlliniCare should ensure consistent application of a process to validate the provision of waiver services for all members.	4A: IlliniCare demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 36D: IlliniCare demonstrated stable performance during SFY 2020. 37D: IlliniCare demonstrated stable performance during SFY 2020. 39D: IlliniCare realized a statistically significant increase in performance in measure 39D, with a resulting increase of 11 percentage points.
Meridian should focus efforts on measures 4A, 36D, 37D, and 39D. Meridian should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Meridian should ensure consistent application of a process to validate the provision of waiver services for all members.	4A: Meridian demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 36D: Meridian realized a statistically significant increase in performance in measure 36D, with a resulting increase of nine percentage points. 37D: Meridian realized a statistically significant increase in performance in measure 37D, with a resulting increase of 10 percentage points. 39D: Meridian realized a statistically significant increase in performance in measure 39D, with a resulting increase of 23 percentage points.
Molina should focus efforts on measures 4A, 36D, 37D, and 39D. Molina should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Molina should ensure consistent application of a process to validate the provision of waiver services for all members.	4A: Molina demonstrated stable performance during SFY 2020. 36D: Molina demonstrated stable performance during SFY 2020. 37D: Molina demonstrated stable performance during SFY 2020. 39D: Molina demonstrated stable performance during SFY 2020.
NextLevel should focus efforts on measure 39D. NextLevel should ensure consistent application of a process to validate the provision of waiver services for all members.	39D: NextLevel demonstrated stable performance during SFY 2020.
Waiver-specific	

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
BI: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee at least one time a month, demonstrated stable performance from SFY 2019 to SFY 2020. Focused efforts related to measure 36D were recommended during SFY 2020, and remain as a recommendation for SFY 2021.
HIV: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee once a month, with a face-to-face contact bimonthly, demonstrated stable performance from SFY 2019 to SFY 2020. Focused efforts related to measure 36D were recommended during SFY 2020, and remain as a recommendation for SFY 2021.
Performance-measure specific	
All health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.	4A: Overall performance was 23 percent in SFY 2020. 36D: Overall performance averaged 52 percent and 44 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. 37D: Overall performance was 89 percent in SFY 2020, a statistically significant increase from SFY 2019 performance. 39D: Overall performance for measure 39D was 78 percent in SFY 2020, a statistically significant increase from SFY 2019 performance. Focused efforts will continue to remain as recommendations for measures 4A, 36D, and 39D.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY20. Technical assistance was provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- Validation of waiver service provision.

- Timely case reassignment for beneficiaries who require a new case manager.
- Timely completion of annual reassessments, care plan and waiver service plan.
- Timely completion of assessment, care plan and waiver service plan update for beneficiary change in condition and/or needs.
- Timely completion of the initial service plan for beneficiaries determined to be newly waiver eligible.
- Effective use of online record review result reports.

HFS Policy Guidance

As a result of HFS's efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during COVID-19, and
- Guidance regarding determinations and documentation of waiver service validation.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Plan-specific, waiver-specific, and performance measure-specific recommendations are identified below.

Plan-specific

All health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

BCBSIL should focus efforts on measures 4A and 39D. BCBSIL should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. BCBSIL should ensure consistent application of a process to validate the provision of waiver services for all members.

CountyCare should focus efforts on measures 4A, 36D, 37D, and 39D. CountyCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. CountyCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. CountyCare should ensure consistent application of a process to validate the provision of waiver services for all members.

IlliniCare should focus efforts on measures 4A, 36D, and 39D. IlliniCare should also review any changes to processes that may have resulted in the decreased performance noted in Q4 SFY 2020 as compared to Q1 SFY 2020. IlliniCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. IlliniCare should ensure consistent application of a process to validate the provision of waiver services for all members.

Meridian should focus efforts on measures 4A, 36D, 37D, and 39D. Meridian should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Meridian should ensure consistent application of a process to validate the provision of waiver services for all members.

Molina should focus efforts on measures 4A, 36D, and 39D. Molina should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Molina should ensure consistent application of a process to validate the provision of waiver services for all members.

NextLevel exited the Illinois Medicaid managed care program at the end of SFY 2020; therefore, recommendations are not noted.

Waiver-specific

BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Performance measure-specific

Health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. as applicable. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A and 37D, efforts might include:

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

For measure 36D, efforts might include:

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

For measure 39D, efforts might include:

- Establish a process to complete ongoing claims validation of the waiver service plan.
- Conduct root cause analysis to determine service providers who may benefit from outreach and education regarding claims submission.
- Ensure completion of education with beneficiaries related to approved hours for personal assistants.
- Conduct staff training to ensure timely follow up with beneficiaries who have a change in service provider. Training should include a component for review of claims to validate service provision and steps to ensure there are no gaps in waiver services.
- Ensure all appropriate staff are provided access and trained on navigation of waiver agency portals to review beneficiary information.
- Develop relationships with service providers to ensure timely communication to the health plan when services cannot be provided per the waiver service plan, and ensure documentation of the communication in the beneficiary's record.

2. Data Collection and Methodology

Background

The Illinois Department of Healthcare and Family Services (HFS) implemented the Integrated Care Program (ICP) for seniors and adults with disabilities on May 1, 2011. The ICP provides integration of an individual's physical, behavioral, and social needs to improve health outcomes and enhance quality of life by providing individuals the support necessary to live more independently in the community. The ICP began as a pilot program in the greater Chicago region and now operates in 29 counties in five regions of Illinois. Management of the Home and Community-Based Services (HCBS) waiver populations was initiated in 2013.

In addition to the ICP, some enrollees receive their HCBS waiver services through the Family Health Plan (FHP)/Affordable Care Act (ACA). Voluntary managed care (VMC) was a healthcare option for medical assistance participants in Illinois from 1976 until it was phased out in July 2014 and replaced with FHP/ACA. FHP/ACA is a mandatory program for children and their families as well as the ACA adults and includes those who are eligible for HCBS waiver programs.

Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which combined the FHP/ACA and ICP populations into one managed care program.

All waiver beneficiaries enrolled in HealthChoice receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the External Quality Review Organization (EQRO) for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the HCBS waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to

demonstrate that the health plan was ready to provide services to HCBS waiver enrollees in a safe and efficient manner.

HSAG began on-site record reviews in state fiscal year 2014 to monitor ICP health plan performance on the HCBS waiver performance measures and added FHP/ACA upon waiver service provision inclusion in SFY 2016. MLTSS was included in Quarter 3 (Q3) FY 2018.

Waiver Programs and Performance Measures Included in Reviews

The following HCBS Waiver Programs were included in the Centers for Medicare & Medicaid Services (CMS) performance measures record reviews:

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

For the FY 2020 review, HFS identified 15 CMS waiver performance measures for review. These performances measures were aligned with the state approved 1915(c) waiver applications for the waiver types listed above. For FY 2020, the following changes were identified from FY 2019 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2020 to exclude the BI and SLF waivers (previously captured for all waivers).
- Measure 37D, the most recent service plan is in the record and completed in a timely manner, was revised for FY 2020 to incorporate annual renewal for the BI waiver (previously required every six months).
- Measure 49G, most recent service plan includes a backup plan that includes the name of the backup, was revised to include the ELD waiver (previously captured for BI, HIV, and PD waivers only).

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

HSAG developed a sampling methodology based on the waiver requirements approved by HFS. HSAG conducted a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selected a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group were determined based on the number of eligible members in each waiver program. Once the required sample sizes were identified, a proportional random sample was selected based on the distribution of the health plans' population within each designated waiver program. Each sample was selected to ensure a 95 percent confidence level and five percent margin of error at the waiver program level, with a maximum sample population of 5,000 cases across the HealthChoice, MLTSS and Medicare Medicaid Alignment Initiative (MMAI) waiver enrollees. Additionally, a ten percent oversample based on the proportional distribution of enrollees across health plans was selected to replace ineligible cases. The samples were selected in April 2019 and included waiver members enrolled as of March 1, 2019. Table 2.1 and Table 2.2 display the FY 2020 record review sample size by health plan and waiver program for HealthChoice and MLTSS.

Table 2.1—HealthChoice Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLP
BCBSIL	4,361	364	102	65	43	81	73
CountyCare	3,722	339	75	81	74	81	28
IlliniCare	3,741	318	79	57	48	80	54
Meridian	4,161	301	89	49	23	94	46
Molina	877	75	17	10	10	21	17
NextLevel	355	30	8	4	2	7	9
Statewide Total	**17,217**	**1,427**	**370**	**266**	**200**	**364**	**227**

Table 2.2—MLTSS Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
BCBSIL	5,560	398	114	50	42	99	93
CountyCare	3,963	308	80	65	42	80	41

Table 2.2—MLTSS Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLF
IlliniCare	3,914	312	75	46	23	68	100
Meridian	4,300	294	90	42	21	75	66
Molina	432	30	9	5	3	10	3
NextLevel	334	21	7	3	0	7	4
Statewide Total	**18,503**	**1,363**	**375**	**211**	**131**	**339**	**307**

Limitations to the sampling methodology included known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g. previously enrolled as MMAI and transferred to MLTSS).

In addition, to be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.
2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.
- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) is different from the program type identified on the sample.
- Beneficiaries in long-term care.

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the

health plans were reviewed. The six-month look back periods during SFY 2020 consisted of the following:

- Quarter 1, SFY 2020: December 1, 2018 – May 31, 2019
- Quarter 2, SFY 2020: March 1, 2019 – August 31, 2019
- Quarter 3, SFY 2020: June 1, 2019 – November 30, 2019
- Quarter 4, SFY 2020: September 1, 2019 – February 29, 2020

Web-Based Abstraction Tool and Scoring Methodology

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

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

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

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

Interrater Reliability (IRR)

In order to ensure accuracy of the reviews, HSAG conducted Interrater Reliability (IRR) on all review team members. The IRR reviews were conducted by the HSAG Senior Project Manager for ten percent of all records completed by each individual reviewer, via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95% was required, with retraining completed if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95% accuracy rate standard. All members of the HSAG review team maintained a rate above 95% during SFY20.

Remediation Actions & Tracking

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

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

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG will complete remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. HealthChoice Overall Summary of Record Review Findings for SFY20

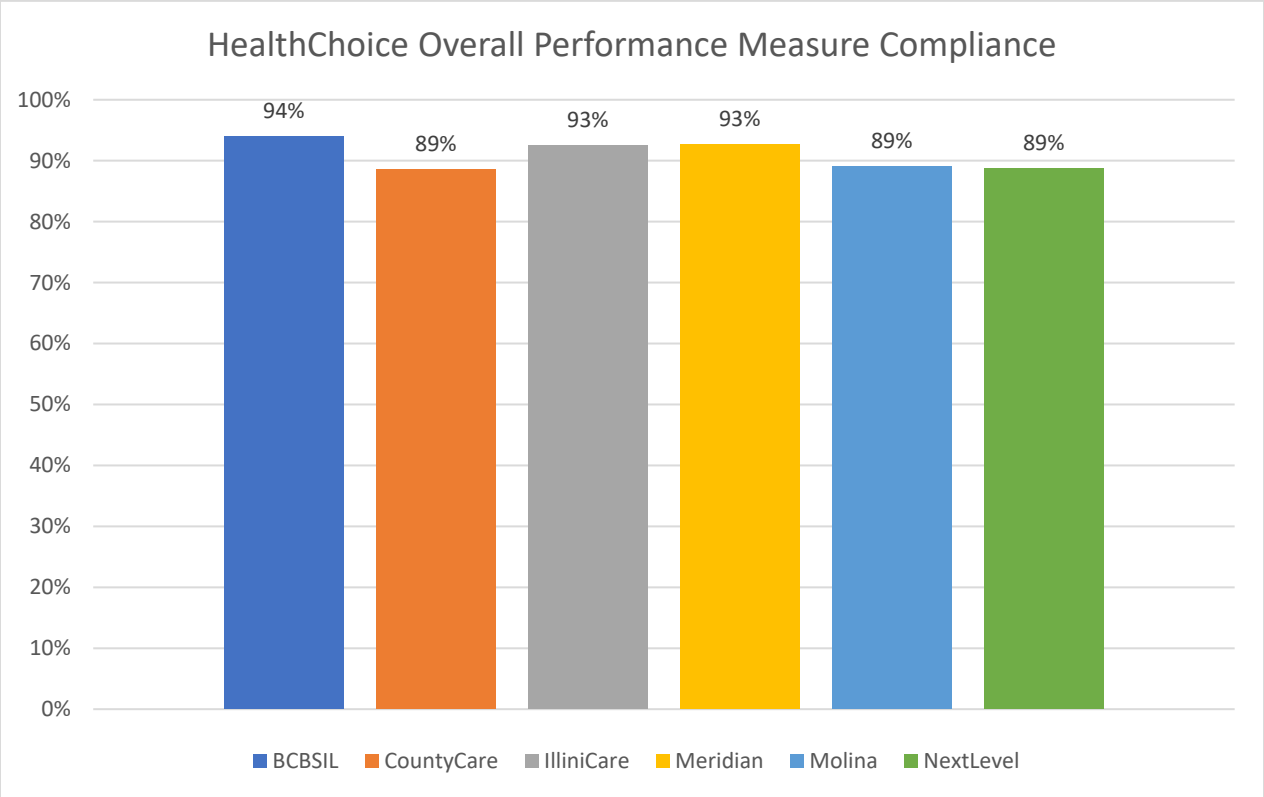
Overall Performance

Overall Health Plan Performance and Comparisons

Six health plans were reviewed during SFY 2020. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Displaying each health plan's overall average on the 15 Home and Community-Based Services (HCBS) CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the six health plans averaged greater than 90 percent compliance in SFY 2020. There was a 5-percentage point difference (89% to 94%) among health plans.

Figure 3.1 – Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- BCBSIL performed at a statistically significant higher rate than all other health plans.
- CountyCare performed at a statistically significant lower rate than BCBSIL, IlliniCare, and Meridian.
- IlliniCare performed at a statistically significant higher rate than Molina and NextLevel.
- Meridian performed at a statistically significant higher rate than Molina and NextLevel.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analysis identified the following.

Blue Cross Blue Shield of Illinois (BCBSIL)

BCBSIL realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020 (+15 percentage points, p=<0.0001). BCBSIL also realized statistically significant increases in 11 measures from SFY 2019 to SFY 2020.

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 24 percent (9 of 38 records). BCBSIL also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 83 percent; BCBSIL realized a statistically significant increase in performance for measure 39D, with a resulting increase of 24 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

CountyCare Health Plan (CountyCare)

CountyCare realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, CountyCare demonstrated stable performance in SFY 2020. CountyCare also realized statistically significant increases in three measures, and demonstrated a statistically significant decrease in one measure, from SFY 2019 to SFY 2020.

Analysis identified that CountyCare's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 15 percent (10 of 67 records). CountyCare also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type,

amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 64 percent; CountyCare realized a statistically significant increase in performance for measure 39D, with a resulting increase of 14 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

IlliniCare Health Plan, Inc. (IlliniCare)

IlliniCare demonstrated a statistically significant decrease in overall performance from Q1 to Q4 SFY 2020, but realized a statistically significant improvement from SFY 2019 to SFY 2020 (+2 percentage points, p=0.0091). IlliniCare also realized statistically significant increases in two measures, and demonstrated a statistically significant decrease in three measures, from SFY 2019 to SFY 2020.

Analysis identified that IlliniCare's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 38 percent. IlliniCare also had opportunity for improvement in measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, which demonstrated performance of 77 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Meridian Health Plan, Inc. (Meridian)

Meridian demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020 (+7 percentage points, p=<0.0001). Meridian also realized statistically significant increases in seven measures from SFY 2019 to SFY 2020.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 25 percent (13 of 53 records). Meridian also had opportunity for improvement in measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, which demonstrated performance of 80 percent; Meridian realized a statistically significant increase in performance for measure 36D, with a resulting increase of nine percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Molina Healthcare of Illinois, Inc. (Molina)

Molina demonstrated stable overall performance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Molina demonstrated a statistically significant decrease in one measure from SFY 2019 to SFY 2020.

Analysis identified that Molina's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 0 percent (0 of 5 records). Molina also had opportunity for improvement in measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, which

demonstrated performance of 73 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

NextLevel Health Partners, LLC (NextLevel)

NextLevel demonstrated stable overall performance from Q1 to Q4 SFY 2020. NextLevel demonstrated a statistically significant decrease in overall performance in SFY 2020 when compared to SFY 2019 (-8 percentage points, p=0.0003).

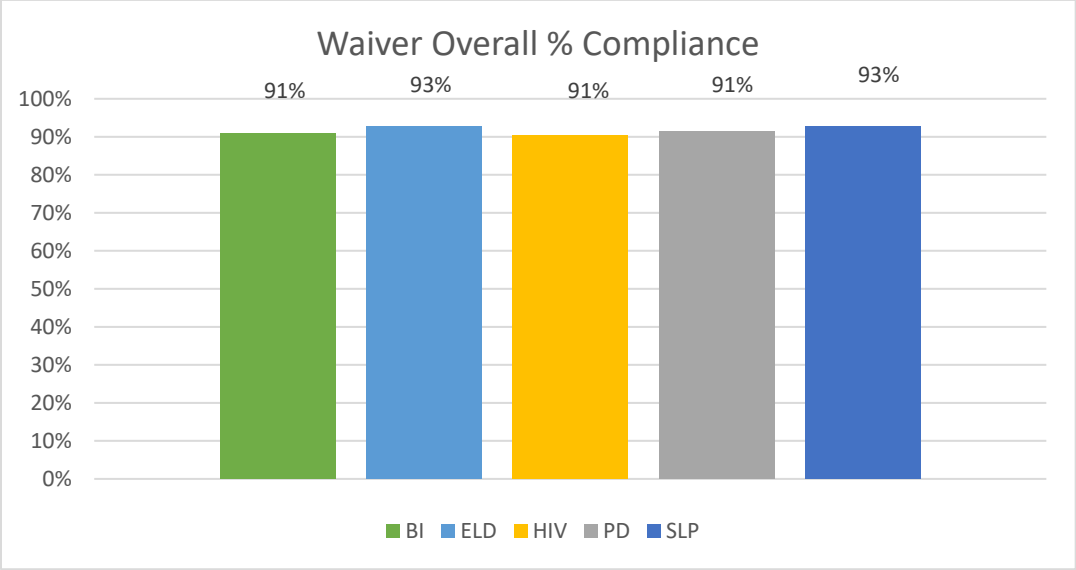
Analysis identified that NextLevel's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 0 percent (0 of 3 records). NextLevel also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 72 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific, as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3.2 displays below, all five waiver types averaged greater than 90 percent overall compliance in SFY 2020.

Figure 3.2—Overall Compliance Across Waiver Types



Statistical significance testing was also performed to compare each waiver's average overall compliance against all other waiver types, and the following differences were noted:

- The ELD waiver performed at a statistically significant higher rate than the BI, HIV, and PD waivers.
- The SLP waiver performed at a statistically significant higher rate than the BI, HIV, and PD waivers.

Differences between some waiver types may be attributable to different waiver requirements:

- BI, HIV, and PD waiver records are applicable to 12 of the 15 performance measures.
- SLP waiver records are applicable to 10 of the 15 performance measures.
- The ELD and PD waivers have different requirements for contact (annual) than the BI and HIV waivers (monthly), which may result in different performance in measure 36D.

Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Individual waiver performance analysis identified the following.

BI Waiver

The BI waiver realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the BI waiver realized a statistically significant increase in overall performance in SFY 2020 (+8 percentage points, p=<0.0001). The BI waiver also realized statistically significant increases in three measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 0 percent compliance (0 of 1 record).
- Measure 36D, the case manager made valid contact with the enrollee once a month or valid justification is documented in the enrollee's record, which performed at a rate of 52 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 78 percent compliance.

ELD Waiver

The ELD waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the ELD waiver realized a statistically significant increase in overall performance in SFY 2020 (+4 percentage points, p=<0.0001). The ELD waiver also realized statistically significant increases in five measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 17 percent compliance (17 of 100 records).
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 68 percent compliance.

HIV Waiver

The HIV waiver realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the HIV waiver realized a statistically significant increase in overall performance in SFY 2020 (+4 percentage points, p=<0.0001). The HIV waiver realized a statistically significant improvement in one measure and demonstrated a statistically significant decrease in one measure from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 20 percent compliance (2 of 10 records).
- Measure 36D, the case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record, which performed at a rate of 44 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 81 percent compliance.

PD Waiver

The PD waiver realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the PD waiver realized a statistically significant increase in overall performance in SFY 2020 (+4 percentage points, p=<0.0001). The PD waiver also realized statistically significant increases in six measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 30 percent compliance (27 of 91 records).
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 70 percent compliance.

SLP Waiver

The SLP waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in overall performance in SFY 2020 (+8

percentage points, *p*=<0.0001). The SLP waiver also realized statistically significant increases in six measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 37D, the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 83 percent compliance.

Performance was analyzed for the subset of SLP waiver members enrolled in the dementia care program. Results are identified in Table 3.1.

Table 3.1—SLP Dementia Care: Compliance with CMS Performance Measures

Measure	Measure Text	FY2019	FY2020
4A	*Overdue service plan was completed within 30 days of expected renewal.*	33% (1/3)	NA (0/0)
31D	*The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)
32D	*The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)
33D	*The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)
35D	*The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	92% (12/13)	73% (16/22)
37D	*The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	77% (10/13)	77% (17/22)
38D	*The service plan was updated when the enrollee needs changed.*	0% (0/1)	NA (0/0)
39D	*Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	92% (12/13)	100% (19/19)
41D	*The enrollee has been given the opportunity to participate in choosing types of services and providers.*	92% (12/13)	59% (13/22)
42G	*The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	92% (12/13)	55% (12/22)

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B. Trend analysis in Table 3.2 includes SFY 2020 performance, as well as FY2020 performance compared to SFY 2019.

Table 3.2—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
4A *Overdue service plan was completed within 30 days of expected renewal.*	Overall, this measure demonstrated stable performance from Q1 to Q4. This measure was the lowest-performing, averaging 23% over SFY 2020.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, CountyCare demonstrated a statistically significant decrease in this measure in SFY 2020. Compared to SFY 2019, the HIV waiver demonstrated a statistically significant decrease in performance in SFY 2020.
31D *The most recent care/service plan includes all enrollee goals as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL, CountyCare, and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the BI, ELD, PD, and SLP waiver realized a statistically significant increase in this measure in SFY 2020.
32D *The most recent care/service plan includes all enrollee needs as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, IlliniCare demonstrated a statistically significant decrease in this measure in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
		Compared to SFY 2019, the PD and SLP waiver realized a statistically significant increase in this measure in SFY 2020.
33D *The most recent care/service plan includes all enrollee risks as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. IlliniCare demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the PD and SLP waiver realized a statistically significant increase in this measure in SFY 2020.
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
35D *The most recent care/service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	Overall, this measure demonstrated stable performance from Q1 to Q4. IlliniCare demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, Molina demonstrated a statistically significant decrease in this measure in SFY 2020.
36D *PD & ELD Waiver – The case manager made annual contact with the enrollee or there is valid justification in the record. HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record.*	Overall, this measure demonstrated stable performance from Q1 to Q4. CountyCare realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
BI Waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.	IlliniCare demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, the ELD and PD waiver realized a statistically significant increase in this measure in SFY 2020.
37D *The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	Overall, this measure demonstrated stable performance from Q1 to Q4. CountyCare realized a statistically significant increase in performance from Q1 to Q4. The BI and PD waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL, IlliniCare, and Meridian realized a statistically significant increase in performance in SFY 2020. Compared to SFY 2019, the BI, ELD, and SLP waiver realized a statistically significant increase in performance in SFY 2020.
38D *The care/service plan was updated when the enrollee needs changed.*	Overall, this measure demonstrated stable performance from Q1 to Q4. BCBSIL and CountyCare realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, the ELD and PD waiver realized a statistically significant increase in this measure in SFY 2020.
39D *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. CountyCare and Meridian realized a statistically significant increase in performance from Q1 to Q4. The BI, HIV, and PD waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020). Compared to SFY 2019, BCBSIL, CountyCare, IlliniCare, and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the BI, ELD, HIV, PD, and SLP waiver realized a statistically significant increase in performance in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
41D *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance in SFY 2020. Compared to SFY 2019, IlliniCare demonstrated a statistically significant decrease in performance in SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in performance in SFY 2020.
42G *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. IlliniCare demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in performance in SFY 2020. Compared to SFY 2019, IlliniCare demonstrated a statistically significant decrease in performance in SFY 2020.
44G *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
49G *(BI, HIV, PD Waivers)* *The most recent care/service plan includes the name of the backup personal assistant (PA) service (if receiving PA).*	Overall, this measure demonstrated stable performance from Q1 to Q4. The HIV waiver realized a statistically significant	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
	increase in performance from Q1 to Q4.	increase in this measure in SFY 2020.

Analysis of Lowest-Performing Measure

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

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which averaged 23 percent compliance during SFY 2020.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which averaged 78 percent compliance during SFY 2020.

Health plans also had opportunity for improvement in the BI and HIV waivers related to measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record,* which averaged 52 percent and 44 percent compliance, respectively, during SFY 2020.

Measure 4A

This measure is only applicable to records in which there was an overdue service plan. Health plans should make efforts to ensure that overdue service plans are completed within 30 days of expected renewal.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should also make efforts to ensure that overdue service plans are completed within 30 days of expected renewal. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals.

Measure 39D

During record review, measure 39D was collected by validating the services identified on the waiver service plan against claims.

Performance during SFY 2020 was analyzed to determine any health plan-specific differences, and the following were identified:

- CountyCare performed at a statistically significant lower rate (64 percent) than BCBSIL, IlliniCare, Meridian, and Molina.

Performance was also analyzed across waiver types:

- The SLP waiver performed at a statistically significant higher rate (99 percent) than all other waiver types. Higher performance is expected for the SLP waiver, as claims review validates that the beneficiary maintains the SLP as his/her permanent residence.
- The BI and HIV waivers performed at a statistically significant higher rate than the ELD and PD waivers.

Analysis was performed to determine if there were any waiver service types that contributed to performance on measure 39D. Of the non-compliant records, non-compliant homemaker services and non-compliant personal assistant services represented the greatest opportunity for improvement.

The health plans were encouraged to ensure that they had a process to complete waiver service validation on an ongoing basis. Health plans may consider focusing on beneficiaries with homemaker and personal assistant services to ensure that waiver services are provided per the service plan and that homemaker agencies and personal assistants are appropriately educated to ensure compliance to the service plan.

Measure 36D

Performance on measure 36D was stable during SFY 2020 and when SFY 2020 performance is compared against SFY 2019. During SFY 2020, performance on measure 36D for the BI waiver resulted in a rate of 52 percent. Performance related to the HIV waiver resulted in a rate of 44 percent.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in 36D can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct root cause analysis on their HIV and BI cases to determine opportunities to affect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads.

Remediation and Remediation Validation

Remediation

As a result of the on-site reviews, HSAG identified non-compliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were

required to remediate the non-compliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for the waiver enrollees.

Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure. The timeframe for remediation of findings was 60 days, except for two measures, 42G and 49G, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. Compliance with timely remediation of these findings was monitored by HSAG through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2020, all health plans demonstrated full compliance with completion of remediation action documentation for all non-compliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3.4 indicates the number of cases reviewed per health plan for HealthChoice, and Table 3.5 indicates the number of cases reviewed per health plan for MLTSS.

Table 3.4 – Health Plans Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	14/15	10/11
CountyCare	32/32	16/16
IlliniCare	7/16	10/14
Meridian	18/18	12/12
Molina	12/12	9/9
NextLevel	4/4	14/14

Table 3.5 – Health Plans Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2* (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	ND	11/11
CountyCare	ND	14/16
IlliniCare	ND	10/14
Meridian	ND	15/15
Molina	ND	10/10
NextLevel**	ND	ND

**MLTSS-specific remediation validation was implemented during Q4*
***NextLevel did not have any MLTSS cases requiring remediation validation*

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

Overall remediation validation among the six HealthChoice health plans cases averaged 91 percent. Four of the six health plans demonstrated 100 percent compliance with remediation validation. BCBSIL and IlliniCare did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database or documentation was unable to be located to validate remediation. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Overall remediation validation among the five MLTSS health plans with remediation validation cases averaged 91 percent. Three of the five health plans demonstrated 100 percent compliance with remediation validation. CountyCare and IlliniCare did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database or documentation was unable to be located to validate remediation. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2021 and will include review of any records that were found to be not fully remediated during the SFY 2020 reviews.

Appendix A. CMS Performance Measures Description

Table A.1 provides a description of each Centers for Medicare & Medicaid Services (CMS) performance measure, including the identification of waiver-specific measures.

Table A.1—CMS Waiver Performance Measure Descriptions

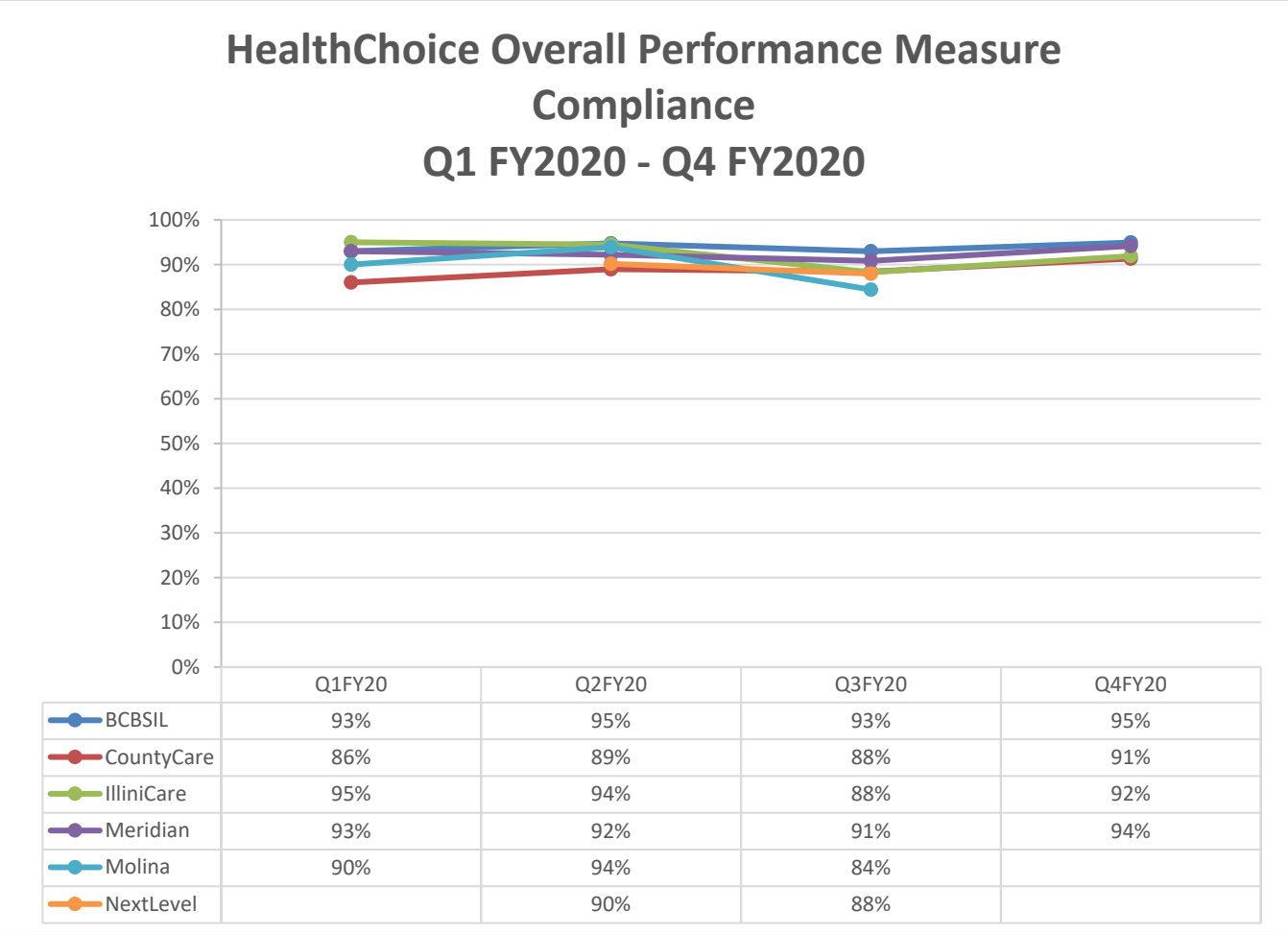
Measure #	Measure Description
4A	Overdue Service Plan was completed within 30 days of expected renewal. ELD, HIV, PD Waivers
31D	The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.
32D	The most recent service plan includes all enrollee needs as identified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

Appendix B. Performance Trending – HealthChoice

Overall Trend Performance

Figure B.1 displays a computed average of the performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.1 – Overall Compliance



	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	93%	95%	93%	95%
CountyCare	86%	89%	88%	91%
IlliniCare	95%	94%	88%	92%
Meridian	93%	92%	91%	94%
Molina	90%	94%	84%	
NextLevel		90%	88%	

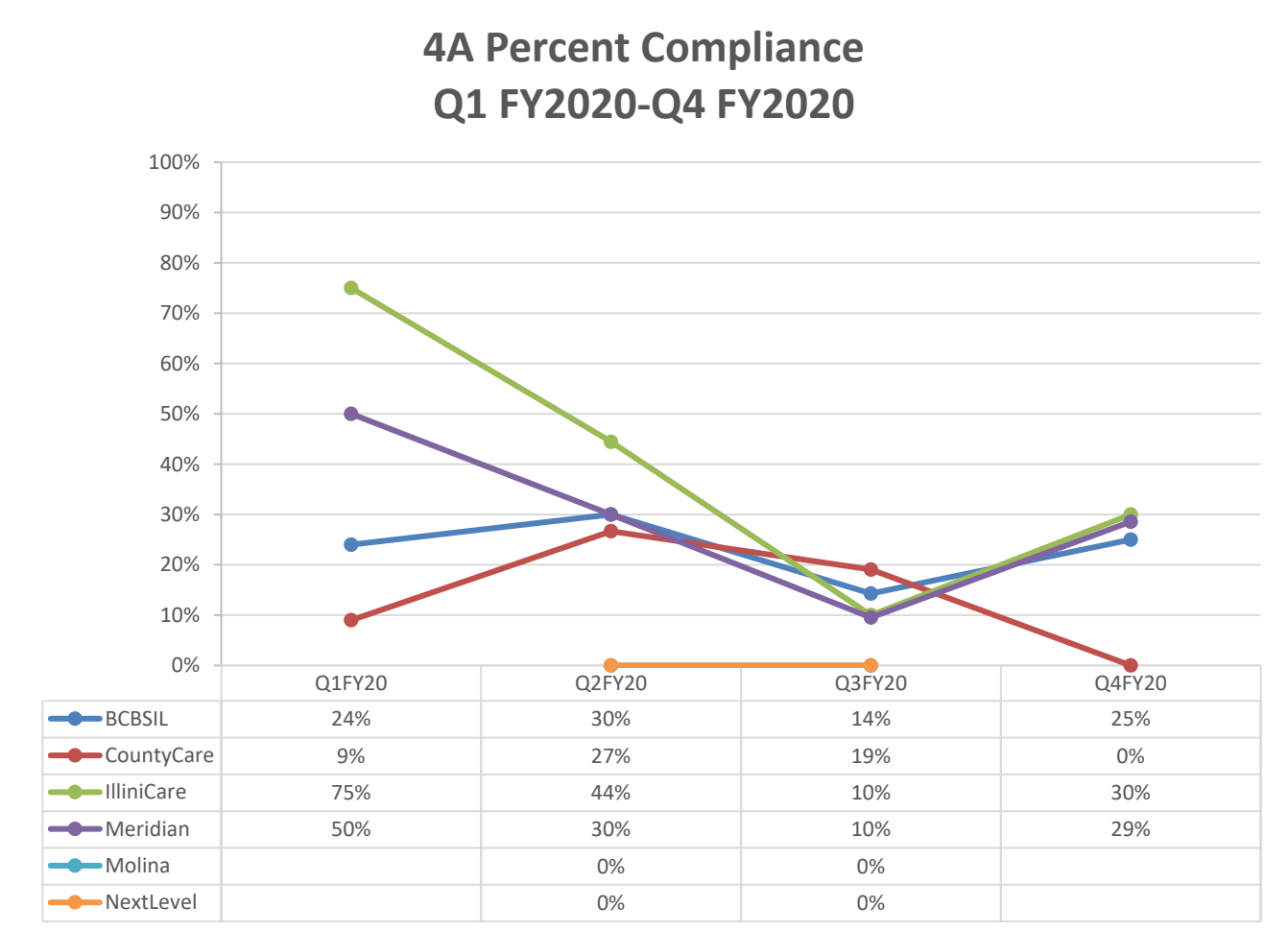
Note: Blank cells represent quarters in which the health plan was not reviewed.

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal. (ELD, HIV, and PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.2 – Measure 4A

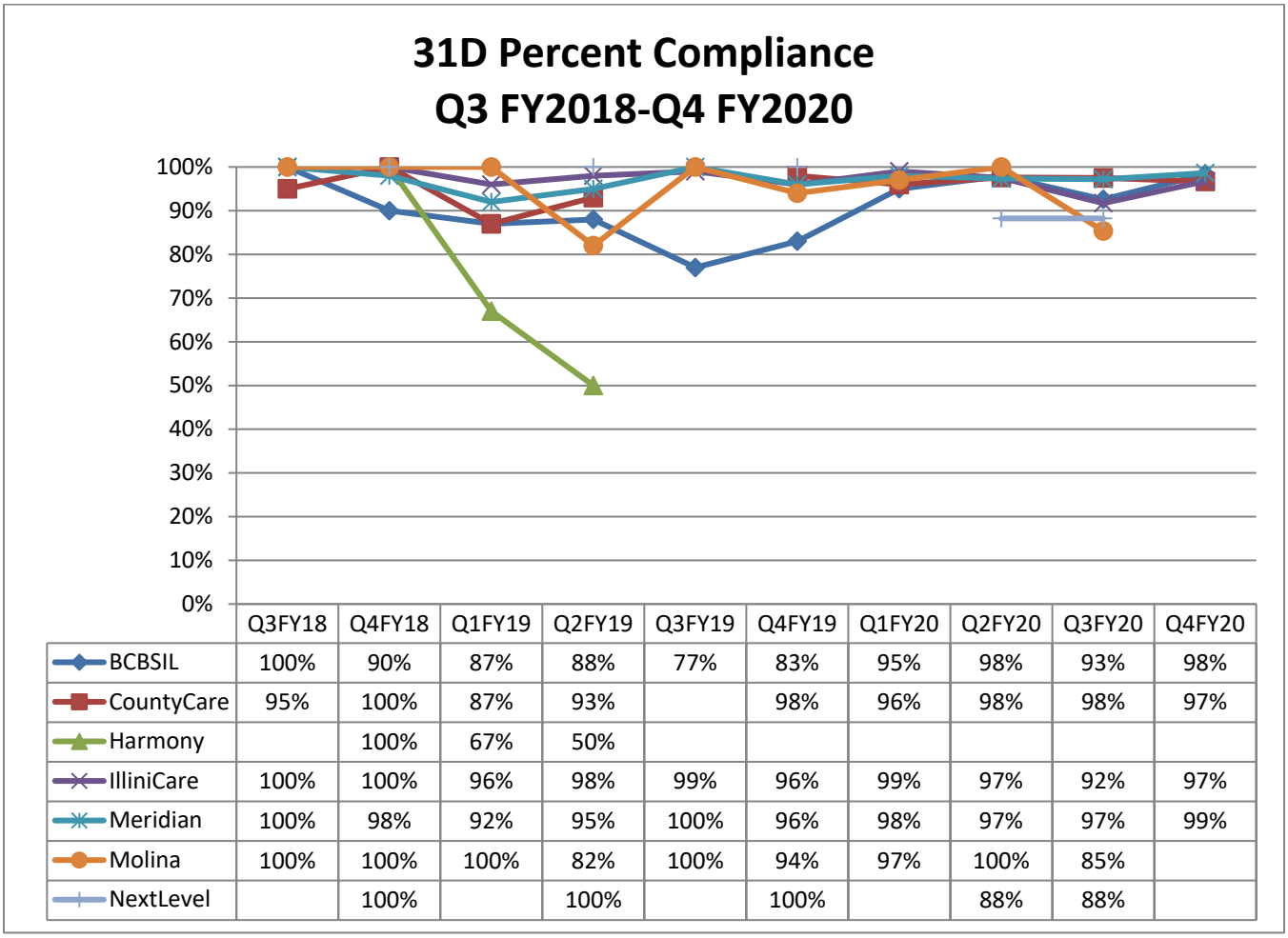


	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	24%	30%	14%	25%
CountyCare	9%	27%	19%	0%
IlliniCare	75%	44%	10%	30%
Meridian	50%	30%	10%	29%
Molina		0%	0%	
NextLevel		0%	0%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 31D - The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.

Figure B.3 – Measure 31D



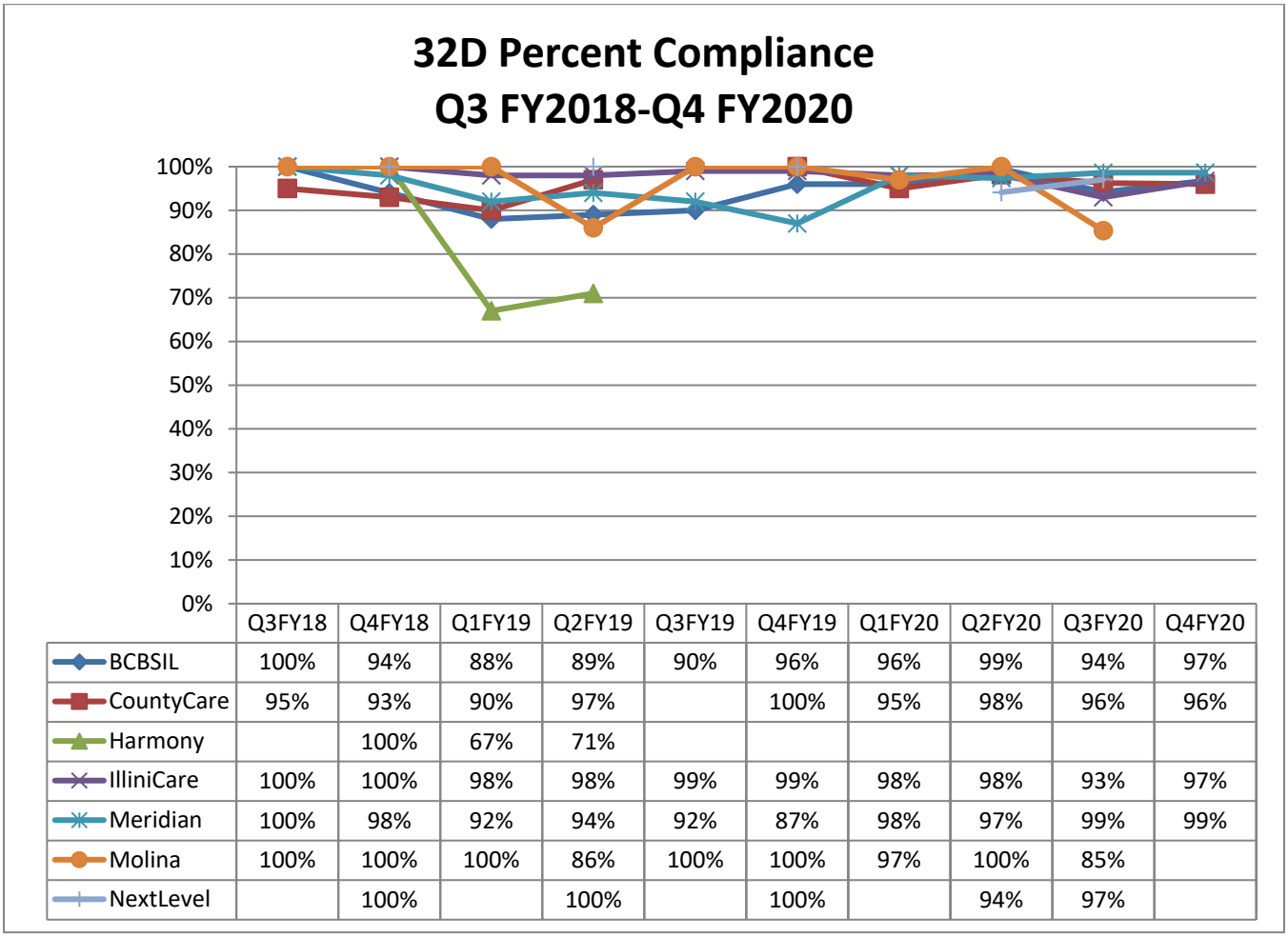
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	90%	87%	88%	77%	83%	95%	98%	93%	98%
CountyCare	95%	100%	87%	93%		98%	96%	98%	98%	97%
Harmony		100%	67%	50%						
IlliniCare	100%	100%	96%	98%	99%	96%	99%	97%	92%	97%
Meridian	100%	98%	92%	95%	100%	96%	98%	97%	97%	99%
Molina	100%	100%	100%	82%	100%	94%	97%	100%	85%	
NextLevel		100%		100%		100%		88%	88%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 32D - The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.

Figure B.4 – Measure 32D



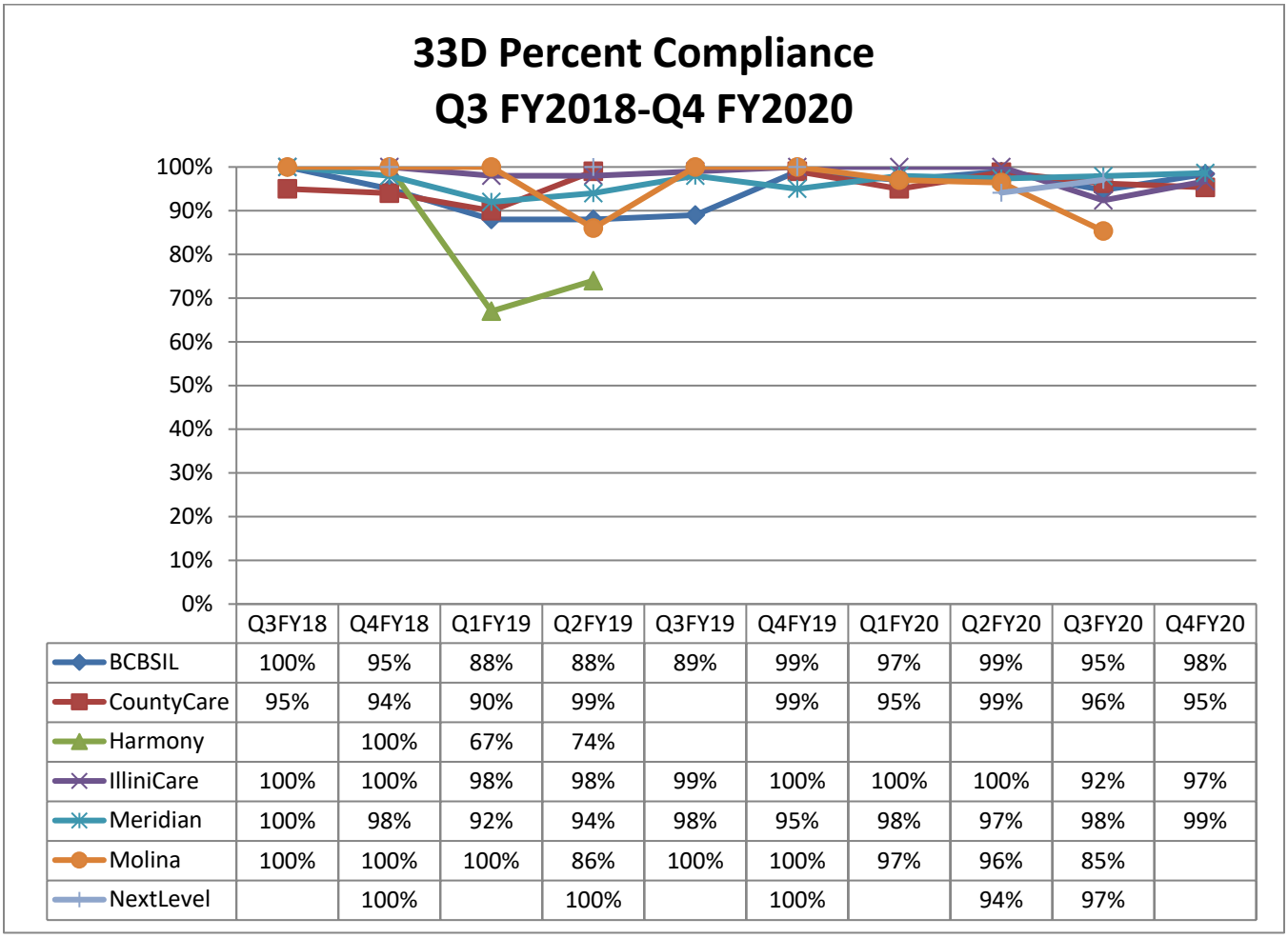
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	94%	88%	89%	90%	96%	96%	99%	94%	97%
CountyCare	95%	93%	90%	97%		100%	95%	98%	96%	96%
Harmony		100%	67%	71%						
IlliniCare	100%	100%	98%	98%	99%	99%	98%	98%	93%	97%
Meridian	100%	98%	92%	94%	92%	87%	98%	97%	99%	99%
Molina	100%	100%	100%	86%	100%	100%	97%	100%	85%	
NextLevel		100%		100%		100%		94%	97%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 33D - The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.

Figure B.5 – Measure 33D



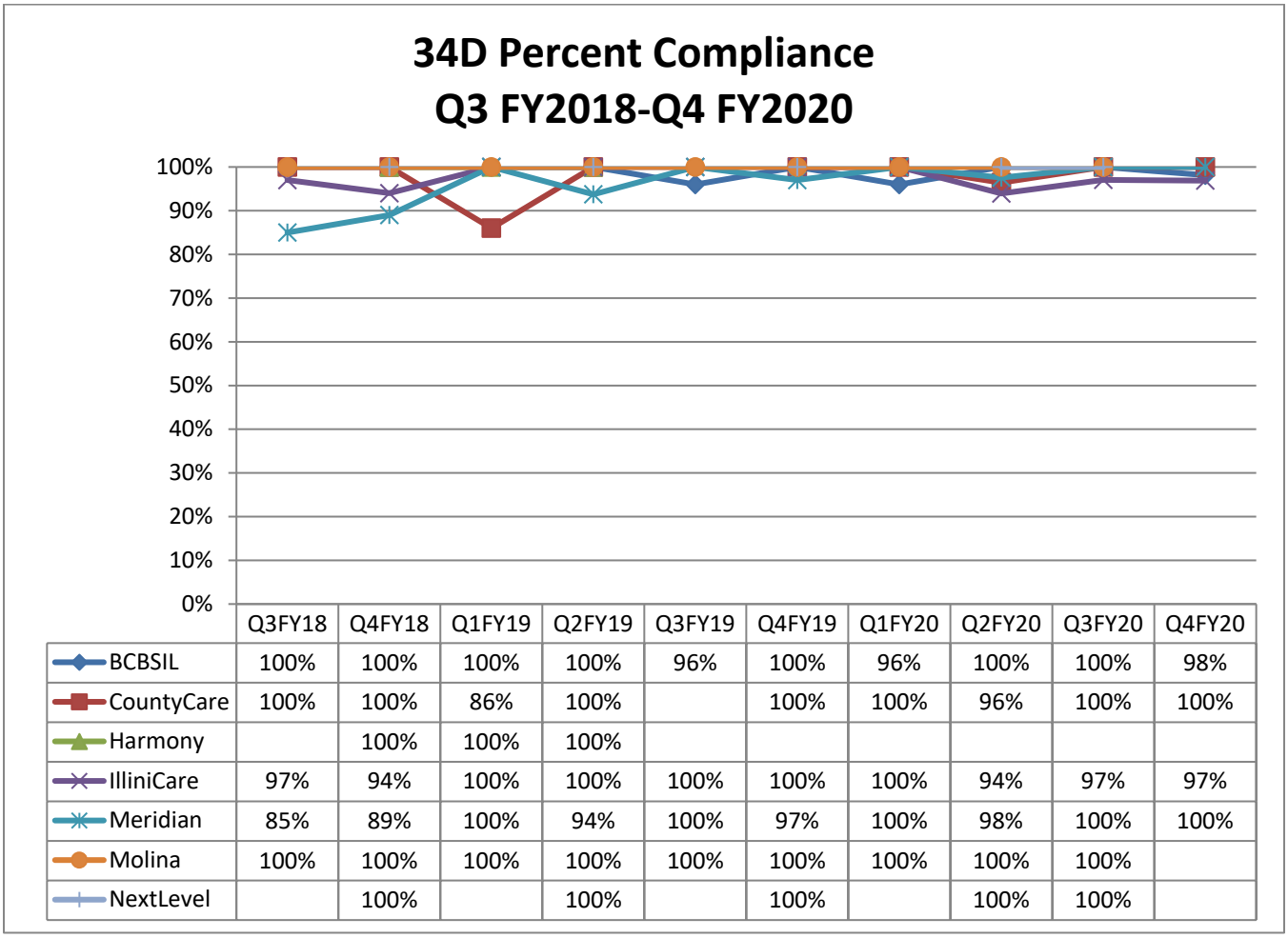
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	95%	88%	88%	89%	99%	97%	99%	95%	98%
CountyCare	95%	94%	90%	99%		99%	95%	99%	96%	95%
Harmony		100%	67%	74%						
IlliniCare	100%	100%	98%	98%	99%	100%	100%	100%	92%	97%
Meridian	100%	98%	92%	94%	98%	95%	98%	97%	98%	99%
Molina	100%	100%	100%	86%	100%	100%	97%	96%	85%	
NextLevel		100%		100%		100%		94%	97%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 34D - The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B.6 – Measure 34D



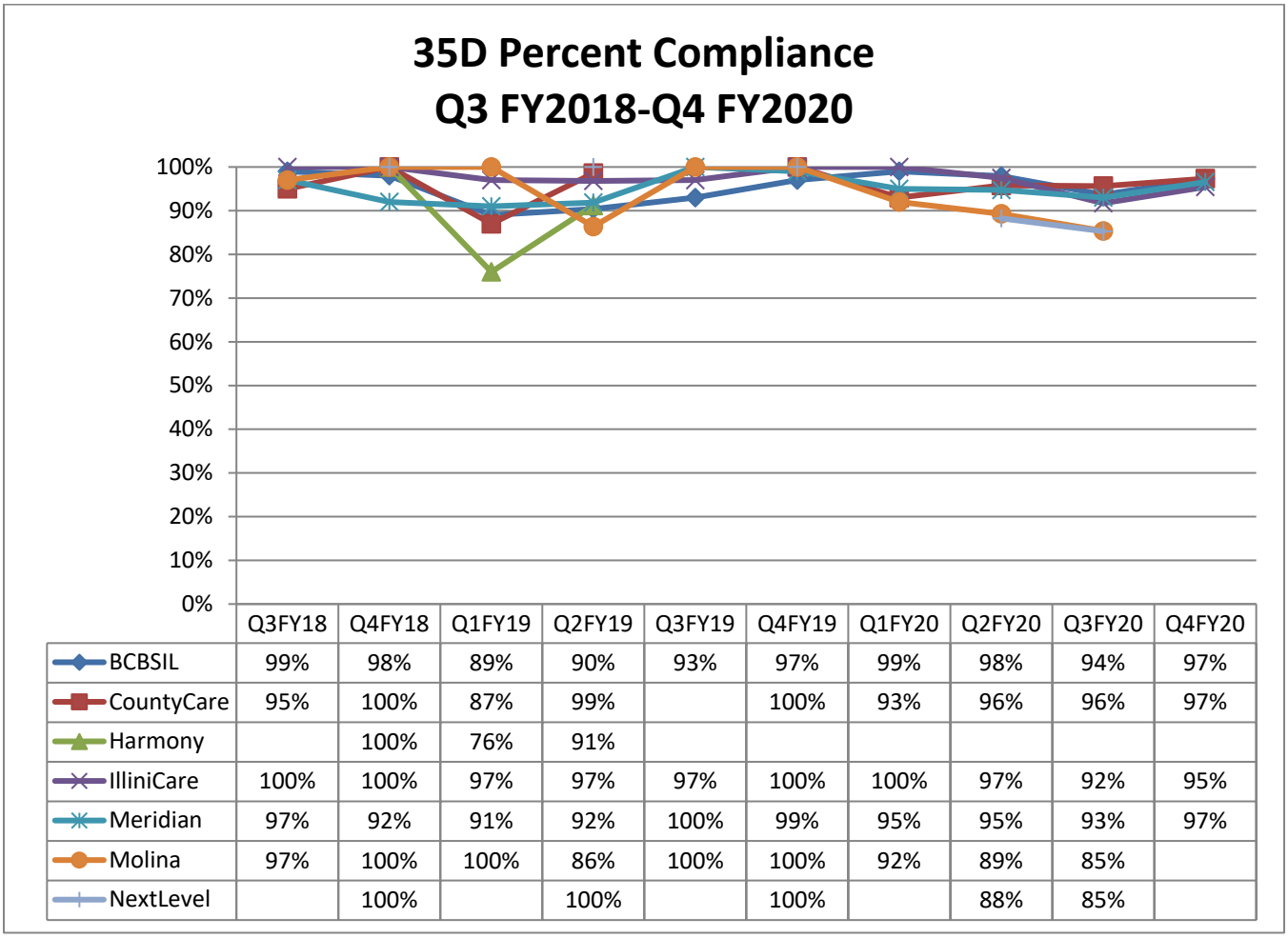
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	100%	100%	100%	96%	100%	96%	100%	100%	98%
CountyCare	100%	100%	86%	100%		100%	100%	96%	100%	100%
Harmony		100%	100%	100%						
IlliniCare	97%	94%	100%	100%	100%	100%	100%	94%	97%	97%
Meridian	85%	89%	100%	94%	100%	97%	100%	98%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%	
NextLevel		100%		100%		100%		100%	100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 35D - The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.

Figure B.7 – Measure 35D



	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	99%	98%	89%	90%	93%	97%	99%	98%	94%	97%
CountyCare	95%	100%	87%	99%		100%	93%	96%	96%	97%
Harmony		100%	76%	91%						
IlliniCare	100%	100%	97%	97%	97%	100%	100%	97%	92%	95%
Meridian	97%	92%	91%	92%	100%	99%	95%	95%	93%	97%
Molina	97%	100%	100%	86%	100%	100%	92%	89%	85%	
NextLevel		100%		100%		100%		88%	85%	

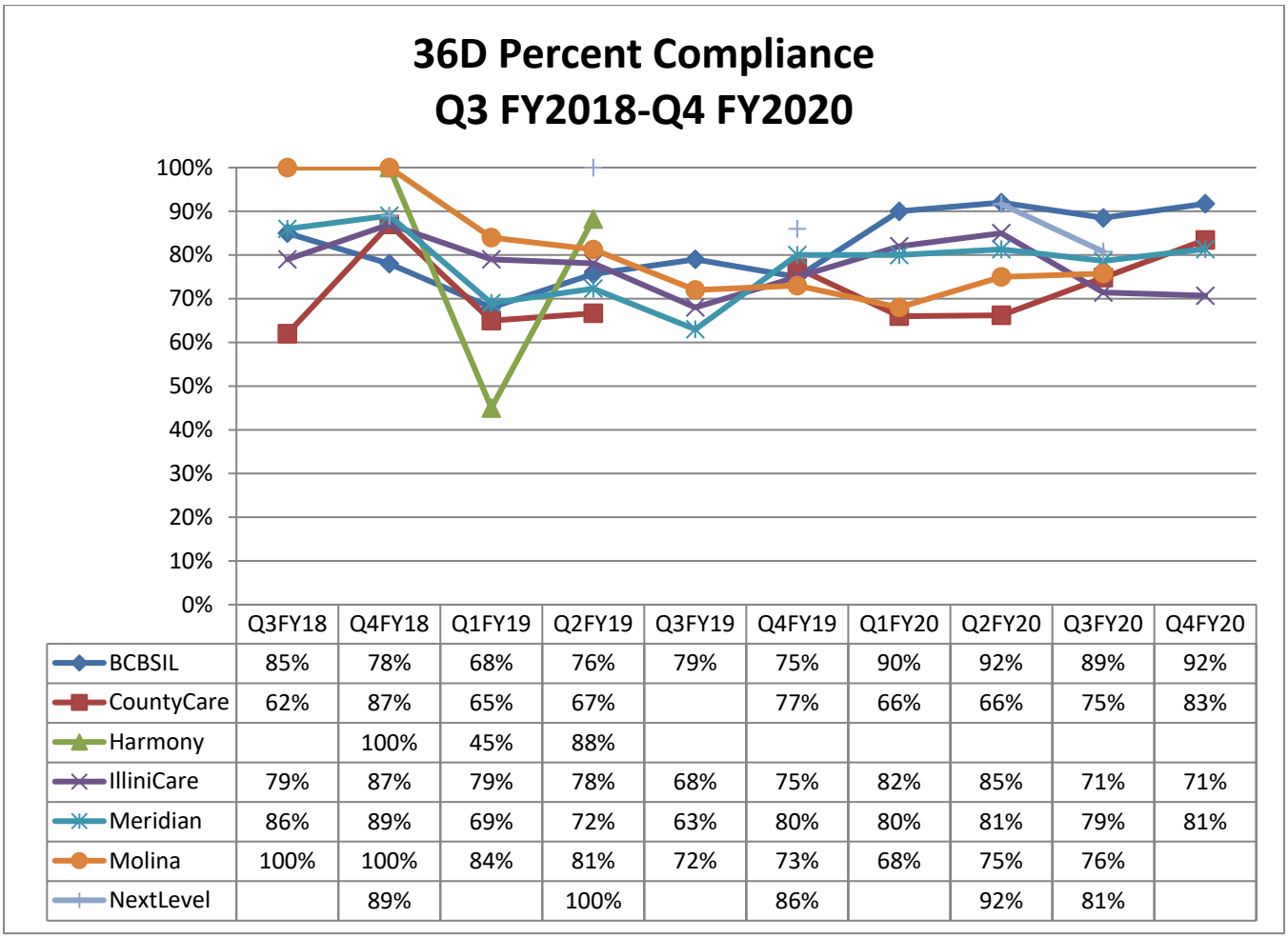
Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 36D - the Case Manager made valid timely contact or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one contact face-to-face bi-monthly.
BI: Monthly contact.
PD: Annual contact.
ELD: Annual contact
SLP records are not eligible for this measure

Figure B.8 – Measure 36D



	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	85%	78%	68%	76%	79%	75%	90%	92%	89%	92%
CountyCare	62%	87%	65%	67%		77%	66%	66%	75%	83%
Harmony		100%	45%	88%						
IlliniCare	79%	87%	79%	78%	68%	75%	82%	85%	71%	71%
Meridian	86%	89%	69%	72%	63%	80%	80%	81%	79%	81%
Molina	100%	100%	84%	81%	72%	73%	68%	75%	76%	
NextLevel		89%		100%		86%		92%	81%	

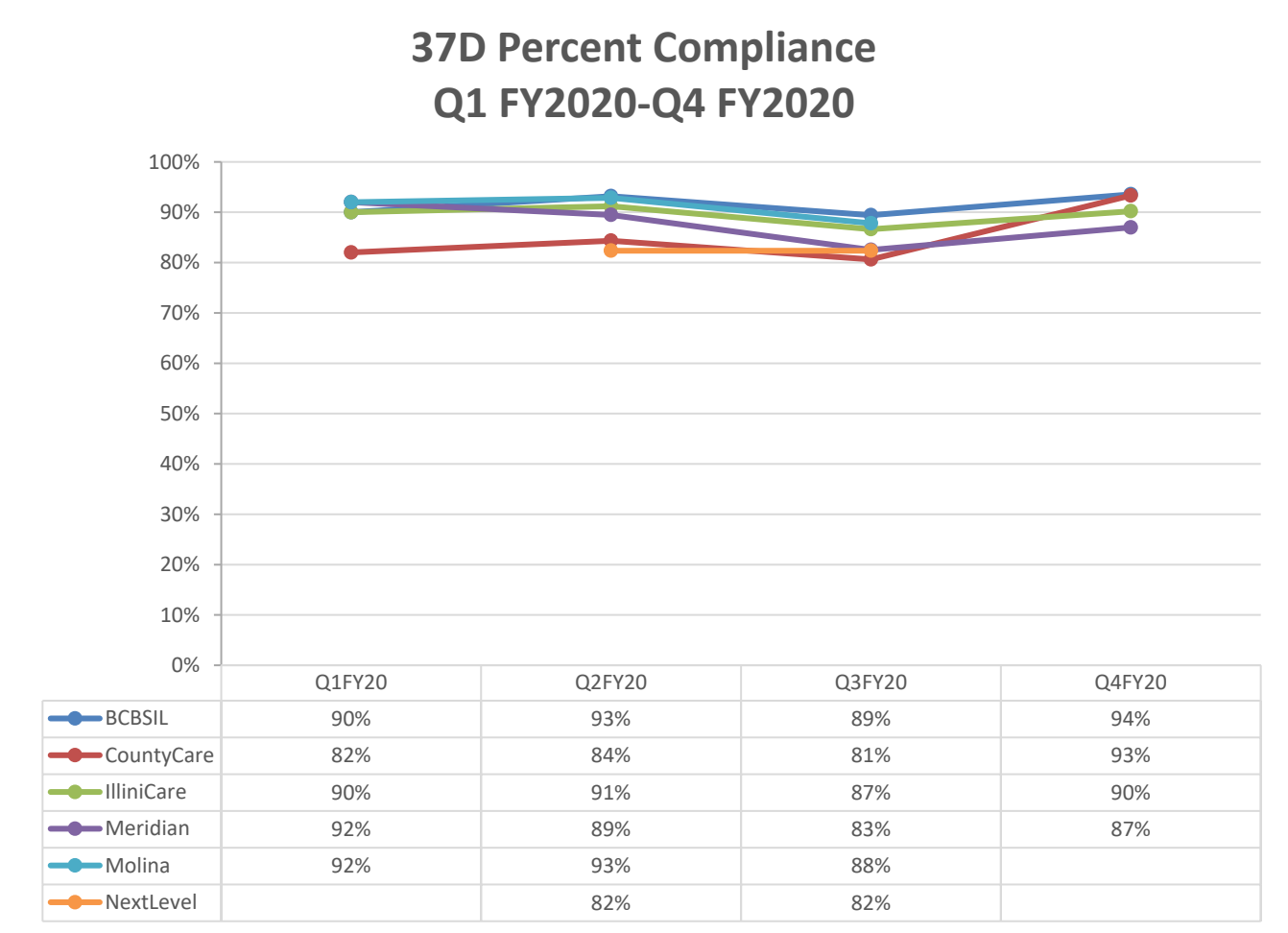
Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Data prior to Q3 FY2018 is available in prior years' reports.

Measure 37D - The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.9 – Measure 37D

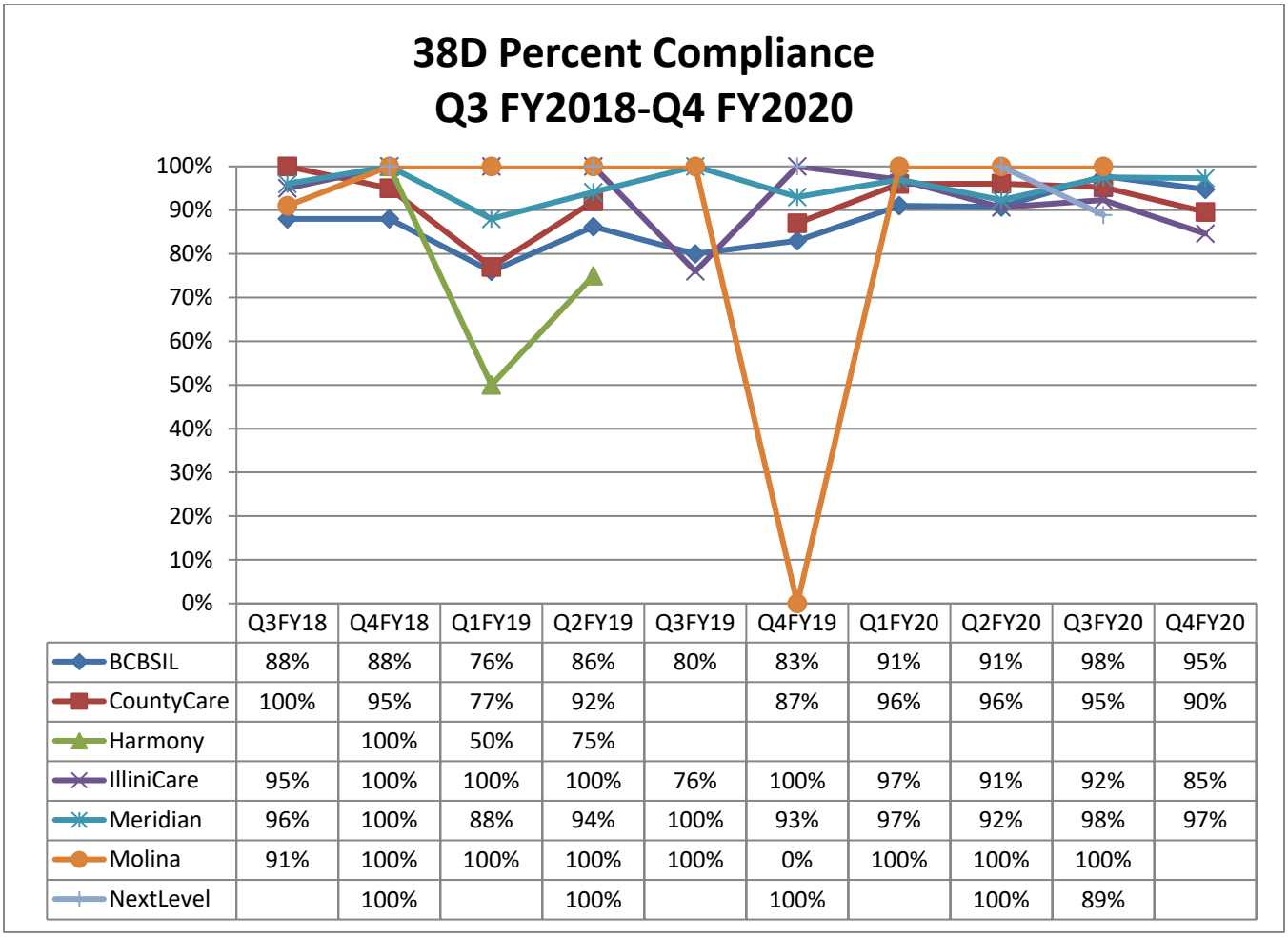


	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	90%	93%	89%	94%
CountyCare	82%	84%	81%	93%
IlliniCare	90%	91%	87%	90%
Meridian	92%	89%	83%	87%
Molina	92%	93%	88%	
NextLevel		82%	82%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 38D - The service plan was updated when the enrollee needs changed.

Figure B.10 – Measure 38D

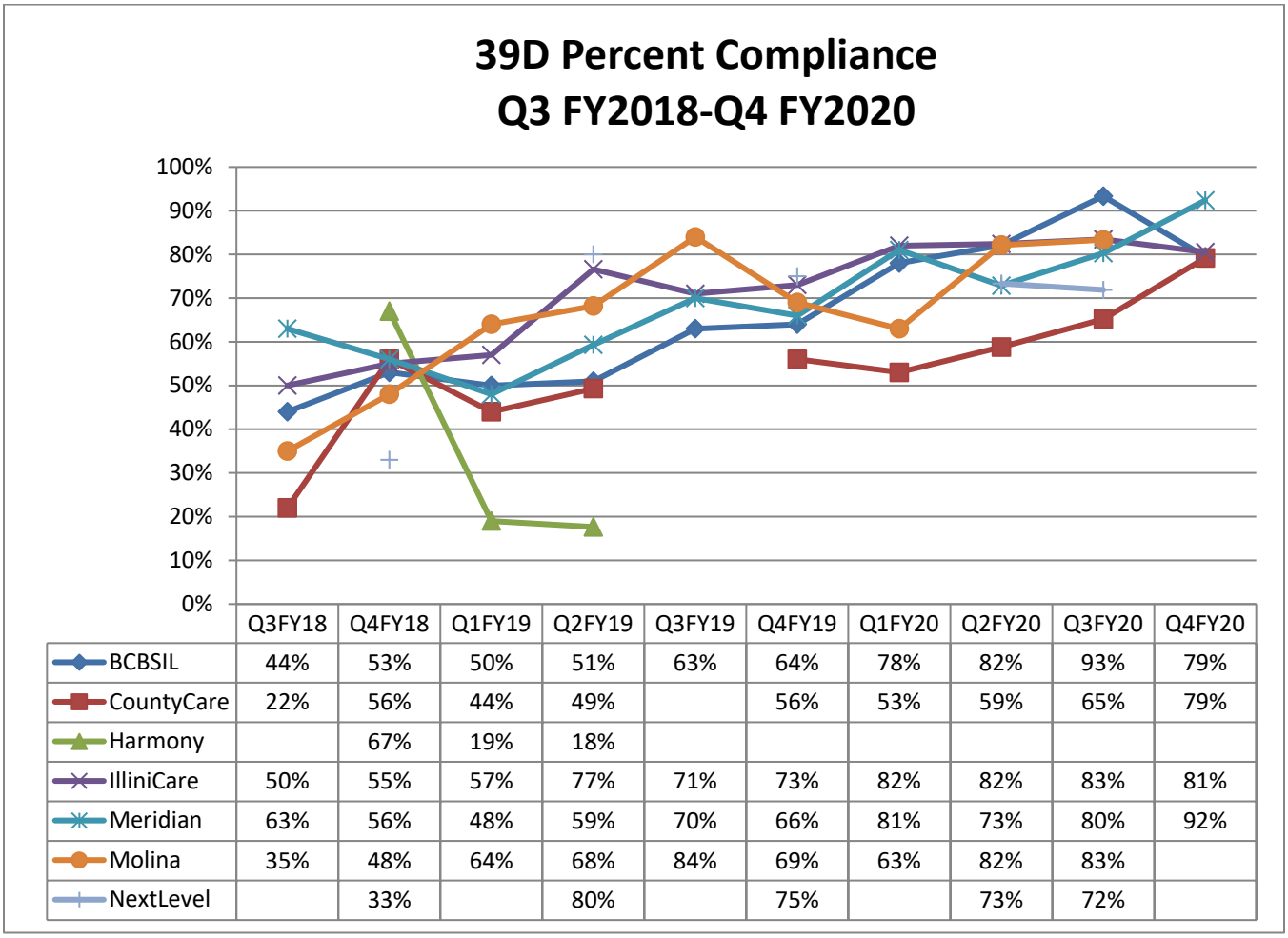


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	88%	88%	76%	86%	80%	83%	91%	91%	98%	95%
CountyCare	100%	95%	77%	92%		87%	96%	96%	95%	90%
Harmony		100%	50%	75%						
IlliniCare	95%	100%	100%	100%	76%	100%	97%	91%	92%	85%
Meridian	96%	100%	88%	94%	100%	93%	97%	92%	98%	97%
Molina	91%	100%	100%	100%	100%	0%	100%	100%	100%	
NextLevel		100%		100%		100%		100%	89%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 39D - Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.

Figure B.11 – Measure 39D

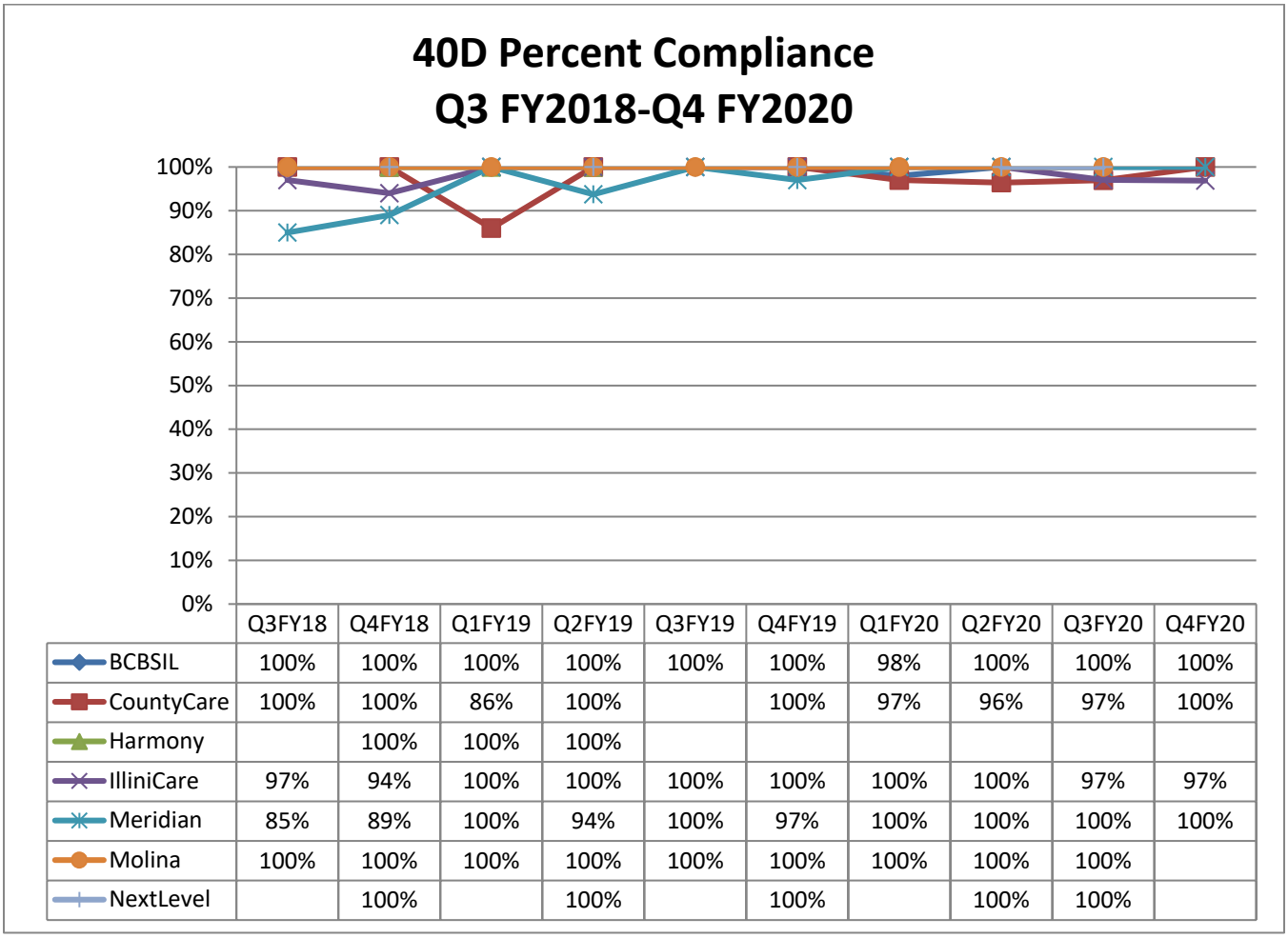


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	44%	53%	50%	51%	63%	64%	78%	82%	93%	79%
CountyCare	22%	56%	44%	49%		56%	53%	59%	65%	79%
Harmony		67%	19%	18%						
IlliniCare	50%	55%	57%	77%	71%	73%	82%	82%	83%	81%
Meridian	63%	56%	48%	59%	70%	66%	81%	73%	80%	92%
Molina	35%	48%	64%	68%	84%	69%	63%	82%	83%	
NextLevel		33%		80%		75%		73%	72%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 40D – The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B.12 – Measure 40D

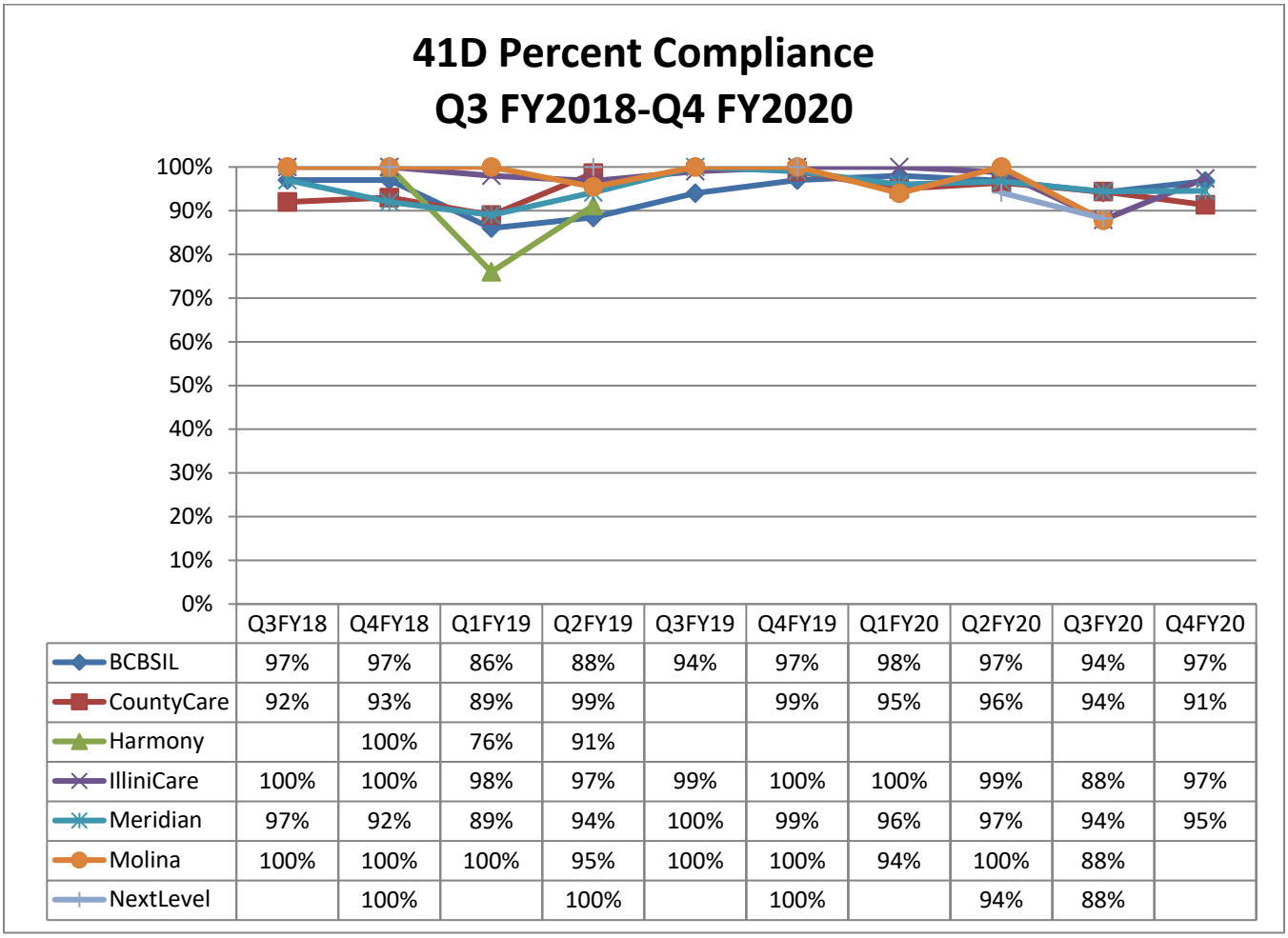


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%
CountyCare	100%	100%	86%	100%		100%	97%	96%	97%	100%
Harmony		100%	100%	100%						
IlliniCare	97%	94%	100%	100%	100%	100%	100%	100%	97%	97%
Meridian	85%	89%	100%	94%	100%	97%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%	
NextLevel		100%		100%		100%		100%	100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 41D - The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B.13 – Measure 41D

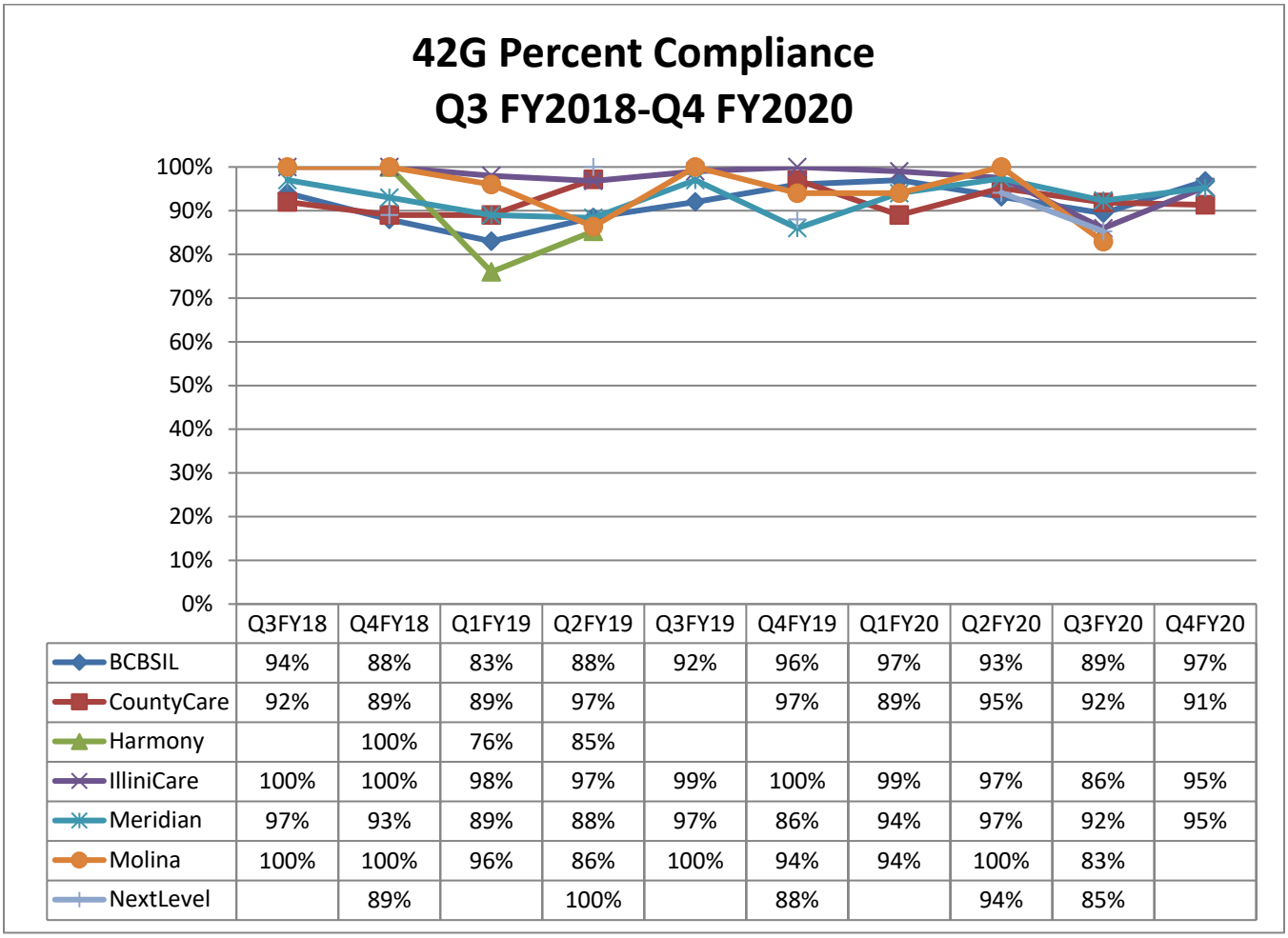


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	97%	97%	86%	88%	94%	97%	98%	97%	94%	97%
CountyCare	92%	93%	89%	99%		99%	95%	96%	94%	91%
Harmony		100%	76%	91%						
IlliniCare	100%	100%	98%	97%	99%	100%	100%	99%	88%	97%
Meridian	97%	92%	89%	94%	100%	99%	96%	97%	94%	95%
Molina	100%	100%	100%	95%	100%	100%	94%	100%	88%	
NextLevel		100%		100%		100%		94%	88%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 42G - The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B.14 – Measure 42G

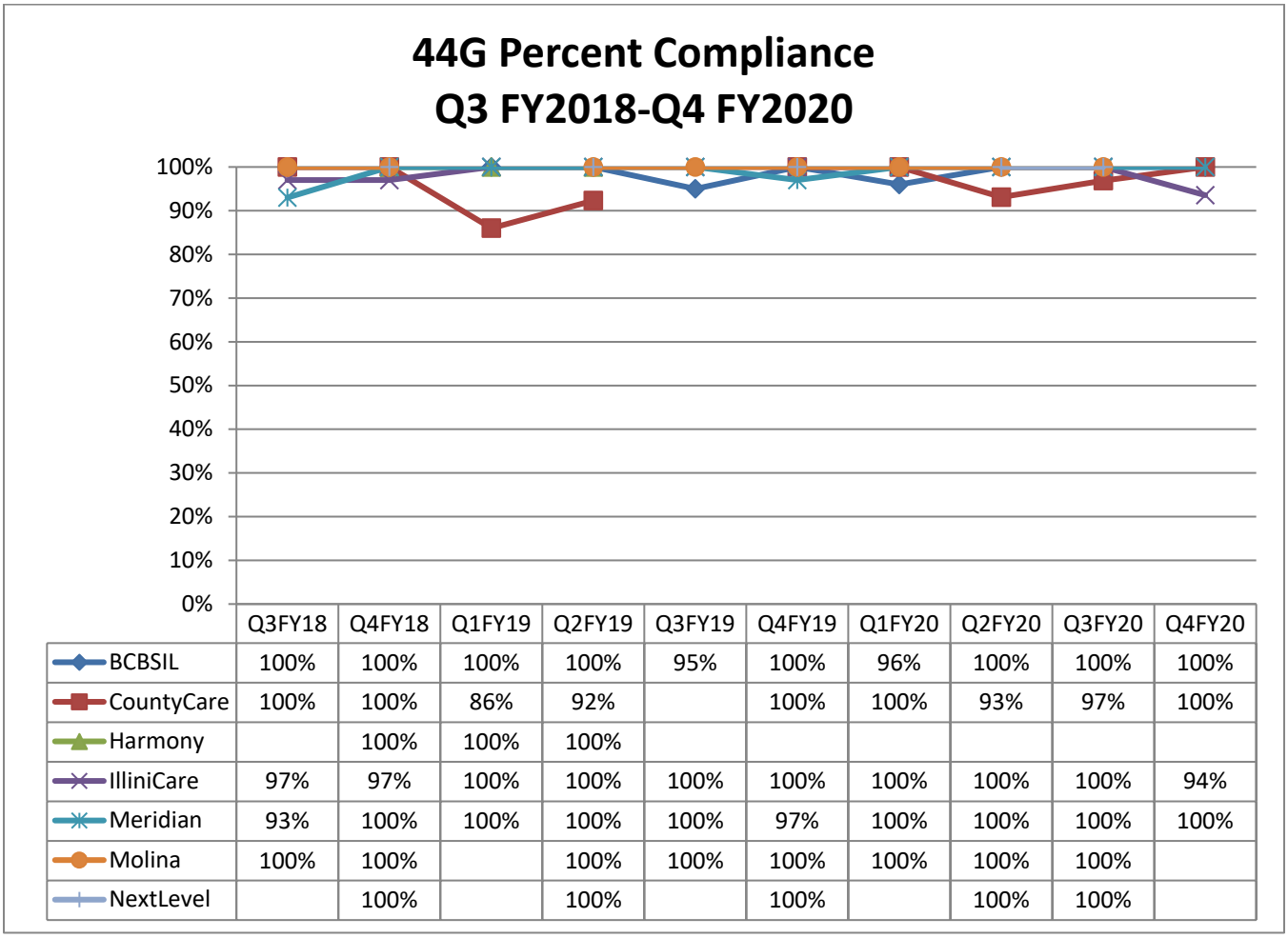


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	94%	88%	83%	88%	92%	96%	97%	93%	89%	97%
CountyCare	92%	89%	89%	97%		97%	89%	95%	92%	91%
Harmony		100%	76%	85%						
IlliniCare	100%	100%	98%	97%	99%	100%	99%	97%	86%	95%
Meridian	97%	93%	89%	88%	97%	86%	94%	97%	92%	95%
Molina	100%	100%	96%	86%	100%	94%	94%	100%	83%	
NextLevel		89%		100%		88%		94%	85%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.15 – Measure 44G



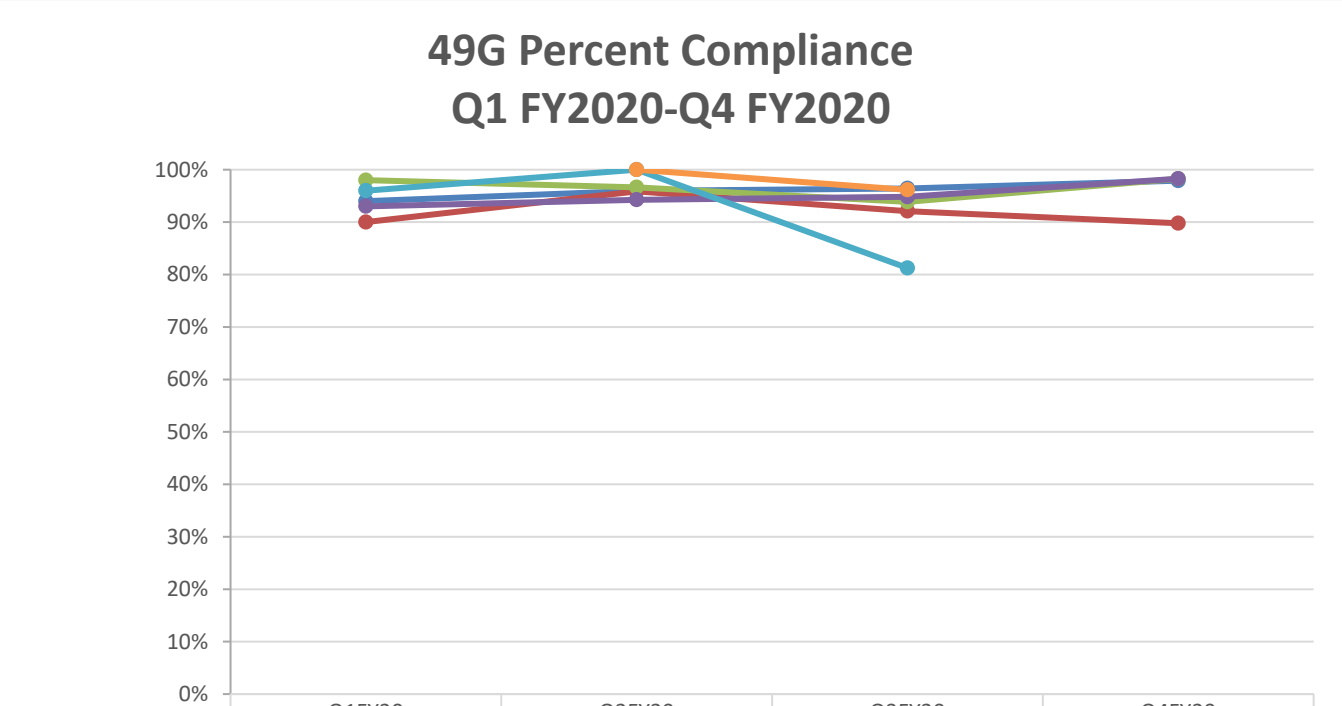
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	100%	100%	100%	100%	95%	100%	96%	100%	100%	100%
CountyCare	100%	100%	86%	92%		100%	100%	93%	97%	100%
Harmony		100%	100%	100%						
IlliniCare	97%	97%	100%	100%	100%	100%	100%	100%	100%	94%
Meridian	93%	100%	100%	100%	100%	97%	100%	100%	100%	100%
Molina	100%	100%		100%	100%	100%	100%	100%	100%	
NextLevel		100%		100%		100%		100%	100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to Q3 FY2018 is available in prior years' reports.

Measure 49G - The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV, PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.16 – Measure 49G



	Q1FY20	Q2FY20	Q3FY20	Q4FY20
BCBSIL	94%	96%	96%	98%
CountyCare	90%	96%	92%	90%
IlliniCare	98%	97%	94%	98%
Meridian	93%	94%	95%	98%
Molina	96%	100%	81%	
NextLevel		100%	96%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Appendix C. Health Plan Performance by Measure by Quarter – HealthChoice

Table C.1 displays health plan compliance per performance measure by quarter. Data prior to Q3 FY2018 is available in previous years' reports.

Table C.1—Waiver Performance Measure Findings

HealthChoice Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A[+1]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
BCBSIL															
Q3 2018	50%	100%	100%	100%	100%	99%	85%	80%	88%	44%	100%	97%	94%	100%	96%
Q4 2018	25%	90%	94%	95%	100%	98%	78%	77%	88%	53%	100%	97%	88%	100%	95%
Q1 2019	31%	87%	88%	88%	100%	89%	68%	66%	76%	50%	100%	86%	83%	100%	90%
Q2 2019	13%	88%	89%	88%	100%	90%	76%	78%	86%	51%	100%	88%	88%	100%	85%
Q3 2019	10%	77%	90%	89%	96%	93%	79%	81%	80%	63%	100%	94%	92%	95%	82%
Q4 2019	18%	83%	96%	99%	100%	97%	75%	89%	83%	64%	100%	97%	96%	100%	87%
Q1 2020	24%	95%	96%	97%	96%	99%	90%	90%	91%	78%	98%	98%	97%	96%	94%
Q2 2020	30%	98%	99%	99%	100%	98%	92%	93%	91%	82%	100%	97%	93%	100%	96%
Q3 2020	14%	93%	94%	95%	100%	94%	89%	89%	98%	93%	100%	94%	89%	100%	96%
Q4 2020	25%	98%	97%	98%	98%	97%	92%	94%	95%	79%	100%	97%	97%	100%	98%
CountyCare															
Q3 2018	8%	95%	95%	95%	100%	95%	62%	67%	100%	22%	100%	92%	92%	100%	93%
Q4 2018	21%	100%	93%	94%	100%	100%	87%	65%	95%	56%	100%	93%	89%	100%	100%
Q1 2019	0%	87%	90%	90%	86%	87%	65%	87%	77%	44%	86%	89%	89%	86%	86%
Q2 2019	40%	93%	97%	99%	100%	99%	67%	92%	92%	49%	100%	99%	97%	92%	98%
Q3 2019															
Q4 2019	64%	98%	100%	99%	100%	100%	77%	86%	87%	56%	100%	99%	97%	100%	98%
Q1 2020	9%	96%	95%	95%	100%	93%	66%	82%	96%	53%	97%	95%	89%	100%	90%
Q2 2020	27%	98%	98%	99%	96%	96%	66%	84%	96%	59%	96%	96%	95%	93%	96%

Table C.1—Waiver Performance Measure Findings

HealthChoice Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A[+1]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q3 2020	19%	98%	96%	96%	100%	96%	75%	81%	95%	65%	97%	94%	92%	97%	92%
Q4 2020	0%	97%	96%	95%	100%	97%	83%	93%	90%	79%	100%	91%	91%	100%	90%
IlliniCare															
Q3 2018	71%	100%	100%	100%	97%	100%	79%	83%	95%	50%	97%	100%	100%	97%	100%
Q4 2018	45%	100%	100%	100%	94%	100%	87%	82%	100%	55%	94%	100%	100%	97%	100%
Q1 2019	55%	96%	98%	98%	100%	97%	79%	89%	100%	57%	100%	98%	98%	100%	98%
Q2 2019	26%	98%	98%	98%	100%	97%	78%	76%	100%	77%	100%	97%	97%	100%	98%
Q3 2019	32%	99%	99%	99%	100%	97%	68%	80%	76%	71%	100%	99%	99%	100%	98%
Q4 2019	50%	96%	99%	100%	100%	100%	75%	88%	100%	73%	100%	100%	100%	100%	100%
Q1 2020	75%	99%	98%	100%	100%	100%	82%	90%	97%	82%	100%	100%	99%	100%	98%
Q2 2020	44%	97%	98%	100%	94%	97%	85%	91%	91%	82%	100%	99%	97%	100%	97%
Q3 2020	10%	92%	93%	92%	97%	92%	71%	87%	92%	83%	97%	88%	86%	100%	94%
Q4 2020	30%	97%	97%	97%	97%	95%	71%	90%	85%	81%	97%	97%	95%	94%	98%
Meridian															
Q3 2018	36%	100%	100%	100%	85%	97%	86%	90%	96%	63%	85%	97%	97%	93%	98%
Q4 2018	30%	98%	98%	98%	89%	92%	89%	90%	100%	56%	89%	92%	93%	100%	98%
Q1 2019	13%	92%	92%	92%	100%	91%	69%	82%	88%	48%	100%	89%	89%	100%	96%
Q2 2019	33%	95%	94%	94%	94%	92%	72%	81%	94%	59%	94%	94%	88%	100%	95%
Q3 2019	19%	100%	92%	98%	100%	100%	63%	75%	100%	70%	100%	100%	97%	100%	94%
Q4 2019	32%	96%	87%	95%	97%	99%	80%	82%	93%	66%	97%	99%	86%	97%	89%
Q1 2020	50%	98%	98%	98%	100%	95%	80%	92%	97%	81%	100%	96%	94%	100%	93%
Q2 2020	30%	97%	97%	97%	98%	95%	81%	89%	92%	73%	100%	97%	97%	100%	94%
Q3 2020	10%	97%	99%	98%	100%	93%	79%	83%	98%	80%	100%	94%	92%	100%	95%
Q4 2020	29%	99%	99%	99%	100%	97%	81%	87%	97%	92%	100%	95%	95%	100%	98%
Molina															
Q3 2018	0%	100%	100%	100%	100%	97%	100%	94%	91%	35%	100%	100%	100%	100%	100%
Q4 2018	33%	100%	100%	100%	100%	100%	100%	76%	100%	48%	100%	100%	100%	100%	100%

Table C.1—Waiver Performance Measure Findings

HealthChoice Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A[+1]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q1 2019	100%	100%	100%	100%	100%	100%	84%	92%	100%	64%	100%	100%	96%		100%
Q2 2019	0%	82%	86%	86%	100%	86%	81%	82%	100%	68%	100%	95%	86%	100%	100%
Q3 2019	20%	100%	100%	100%	100%	100%	72%	80%	100%	84%	100%	100%	100%	100%	100%
Q4 2019	100%	94%	100%	100%	100%	100%	73%	94%	0%	69%	100%	100%	94%	100%	86%
Q1 2020		97%	97%	97%	100%	92%	68%	92%	100%	63%	100%	94%	94%	100%	96%
Q2 2020	0%	100%	100%	96%	100%	89%	75%	93%	100%	82%	100%	100%	100%	100%	100%
Q3 2020	0%	85%	85%	85%	100%	85%	76%	88%	100%	83%	100%	88%	83%	100%	81%
Q4 2020															
NextLevel															
Q3 2018															
Q4 2018	0%	100%	100%	100%	100%	100%	89%	89%	100%	33%	100%	100%	89%	100%	100%
Q1 2019															
Q2 2019		100%	100%	100%	100%	100%	100%	100%	100%	80%	100%	100%	100%	100%	100%
Q3 2019															
Q4 2019		100%	100%	100%	100%	100%	86%	100%	100%	75%	100%	100%	88%	100%	100%
Q1 2020															
Q2 2020	0%	88%	94%	94%	100%	88%	92%	82%	100%	73%	100%	94%	94%	100%	100%
Q3 2020	0%	88%	97%	97%	100%	85%	81%	82%	89%	72%	100%	88%	85%	100%	96%
Q4 2020															
Harmony*															
Q3 2018															
Q4 2018		100%	100%	100%	100%	100%	100%	100%	100%	67%	100%	100%	100%	100%	100%
Q1 2019	14%	67%	67%	67%	100%	76%	45%	67%	50%	19%	100%	76%	76%	100%	80%
Q2 2019	25%	50%	71%	74%	100%	91%	88%	76%	75%	18%	100%	91%	85%	100%	76%

Shaded rows indicate a quarter during which a health plan was not reviewed or there were no eligible records

**Due to exiting HealthChoice Q2 FY2019, Harmony's data is displayed for historic purposes through the last quarter reviewed.*

[+]New measure effective Q1 FY2018.

[++]Revised measure effective Q1 FY2018.

[1]Revised measure effective Q1 FY2020.

Appendix D. Waiver Measure Performance by Quarter – HealthChoice

Table D.1—HealthChoice Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2020																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	88%	92%	91%	93%	93%	92%	92%	93%	89%	91%	90%	93%	92%	94%	87%	93%	95%	94%	88%	94%
4A				0%	24%	20%	11%	13%	33%	33%	0%	0%	35%	44%	14%	42%	0%			
31D	98%	99%	99%	100%	96%	96%	94%	96%	99%	98%	96%	99%	98%	98%	91%	98%	96%	97%	91%	97%
32D	96%	99%	98%	99%	97%	97%	94%	97%	100%	99%	98%	96%	97%	100%	94%	96%	94%	97%	93%	97%
33D	98%	99%	99%	98%	98%	97%	94%	97%	100%	100%	98%	97%	97%	100%	93%	98%	96%	98%	93%	97%
34D					99%	98%	99%	99%												
35D	97%	98%	98%	100%	97%	95%	93%	95%	97%	100%	94%	100%	98%	99%	92%	98%	94%	89%	88%	92%
36D	48%	53%	53%	57%	99%	98%	95%	97%	39%	44%	44%	51%	100%	100%	94%	99%				
37D	91%	98%	96%	98%	86%	86%	87%	87%	97%	97%	95%	100%	85%	89%	78%	93%	88%	82%	77%	83%
38D	96%	96%	91%	94%	93%	92%	98%	90%	96%	100%	100%	87%	95%	90%	96%	95%	100%	100%	100%	
39D	70%	77%	82%	83%	68%	64%	72%	70%	72%	74%	88%	91%	61%	66%	72%	80%	99%	99%	99%	100%
40D					99%	99%	99%	99%												
41D	98%	100%	98%	98%	97%	93%	93%	94%	99%	99%	94%	100%	97%	99%	91%	93%	95%	97%	87%	94%
42G	96%	100%	95%	98%	92%	92%	92%	94%	98%	99%	95%	100%	95%	97%	88%	92%	96%	95%	79%	93%
44G					99%	99%	99%	99%												
49G	89%	95%	92%	94%	97%	99%	96%	99%	91%	96%	95%	99%	94%	93%	92%	93%				

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated.*

Table D.2—HealthChoice Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2019																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	80%	82%	83%	86%	85%	88%	89%	92%	84%	91%	87%	88%	84%	87%	86%	92%	79%	79%	92%	92%
4A	38%	31%	10%	46%	21%	27%	38%	31%	50%	0%		67%	8%	17%	13%	60%	26%	16%	23%	30%
31D	92%	91%	94%	93%	91%	89%	85%	93%	94%	100%	91%	97%	90%	87%	90%	98%	82%	82%	96%	87%
32D	95%	98%	98%	98%	91%	90%	95%	95%	96%	100%	100%	99%	91%	93%	93%	96%	84%	82%	90%	92%
33D	95%	96%	98%	99%	91%	91%	95%	100%	96%	100%	95%	100%	91%	94%	93%	97%	84%	82%	96%	96%
34D					97%	99%	98%	99%												
35D	94%	98%	100%	100%	89%	93%	97%	100%	93%	100%	100%	100%	93%	97%	93%	100%	86%	81%	95%	95%
36D	44%	49%	50%	61%	91%	94%	90%	98%	41%	48%	36%	39%	92%	97%	96%	99%				
37D	70%	65%	61%	75%	79%	88%	78%	88%	91%	98%	100%	92%	87%	88%	78%	90%	73%	65%	82%	87%
38D	85%	97%	100%	88%	82%	90%	72%	85%	90%	100%	85%	90%	87%	87%	81%	92%	0%	50%	100%	0%
39D	39%	44%	57%	53%	46%	46%	51%	50%	50%	62%	66%	66%	33%	47%	61%	61%	81%	94%	99%	99%
40D					97%	99%	100%	99%												
41D	95%	98%	100%	98%	88%	93%	100%	100%	96%	100%	100%	100%	92%	96%	93%	99%	81%	85%	96%	97%
42G	94%	96%	100%	94%	88%	92%	98%	94%	96%	98%	98%	97%	90%	94%	93%	91%	80%	78%	94%	96%
44G					97%	99%	98%	99%												
49G	95%	94%	91%	95%	100%	50%		100%	94%	98%	88%	96%	91%	90%	96%	93%				

Table D.3—HealthChoice Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2018																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall			83%	80%			91%	92%			86%	88%			90%	91%			93%	86%
4A			47%	23%			42%	40%			25%	25%			27%	42%			45%	11%
31D			100%	92%			99%	99%			100%	94%			99%	99%			100%	94%
32D			100%	94%			99%	98%			100%	97%			99%	100%			100%	91%
33D			100%	94%			99%	99%			100%	100%			99%	100%			100%	91%
34D							96%	97%												
35D			100%	97%			97%	99%			100%	100%			97%	98%			100%	91%
36D			48%	56%			99%	98%			30%	49%			99%	100%				
37D			59%	59%			88%	86%			93%	89%			85%	85%			77%	74%
38D			89%	100%			98%	92%			100%	100%			93%	100%				
39D			38%	40%			35%	60%			46%	60%			45%	45%			98%	86%
40D							96%	97%												
41D			99%	97%			97%	96%			98%	100%			97%	98%			95%	89%
42G			96%	92%			97%	94%			98%	100%			97%	95%			93%	89%
44G							98%	99%												
49G			100%	100%			100%	67%			100%	100%			96%	99%				

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated.*

Data prior to Q3 FY2018 is available in previous years' reports.

Appendix E. Acronyms

ACA ..... Affordable Care Act
ADL ..... Activity of Daily Living
ANE ..... Abuse, Neglect, and Exploitation
ARRA ..... American Recovery and Reinvestment Act of 2009
BBA ..... Balanced Budget Act of 1997
BI ..... Persons with Brain Injury Waiver
BMC ..... Bureau of Managed Care
BQM ..... Bureau of Quality Management
CAP ..... Corrective Action Plan
CCU ..... Care Coordination Unit
CFR ..... Code of Federal Regulations
CMS ..... Centers for Medicare & Medicaid Services
DHHS ..... The United States Department of Health and Human Services
DHS ..... Department of Health Services
DOA ..... Department on Aging
DON ..... Determination of Need
DRS ..... Division of Rehabilitation Services
eCCPIS ..... Department on Aging Case Management System
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FHP ..... Family Health Plan
HCBS ..... Home and Community Based Services
HCI ..... HealthChoice Illinois
HFS ..... The Illinois Department of Healthcare and Family Services
HHS ..... Health and Human Services
HIV ..... Persons with HIV/AIDS (HIV) Waiver
IADL ..... Instrumental Activity of Daily Living
ICP ..... Integrated Care Program
IDPH ..... Illinois Department of Public Health
IHH ..... Integrated Health Home
IRR ..... Interrater Reliability
IT ..... Information Technology
LTC ..... Long Term Care

MCO ..... Managed Care Organization
MEDI ..... Medical Electronic Data Interchange
MMAI ..... Medicare-Medicaid Alignment Initiative
NCQA ..... National Committee for Quality Assurance
PA ..... Personal Assistant
PCP ..... Primary Care Physician
PD ..... Persons with Physical Disabilities Waiver
POSM ..... Participants Outcomes and Status Measures
SFY ..... State Fiscal Year
SLP ..... Persons in a Supportive Living Program Waiver
VMC ..... Voluntary Managed Care
VMCO ..... Voluntary Managed Care Organization
WebCM ..... Division of Rehabilitation Services Case Management System

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

Home and Community-Based Service (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Review

of

Managed Care Plans

for the

Managed Long Term Services and Supports (MLTSS) 1915(b) Waiver

Summary of Findings and Recommendations

SFY20 Annual Report

October 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to discover/identify problems/issues within the Home and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG) conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This state fiscal year (SFY) 2020 HCBS Waivers CMS Performance Measures Record Reviews Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the Managed Long-Term Services and Supports (MLTSS) 1915(b) waiver program.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2020 and across review years, and also contains a review of remediation activities conducted within the required timeframes and a summary of technical assistance provided to the health plans by HSAG.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to 15 CMS waiver performance measures, and additional HealthChoice contract measures. During SFY 2020, 1,357 MLTSS records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,294 MLTSS findings of non-compliance were identified.

A detailed description of the sampling methodology and data collection processes is provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1.1 displays the health plans that were reviewed during SFY 2020.

Table 1.1—SFY 2020 MLTSS Health Plans

HealthChoice Health Plan Name
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare (CountyCare)
IlliniCare Health Plan (IlliniCare)
Meridian Health (Meridian)
Molina Healthcare of Illinois (Molina)
NextLevel Health (NextLevel)

Successes

SFY 2020 represented the second year of review for the MLTSS population, and several successes were identified.

☑ Eleven of the 15 CMS performance measures averaged 90 percent or greater compliance in SFY 2020, an increase from SFY 2019.

☑ Five of the 15 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2020 when compared to SFY 2019.

☑ Three of the six health plans averaged greater than 90 percent compliance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance for 11 measures in SFY 2020.

☑ Compared to SFY 2019, CountyCare realized a statistically significant increase in performance for one measure in SFY 2020.

☑ Compared to SFY 2019, IlliniCare realized a statistically significant increase in performance for one measure in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in performance for five measures in SFY 2020.

☑ Compared to SFY 2019, the BI waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for two measures.

☑ Compared to SFY 2019, the ELD waiver realized a statistically significant increase in performance in SFY 2020 and realized a statistically significant increase for one measure.

☑ Compared to SFY 2019, the HIV waiver realized a statistically significant increase in performance in SFY 2020 and realized a statistically significant increase for one measure.

☑ Compared to SFY 2019, the PD waiver realized a statistically significant increase in performance in SFY 2020 and realized a statistically significant increase for one measure.

☑ Compared to SFY 2019, the SLP waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for five measures.

Opportunities for Improvement

Review of SFY 2020 performance identified the following opportunities for improvement:

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 22 percent compliance in SFY 2019. All six health plans performed at a rate of less than 50 percent in SFY 2020. A detailed analysis related to 4A is provided in Section 3 of this report.

Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record,* averaged 53 percent and 50 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to 36D is provided in Section 3 of this report.

Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan,* averaged 75 percent compliance in SFY 2020. A detailed analysis related to 39D is provided in Section 3 of this report.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY20. Technical assistance was provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- Validation of waiver service provision.
- Timely case reassignment for beneficiaries who require a new case manager.
- Timely completion of annual reassessments, care plan and waiver service plan.
- Timely completion of assessment, care plan and waiver service plan update for beneficiary change in condition and/or needs.
- Timely completion of the initial service plan for beneficiaries determined to be newly waiver eligible.
- Effective use of online record review result reports.

HFS Policy Guidance

As a result of HFS's efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during COVID-19, and
- Guidance regarding determinations and documentation of waiver service validation.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Plan-specific, waiver-specific, and performance measure-specific recommendations are identified below.

Plan-specific

All health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

BCBSIL should focus efforts on measures 4A and 39D. BCBSIL should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are

completed within 30 days of the expected date. BCBSIL should ensure consistent application of a process to validate the provision of waiver services for all members.

CountyCare should focus efforts on measures 4A, 36D, 37D, and 39D. CountyCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. CountyCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. CountyCare should ensure consistent application of a process to validate the provision of waiver services for all members.

IlliniCare should focus efforts on measures 4A, 36D, and 39D. IlliniCare should also review any changes to processes that may have resulted in the decreased performance noted in Q4 SFY 2020 as compared to Q1 SFY 2020. IlliniCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. IlliniCare should ensure consistent application of a process to validate the provision of waiver services for all members.

Meridian should focus efforts on measures 4A, 36D, 37D, and 39D. Meridian should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Meridian should ensure consistent application of a process to validate the provision of waiver services for all members.

Molina should focus efforts on measures 4A, 36D, and 39D. Molina should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of timely contacts and service plans. Molina should ensure consistent application of a process to validate the provision of waiver services for all members.

NextLevel exited the Illinois Medicaid managed care program at the end of SFY 2020; therefore, recommendations are not noted.

Waiver-specific

BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Performance measure-specific

Health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. as applicable. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A and 37D, efforts might include:

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

For measure 36D, efforts might include:

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

For measure 39D, efforts might include:

- Establish a process to complete ongoing claims validation of the waiver service plan.
- Conduct root cause analysis to determine service providers who may benefit from outreach and education regarding claims submission.
- Ensure completion of education with beneficiaries related to approved hours for personal assistants.
- Conduct staff training to ensure timely follow up with beneficiaries who have a change in service provider. Training should include a component for review of claims to validate service provision and steps to ensure there are no gaps in waiver services.

- Ensure all appropriate staff are provided access and trained on navigation of waiver agency portals to review beneficiary information.
- Develop relationships with service providers to ensure timely communication to the health plan when services cannot be provided per the waiver service plan, and ensure documentation of the communication in the beneficiary's record.

2. Data Collection and Methodology

Background

The Illinois Department of Healthcare and Family Services (HFS) implemented the Managed Long Term Services and Supports (MLTSS) Waiver upon approval from the Centers for Medicare & Medicaid Services (CMS) effective July 1, 2016. The MLTSS Waiver allowed for the mandatory Medicaid managed care enrollment of beneficiaries 21 years of age and older receiving institutional or community-based long term services and supports who were not enrolled in the State's Medicare-Medicaid Alignment Initiative (MMAI) but were eligible for both Medicare and Medicaid, unless they met the eligibility exclusions.

Beginning in July 2016, the MLTSS Waiver was implemented in the Greater Chicago service area only. Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which consolidated multiple programs, including MLTSS, into a single program. MLTSS services were further expanded statewide effective July 1, 2019.

All waiver beneficiaries enrolled in HealthChoice and the MLTSS Waiver receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the external quality review organization (EQRO) for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the HCBS waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to demonstrate that the health plan was ready to provide services to HCBS waiver enrollees in a safe and efficient manner.

Under the HealthChoice model, HSAG began on-site record reviews in Quarter 3 (Q3) state fiscal year (FY) 2018 to monitor MLTSS health plan performance on the HCBS waiver performance measures.

Waiver Programs and Performance Measures Included in Reviews

Waiver Programs

The following HCBS Waiver Programs were included in the Centers for Medicare & Medicaid Services (CMS) performance measures record reviews:

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

Performance Measures

For the state fiscal year (FY) 2020 review, HFS identified 15 CMS waiver performance measures for review. These performances measures were aligned with the state approved 1915(c) waiver applications for the waiver types listed above. For FY 2020, the following changes were identified from FY 2019 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2020 to exclude the BI and SLF waivers (previously captured for all waivers).
- Measure 37D, the most recent service plan is in the record and completed in a timely manner, was revised for FY 2020 to incorporate annual renewal for the BI waiver (previously required every six months).
- Measure 49G, most recent service plan includes a backup plan that includes the name of the backup, was revised to include the ELD waiver (previously captured for BI, HIV, and PD waivers only).

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

HSAG developed a sampling methodology based on the waiver requirements approved by HFS. HSAG conducted a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selected a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group were determined based on the number of eligible members in each waiver program. Once the required sample sizes were identified, a proportional random sample was selected based on the distribution of the health plans' population within each designated waiver program. Each sample was selected to ensure a 95 percent confidence level and five percent margin of error at the waiver program level, with a maximum sample population of 5,000 cases across the HealthChoice, MLTSS and Medicare Medicaid Alignment Initiative (MMAI) waiver enrollees. Additionally, a ten percent oversample based on the proportional distribution of enrollees across health plans was selected to replace ineligible cases. The samples were selected in April 2019 and included waiver members enrolled as of March 1, 2019. Table 2.1 displays the FY 2020 record review sample size by health plan and waiver program for MLTSS.

Table 2.1—MLTSS Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLP
BCBSIL	5,560	398	114	50	42	99	93
CountyCare	3,963	308	80	65	42	80	41
IlliniCare	3,914	312	75	46	23	68	100
Meridian	4,300	294	90	42	21	75	66
Molina	432	30	9	5	3	10	3
NextLevel	334	21	7	3	0	7	4
Statewide Total	**18,503**	**1,363**	**375**	**211**	**131**	**339**	**307**

Limitations to the sampling methodology included known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g. previously enrolled as MMAI and transferred to MLTSS).

In addition, to be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.
- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) is different from the program type identified on the sample.
- Beneficiaries in long-term care.

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month look back periods during SFY 2020 consisted of the following:

- Quarter 1, SFY 2020: December 1, 2018 – May 31, 2019
- Quarter 2, SFY 2020: March 1, 2019 – August 31, 2019
- Quarter 3, SFY 2020: June 1, 2019 – November 30, 2019
- Quarter 4, SFY 2020: September 1, 2019 – February 29, 2020

Web-Based Abstraction Tool and Scoring Methodology

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

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

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

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

Interrater Reliability—(IRR)

In order to ensure accuracy of the reviews, HSAG conducted Interrater Reliability (IRR) on all review team members. The IRR reviews were conducted by the HSAG Senior Project Manager for ten percent of all records completed by each individual reviewer, via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95% was required, with retraining completed if required. Reviews were completed across all waivers, program types, and health plans to ensure continued compliance to the 95% accuracy rate standard. All members of the HSAG review team maintained a rate above 95% during FY 2020.

Remediation Actions & Tracking

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

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

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG will complete remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. MLTSS Overall Summary of Record Review Findings for SFY20

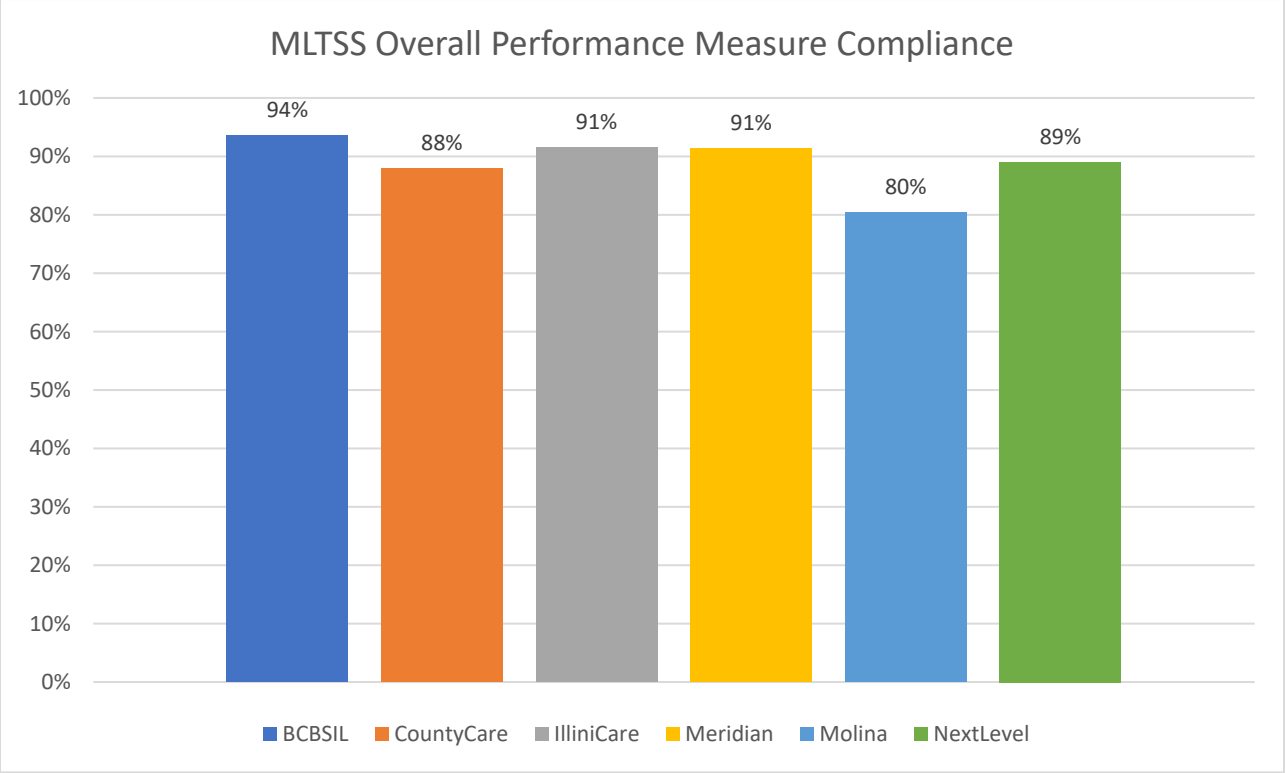
Overall Performance

Overall Health Plan Performance and Comparisons

Six health plans were reviewed during SFY 2020. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Displaying each health plan's overall average on the 15 Home and Community-Based Services (HCBS) CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Three of the six health plans averaged greater than 90 percent compliance in SFY 2020. There was a 14-percentage point difference (80% to 94%) among health plans.

Figure 3.1 – Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- BCBSIL performed at a statistically significant higher rate than all other health plans.
- Molina performed at a statistically significant lower rate than all other health plans.
- CountyCare performed at a statistically significant lower rate than IlliniCare and Meridian.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analysis identified the following.

Blue Cross Blue Shield of Illinois (BCBSIL)

BCBSIL demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020 (+11 percentage points, p=<0.0001). BCBSIL also realized statistically significant increases in 11 measures from SFY 2019 to SFY 2020.

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 18 percent (3 of 17 records). BCBSIL also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 83 percent; BCBSIL realized a statistically significant increase in performance for measure 39D, with a resulting increase of 21 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

CountyCare Health Plan (CountyCare)

CountyCare demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, CountyCare demonstrated stable performance in SFY 2020. CountyCare realized a statistically significant increase in one measure and demonstrated a statistically significant decrease in one measure from SFY 2019 to SFY 2020.

Analysis identified that CountyCare's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 17 percent (6 of 35 records). CountyCare also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 60 percent; CountyCare realized a statistically significant increase in performance for measure 39D,

with a resulting increase of 15 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

IlliniCare Health Plan, Inc. (IlliniCare)

IlliniCare demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, IlliniCare demonstrated stable performance in SFY 2020. IlliniCare realized a statistically significant increase in one measure from SFY 2019 to SFY 2020.

Analysis identified that IlliniCare's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 43 percent (9 of 21 records). IlliniCare also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 78 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Meridian Health Plan, Inc. (Meridian)

Meridian demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020 (+7 percentage points, p=<0.0001). Meridian also realized statistically significant increases in five measures from SFY 2019 to SFY 2020.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 18 percent (4 of 22 records). Meridian also had opportunity for improvement in measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, which demonstrated performance of 80 percent; Meridian realized a statistically significant increase in performance for measure 36D, with a resulting increase of 13 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Molina Healthcare of Illinois, Inc. (Molina)

Molina demonstrated a statistically significant decrease in overall performance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020 (-13 percentage points, p=0.0053). Molina demonstrated a statistically significant decrease in four measures from Q1 to Q4 SFY 2020.

Analysis identified that Molina's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 0 percent (0 of 3 records). Molina also had opportunity for improvement in measure 36D, the case manager made timely contact with the enrollee or there is valid justification in the record, which demonstrated performance of 67 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

NextLevel Health Partners, LLC (NextLevel)

Due to small sample size, NextLevel was only reviewed in Q3 FY 2020. Compared to SFY 2019, NextLevel demonstrated stable performance in SFY 2020.

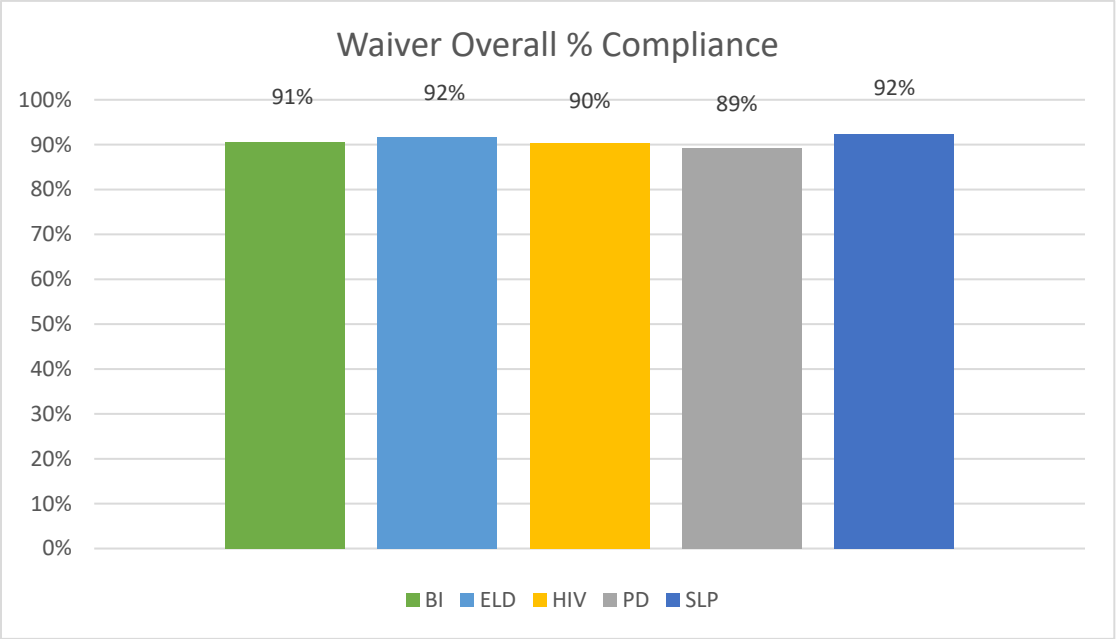
Analysis identified that NextLevel's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 0 percent (0 of 1 record). NextLevel also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 63 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific, as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3.2 displays below, four of the five waiver types averaged 90 percent or greater overall compliance in SFY 2020.

Figure 3.2—Overall Compliance Across Waiver Types



Statistical significance testing was also performed to compare each waiver's average overall compliance against all other waiver types, and the following differences were noted:

- The ELD waiver performed at a statistically significant higher rate than the PD waiver.
- The SLP waiver performed at a statistically significant higher rate than the BI, HIV, and PD waivers.

Differences between some waiver types may be attributable to different waiver requirements:

- BI, HIV, and PD waiver records are applicable to 12 of the 15 performance measures.
- SLP waiver records are applicable to 10 of the 15 performance measures.
- The ELD and PD waivers have different requirements for contact (annual) than the BI and HIV waivers (monthly), which may result in different performance in measure 36D.

Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Individual waiver performance analysis identified the following.

BI Waiver

The BI waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the BI waiver realized a statistically significant increase in overall performance in SFY 2020 (+7 percentage points, p=<0.0001). The BI waiver also realized statistically significant increases in two measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 0 percent compliance (0 of 1 record).
- Measure 36D, the case manager made valid contact with the enrollee once a month or valid justification is documented in the enrollee's record, which performed at a rate of 53 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 77 percent compliance.

ELD Waiver

The ELD waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the ELD waiver realized a statistically significant increase in overall performance in SFY 2020 (+3 percentage points, p=0.0002). The ELD waiver also realized a statistically significant increase in one measure from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 19 percent compliance (10 of 53 records).
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 62 percent compliance.

HIV Waiver

The HIV waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the HIV waiver realized a statistically significant increase in overall performance in SFY 2020 (+4 percentage points, p=0.0040). The HIV waiver realized a statistically significant improvement in one measure from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 25 percent compliance (1 of 4 records).
- Measure 36D, the case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record, which performed at a rate of 50 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 81 percent compliance.

PD Waiver

The PD waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the PD waiver realized a statistically significant increase in overall performance in SFY 2020 (+5 percentage points, p=0.0001). The PD waiver also realized a statistically significant increase in one measure from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 28 percent compliance (11 of 40 records).
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 66 percent compliance.

SLP Waiver

The SLP waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in overall performance in SFY 2020 (+7 percentage points, p=<0.0001). The SLP waiver also realized statistically significant increases in five measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 37D, the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 83 percent compliance.

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B. Trend analysis in Table 3.2 includes SFY 2020 performance, as well as FY2020 performance compared to SFY 2019.

Table 3.2—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
4A *Overdue service plan was completed within 30 days of expected renewal.*	Overall, this measure demonstrated stable performance from Q1 to Q4. This measure was the lowest-performing, averaging 22% over SFY 2020.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, CountyCare demonstrated a statistically significant decrease in this measure in SFY 2020. Compared to SFY 2019, the HIV waiver demonstrated a statistically significant decrease in performance in SFY 2020.
31D *The most recent care/service plan includes all enrollee goals as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. Molina demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in this measure in SFY 2020.
32D *The most recent care/service plan includes all enrollee needs as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
	Molina demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in this measure in SFY 2020.
33D *The most recent care/service plan includes all enrollee risks as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. Molina demonstrated a statistically significant decrease in this measure from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in this measure in SFY 2020.
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
35D *The most recent care/service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, Molina demonstrated a statistically significant decrease in this measure in SFY 2020.
36D *PD & ELD Waiver – The case manager made annual contact with the enrollee or there is valid justification in the record.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record. *BI Waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.*	CountyCare realized a statistically significant increase in performance from Q1 to Q4. IlliniCare demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2020.
37D *The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. BCBSIL realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL, IlliniCare, and Meridian realized a statistically significant increase in performance in SFY 2020. Compared to SFY 2019, the BI and SLP waiver realized a statistically significant increase in performance in SFY 2020.
38D *The care/service plan was updated when the enrollee needs changed.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance in SFY 2020.
39D *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	Overall, this measure demonstrated stable performance from Q1 to Q4. The BI, HIV, and PD waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020). Compared to SFY 2019, BCBSIL, CountyCare, and Meridian realized a statistically significant increase in this measure in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis to SFY 2019**
		Compared to SFY 2019, the BI, ELD, HIV, PD, and SLP waiver realized a statistically significant increase in performance in SFY 2020.
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
41D *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	Overall, this measure demonstrated stable performance from Q1 to Q4. CountyCare demonstrated a statistically significant decrease in performance from Q1 to Q4. The PD waiver demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance in SFY 2020.
42G *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. The PD waiver demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and Meridian realized a statistically significant increase in performance in SFY 2020.
44G *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020.
49G *(BI, HIV, PD Waivers)* *The most recent care/service plan includes the name of the backup personal assistant (PA) service (if receiving PA).*	Overall, this measure demonstrated stable performance from Q1 to Q4. Molina demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020.

Analysis of Lowest-Performing Measure

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

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which averaged 22 percent compliance during SFY 2020.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which averaged 75 percent compliance during SFY 2020.

Health plans also had opportunity for improvement in the BI and HIV waivers related to measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, which averaged 53 percent and 50 percent compliance, respectively, during SFY 2020.

Measure 4A

This measure is only applicable to records in which there was an overdue service plan. Health plans should make efforts to ensure that overdue service plans are completed within 30 days of expected renewal.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should also make efforts to ensure that overdue service plans are completed within 30 days of expected renewal. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals.

Measure 39D

During record review, measure 39D was collected by validating the services identified on the waiver service plan against claims.

Performance during SFY 2020 was analyzed to determine any health plan-specific differences, and the following were identified:

- CountyCare performed at a statistically significant lower rate (60 percent) than BCBSIL, IlliniCare, and Meridian.

Performance was also analyzed across waiver types:

- The SLP waiver performed at a statistically significant higher rate (99 percent) than all other waiver types. Higher performance is expected for the SLP waiver, as claims review validates that the beneficiary maintains the SLP as his/her permanent residence.
- The BI and HIV waivers performed at a statistically significant higher rate than the ELD and PD waivers.

Analysis was performed to determine if there were any waiver service types that contributed to performance on measure 39D. Of the non-compliant records, non-compliant homemaker services and non-compliant personal assistant services represented the greatest opportunity for improvement.

The health plans were encouraged to ensure that they had a process to complete waiver service validation on an ongoing basis. Health plans may consider focusing on beneficiaries with homemaker and personal assistant services to ensure that waiver services are provided per the service plan and that homemaker agencies and personal assistants are appropriately educated to ensure compliance to the service plan.

Measure 36D

Performance on measure 36D was stable during SFY 2020 and when SFY 2020 performance is compared against SFY 2019. During SFY 2020, performance on measure 36D for the BI waiver resulted in a rate of 53 percent. Performance related to the HIV waiver resulted in a rate of 50 percent.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in 36D can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct root cause analysis on their HIV and BI cases to determine opportunities to affect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads.

Remediation and Remediation Validation

Remediation

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

Remediation actions were defined in the HealthChoice contract and were specific to each CMS waiver performance measure. The timeframe for remediation of findings was 60 days, except for two measures, 42G and 49G, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. Compliance with timely remediation of these findings was monitored by HSAG through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2020, all health plans demonstrated full compliance with completion of remediation action documentation for all non-compliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3.4 indicates the number of cases reviewed per health plan for MLTSS.

Table 3.4 – Health Plans Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2* (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	ND	11/11
CountyCare	ND	14/16
IlliniCare	ND	10/14
Meridian	ND	15/15
Molina	ND	10/10
NextLevel**	ND	ND

**MLTSS-specific remediation validation was implemented during Q4*
***NextLevel did not have any MLTSS cases requiring remediation validation*

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

Overall remediation validation among the five MLTSS health plans with remediation validation cases averaged 91 percent. Three of the five health plans demonstrated 100 percent compliance with remediation validation. CountyCare and IlliniCare did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database or documentation was unable to be located to validate remediation. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2021 and will include review of any records that were found to be not fully remediated during the SFY 2020 reviews.

Appendix A. CMS Performance Measures Description

Table A.1 provides a description of each Centers for Medicare & Medicaid Services (CMS) performance measure, including the identification of waiver-specific measures.

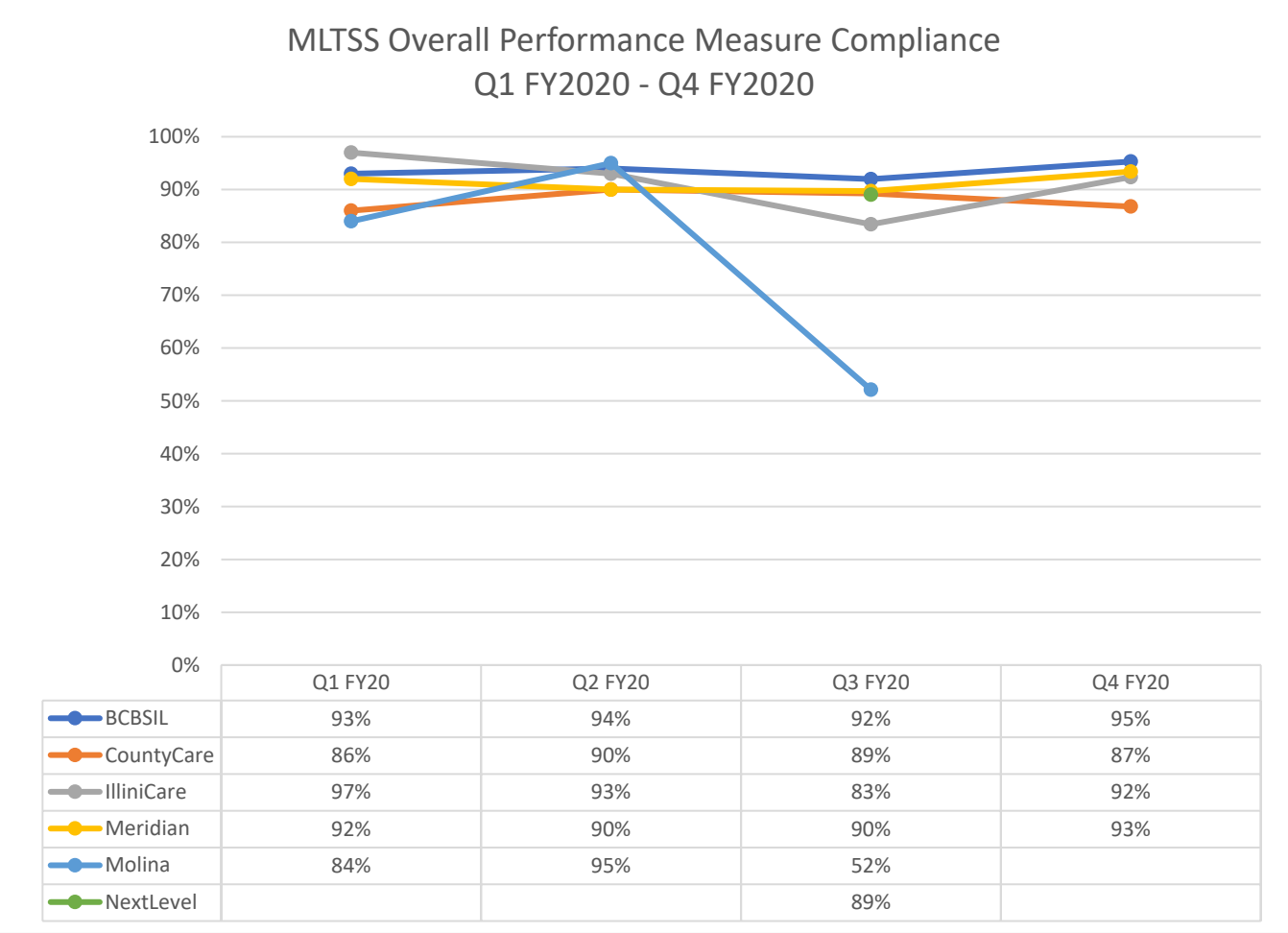
Table A.1—CMS Waiver Performance Measure Descriptions

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

Overall Trend Performance

Figure B.1 displays a computed average of the performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.1 – Overall Compliance



	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	93%	94%	92%	95%
CountyCare	86%	90%	89%	87%
IlliniCare	97%	93%	83%	92%
Meridian	92%	90%	90%	93%
Molina	84%	95%	52%	
NextLevel			89%	

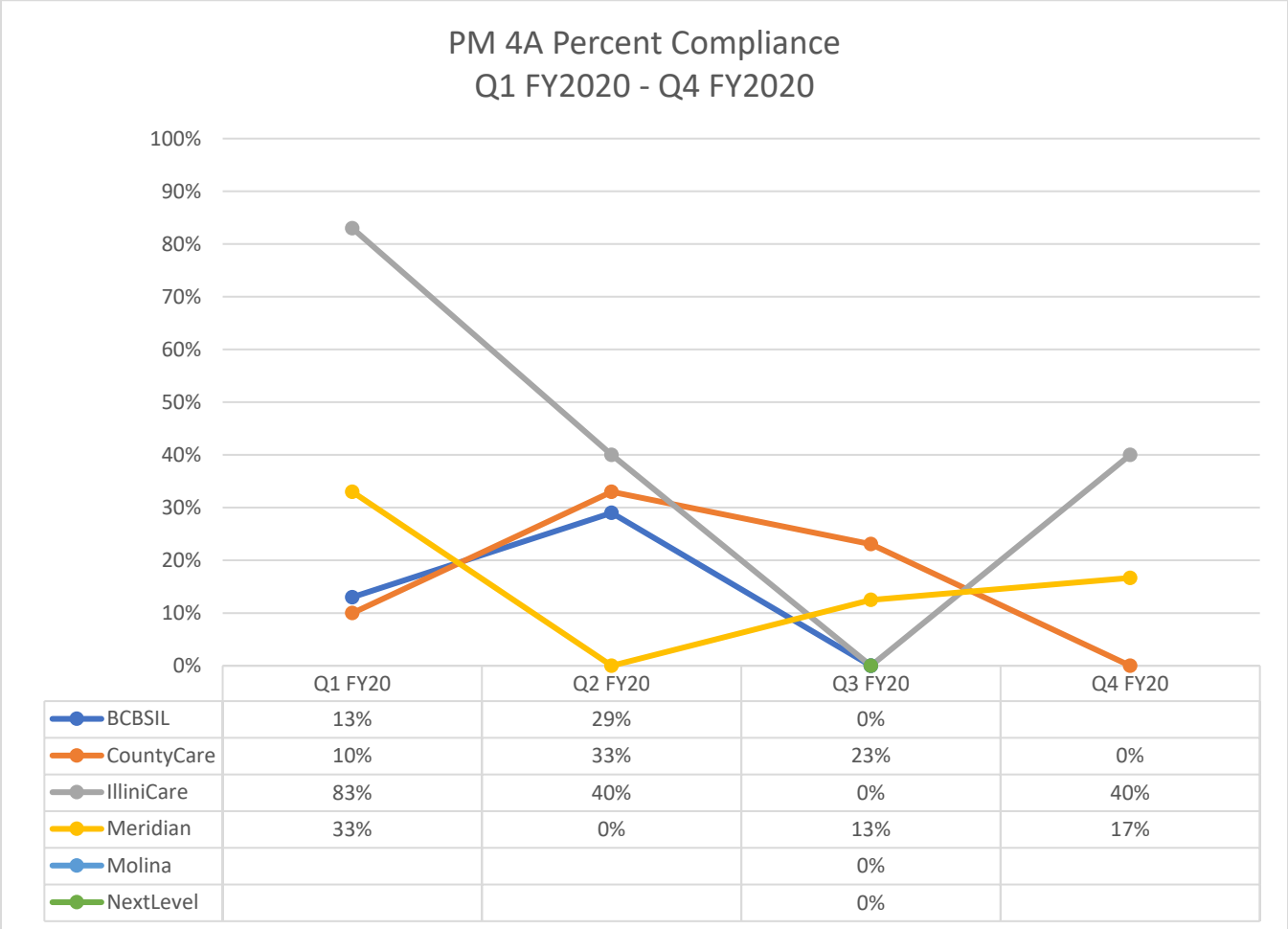
Note: Blank cells represent quarters in which the health plan was not reviewed.

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal. (ELD, HIV, and PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.2 – Measure 4A

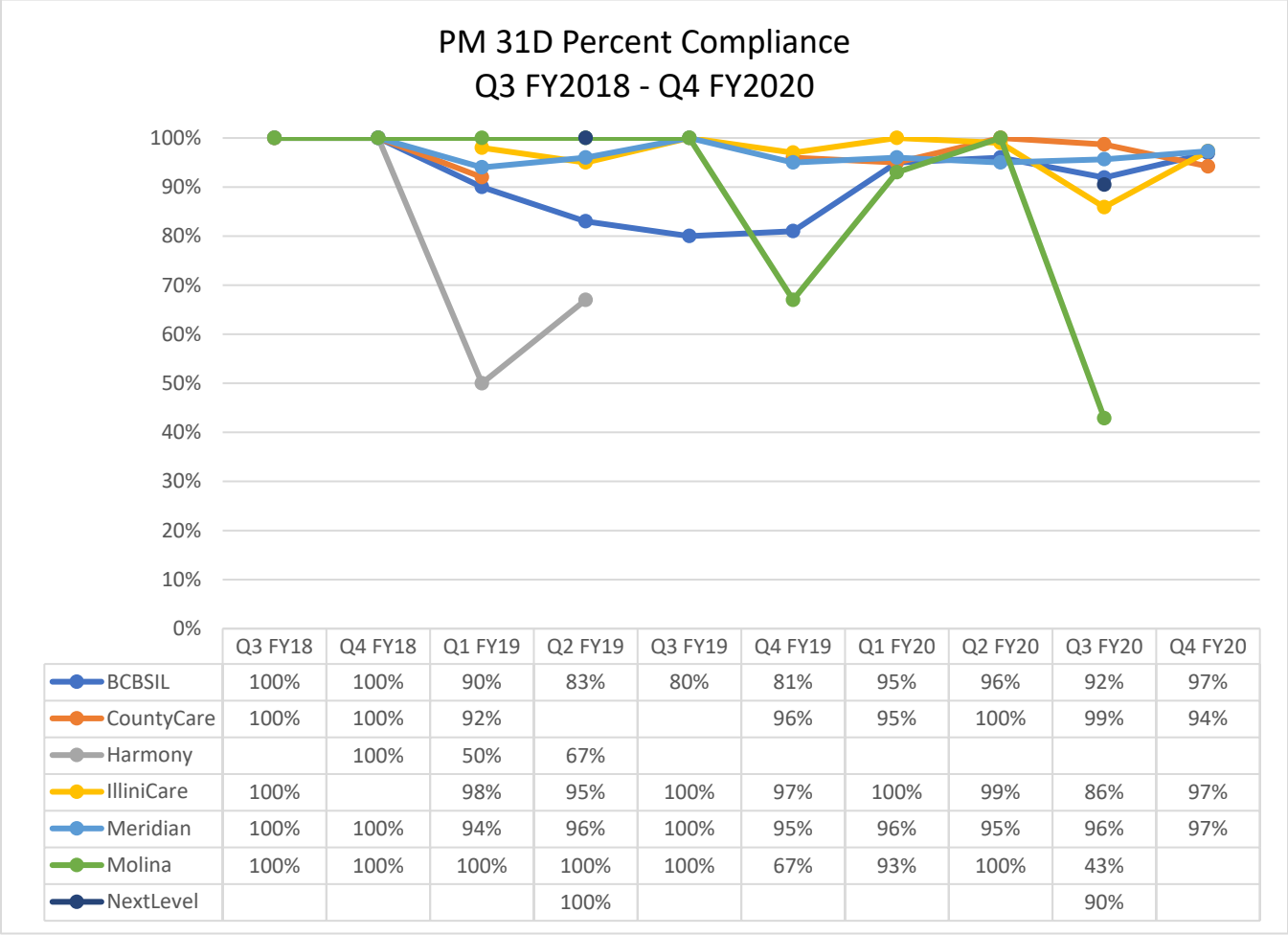


	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	13%	29%	0%	
CountyCare	10%	33%	23%	0%
IlliniCare	83%	40%	0%	40%
Meridian	33%	0%	13%	17%
Molina			0%	
NextLevel			0%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 31D - The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.

Figure B.3 – Measure 31D

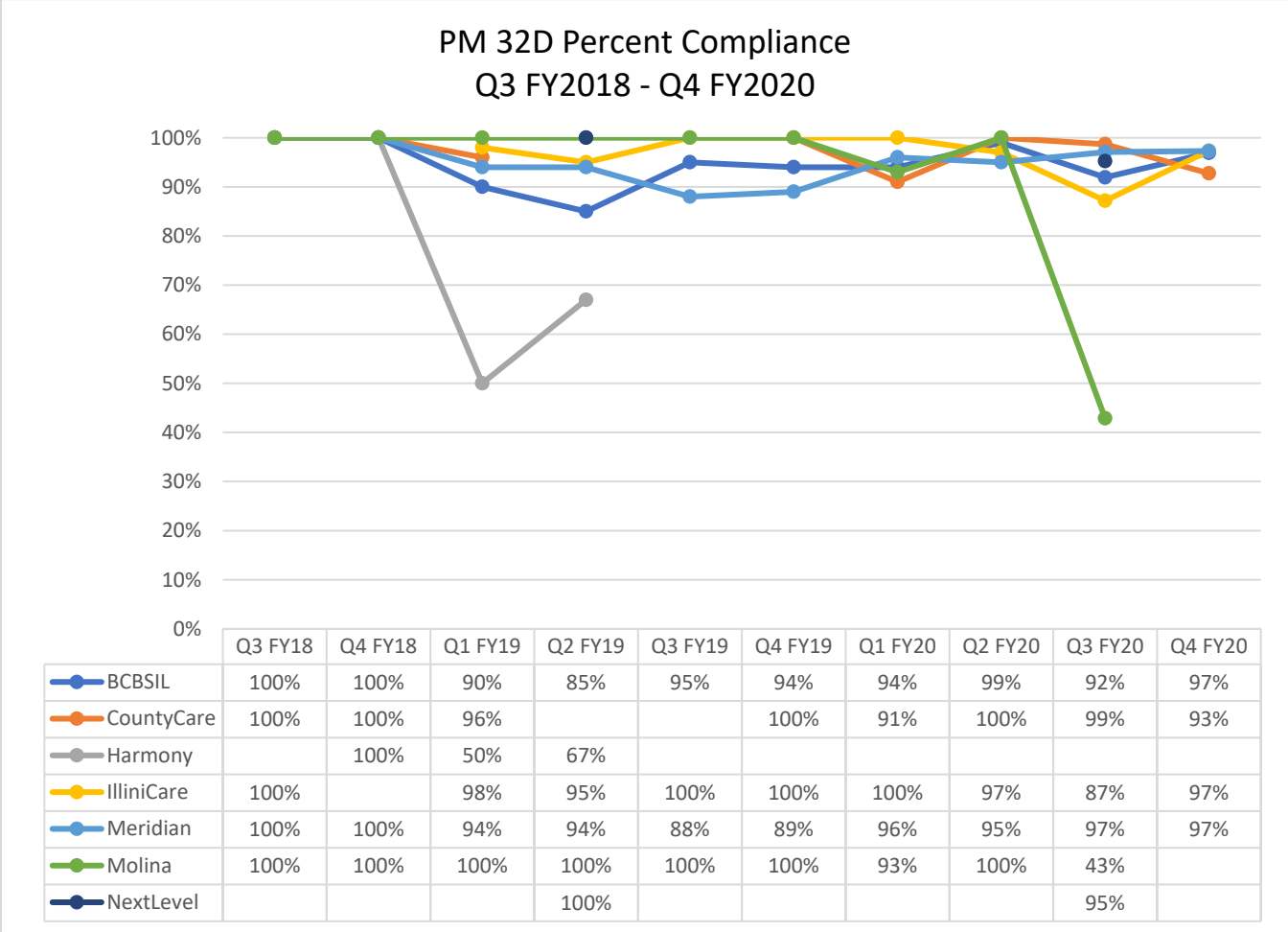


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	90%	83%	80%	81%	95%	96%	92%	97%
CountyCare	100%	100%	92%			96%	95%	100%	99%	94%
Harmony		100%	50%	67%						
IlliniCare	100%		98%	95%	100%	97%	100%	99%	86%	97%
Meridian	100%	100%	94%	96%	100%	95%	96%	95%	96%	97%
Molina	100%	100%	100%	100%	100%	67%	93%	100%	43%	
NextLevel				100%					90%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 32D - The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.

Figure B.4 – Measure 32D

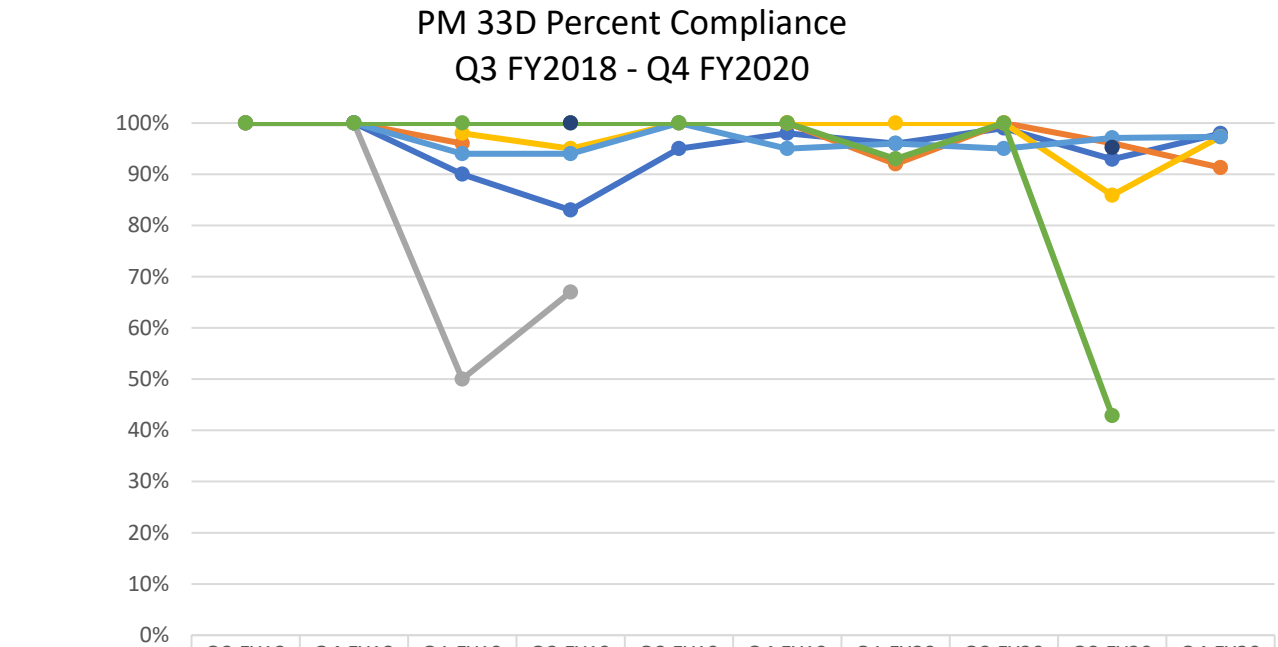


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	90%	85%	95%	94%	94%	99%	92%	97%
CountyCare	100%	100%	96%			100%	91%	100%	99%	93%
Harmony		100%	50%	67%						
IlliniCare	100%		98%	95%	100%	100%	100%	97%	87%	97%
Meridian	100%	100%	94%	94%	88%	89%	96%	95%	97%	97%
Molina	100%	100%	100%	100%	100%	100%	93%	100%	43%	
NextLevel				100%					95%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 33D - The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.

Figure B.5 – Measure 33D

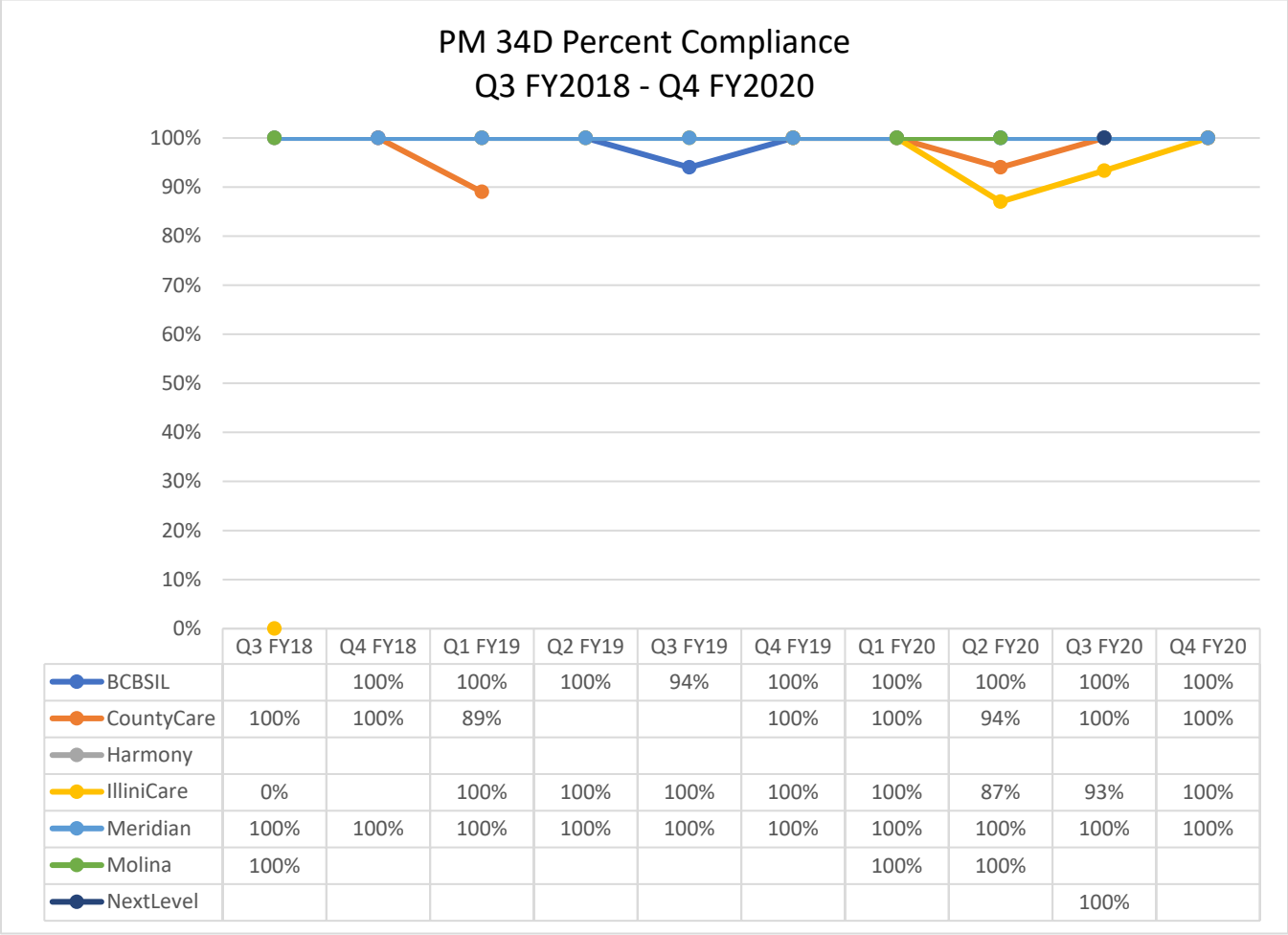


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	90%	83%	95%	98%	96%	99%	93%	98%
CountyCare	100%	100%	96%			100%	92%	100%	96%	91%
Harmony		100%	50%	67%						
IlliniCare	100%		98%	95%	100%	100%	100%	100%	86%	97%
Meridian	100%	100%	94%	94%	100%	95%	96%	95%	97%	97%
Molina	100%	100%	100%	100%	100%	100%	93%	100%	43%	
NextLevel				100%					95%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 34D - The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B.6 – Measure 34D

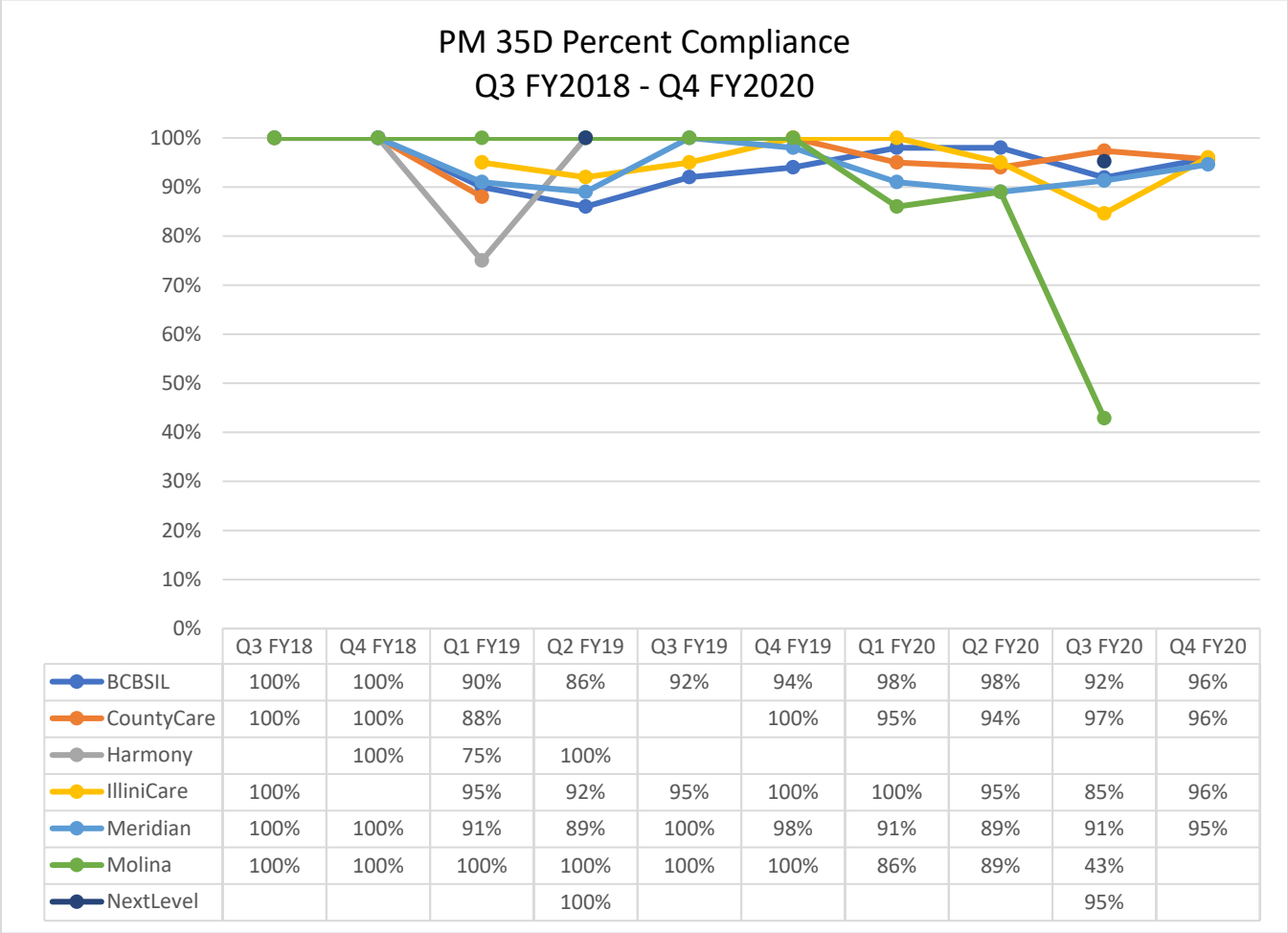


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL		100%	100%	100%	94%	100%	100%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	94%	100%	100%
Harmony										
IlliniCare	0%		100%	100%	100%	100%	100%	87%	93%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%						100%	100%		
NextLevel									100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 35D - The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.

Figure B.7 – Measure 35D



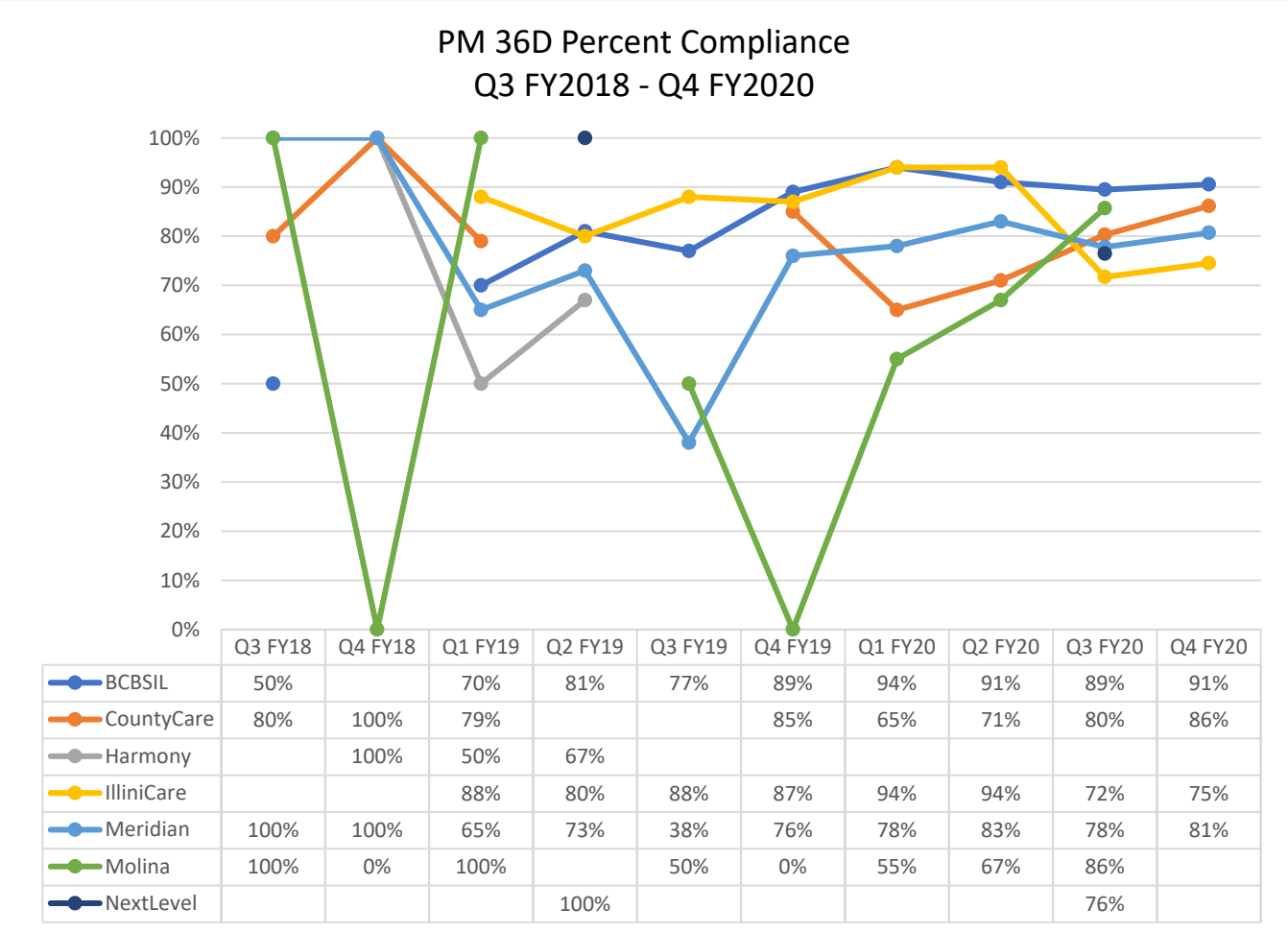
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	90%	86%	92%	94%	98%	98%	92%	96%
CountyCare	100%	100%	88%			100%	95%	94%	97%	96%
Harmony		100%	75%	100%						
IlliniCare	100%		95%	92%	95%	100%	100%	95%	85%	96%
Meridian	100%	100%	91%	89%	100%	98%	91%	89%	91%	95%
Molina	100%	100%	100%	100%	100%	100%	86%	89%	43%	
NextLevel				100%					95%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 36D - the Case Manager made valid timely contact or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one contact face-to-face bi-monthly.
BI: Monthly contact.
PD: Annual contact.
ELD: Annual contact
SLP records are not eligible for this measure

Figure B.8 – Measure 36D



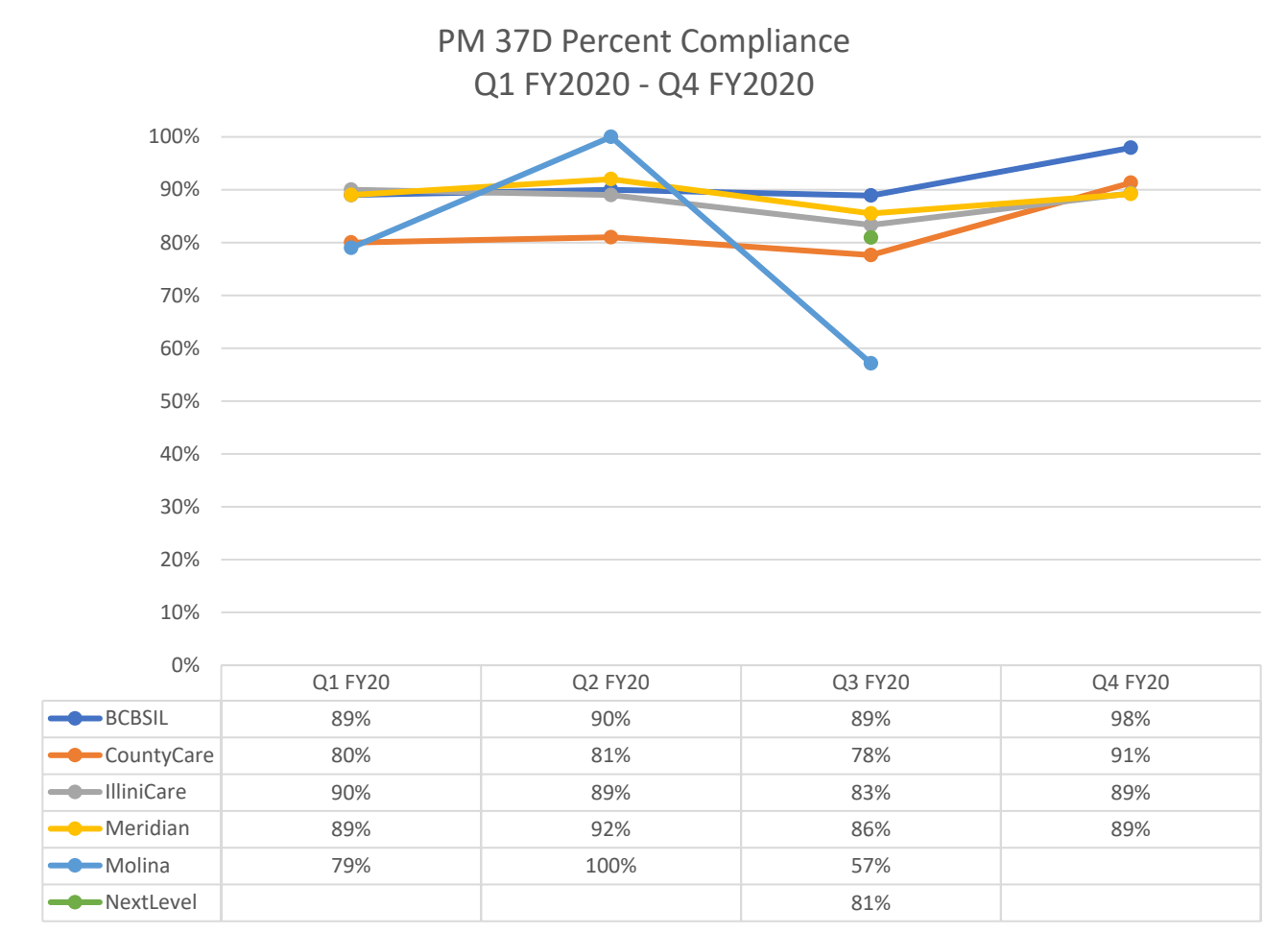
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	50%		70%	81%	77%	89%	94%	91%	89%	91%
CountyCare	80%	100%	79%			85%	65%	71%	80%	86%
Harmony		100%	50%	67%						
IlliniCare			88%	80%	88%	87%	94%	94%	72%	75%
Meridian	100%	100%	65%	73%	38%	76%	78%	83%	78%	81%
Molina	100%	0%	100%		50%	0%	55%	67%	86%	
NextLevel				100%					76%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 37D - The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.9 – Measure 37D

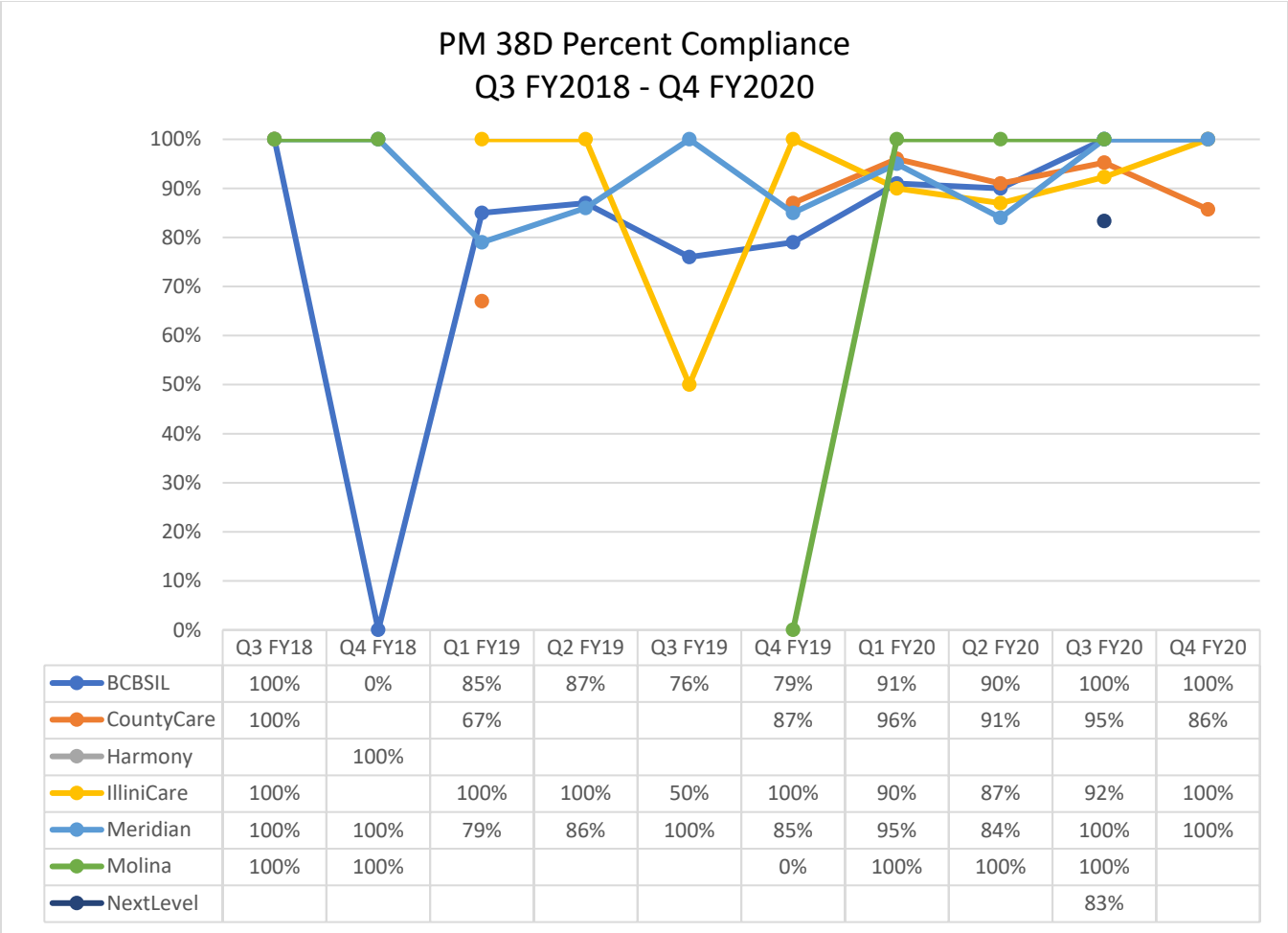


	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	89%	90%	89%	98%
CountyCare	80%	81%	78%	91%
IlliniCare	90%	89%	83%	89%
Meridian	89%	92%	86%	89%
Molina	79%	100%	57%	
NextLevel			81%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 38D - The service plan was updated when the enrollee needs changed.

Figure B.10 – Measure 38D

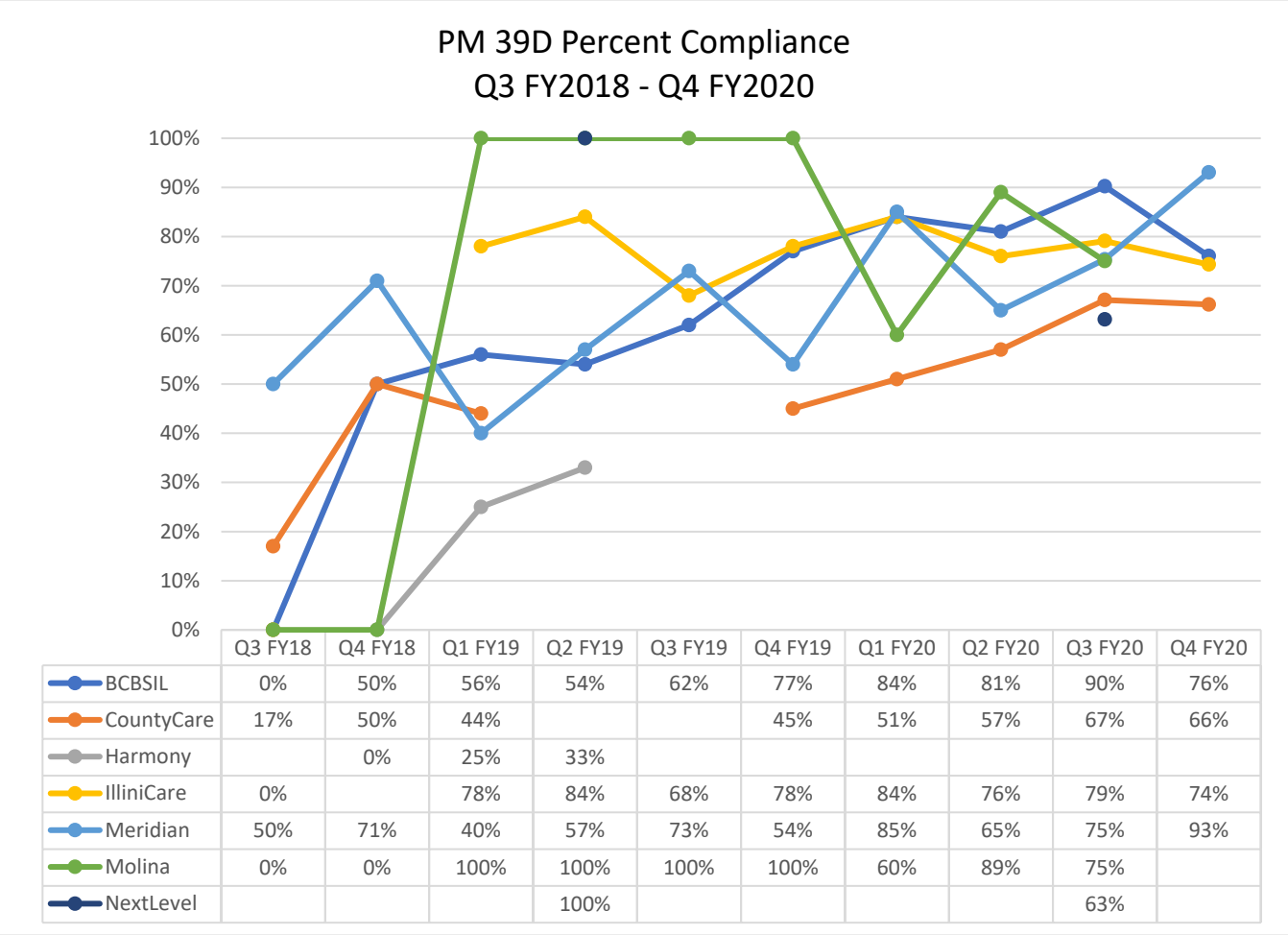


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	0%	85%	87%	76%	79%	91%	90%	100%	100%
CountyCare	100%		67%			87%	96%	91%	95%	86%
Harmony		100%								
IlliniCare	100%		100%	100%	50%	100%	90%	87%	92%	100%
Meridian	100%	100%	79%	86%	100%	85%	95%	84%	100%	100%
Molina	100%	100%				0%	100%	100%	100%	
NextLevel									83%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 39D - Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.

Figure B.11 – Measure 39D

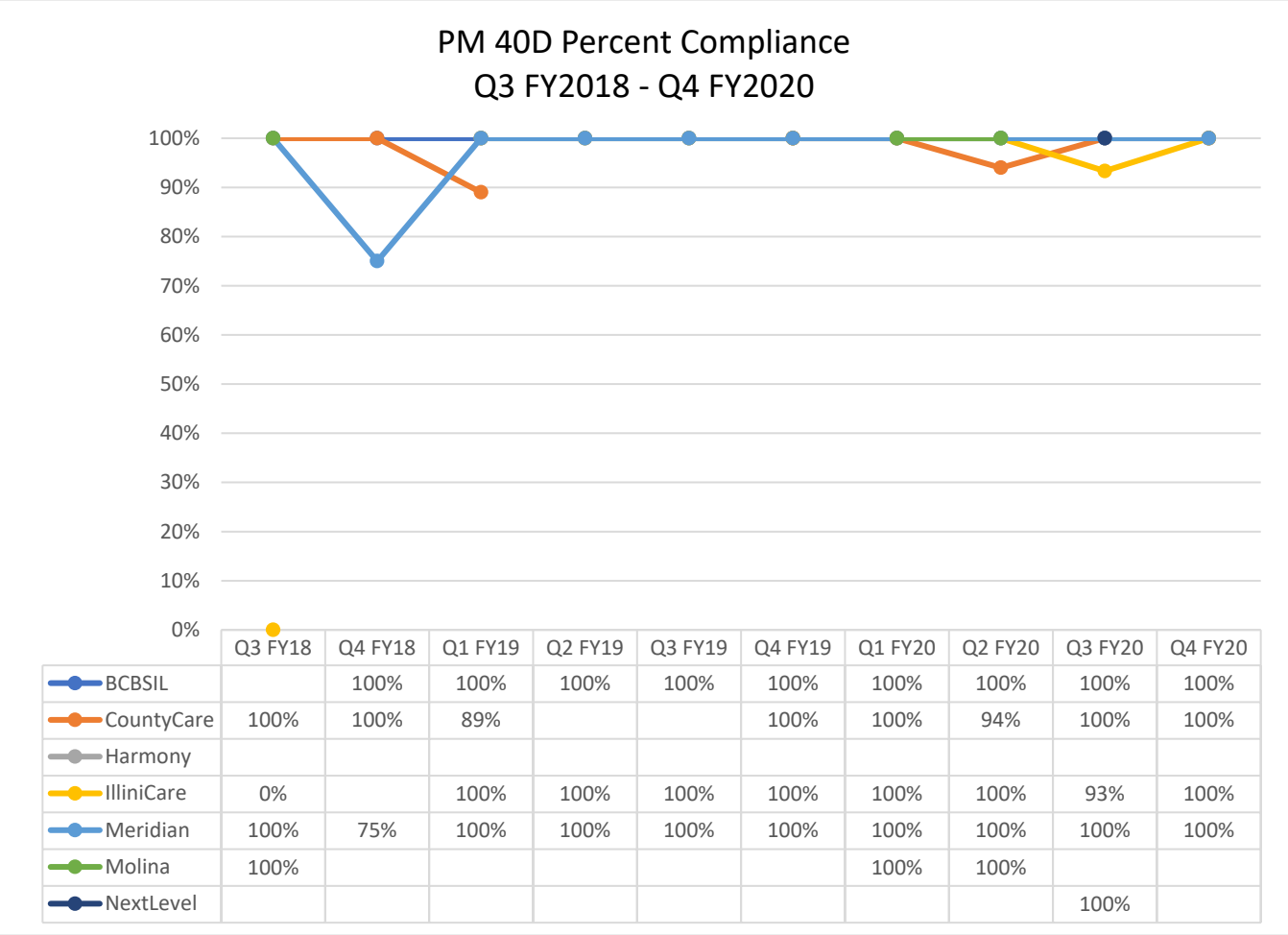


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	0%	50%	56%	54%	62%	77%	84%	81%	90%	76%
CountyCare	17%	50%	44%			45%	51%	57%	67%	66%
Harmony		0%	25%	33%						
IlliniCare	0%		78%	84%	68%	78%	84%	76%	79%	74%
Meridian	50%	71%	40%	57%	73%	54%	85%	65%	75%	93%
Molina	0%	0%	100%	100%	100%	100%	60%	89%	75%	
NextLevel				100%					63%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 40D – The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B.12 – Measure 40D

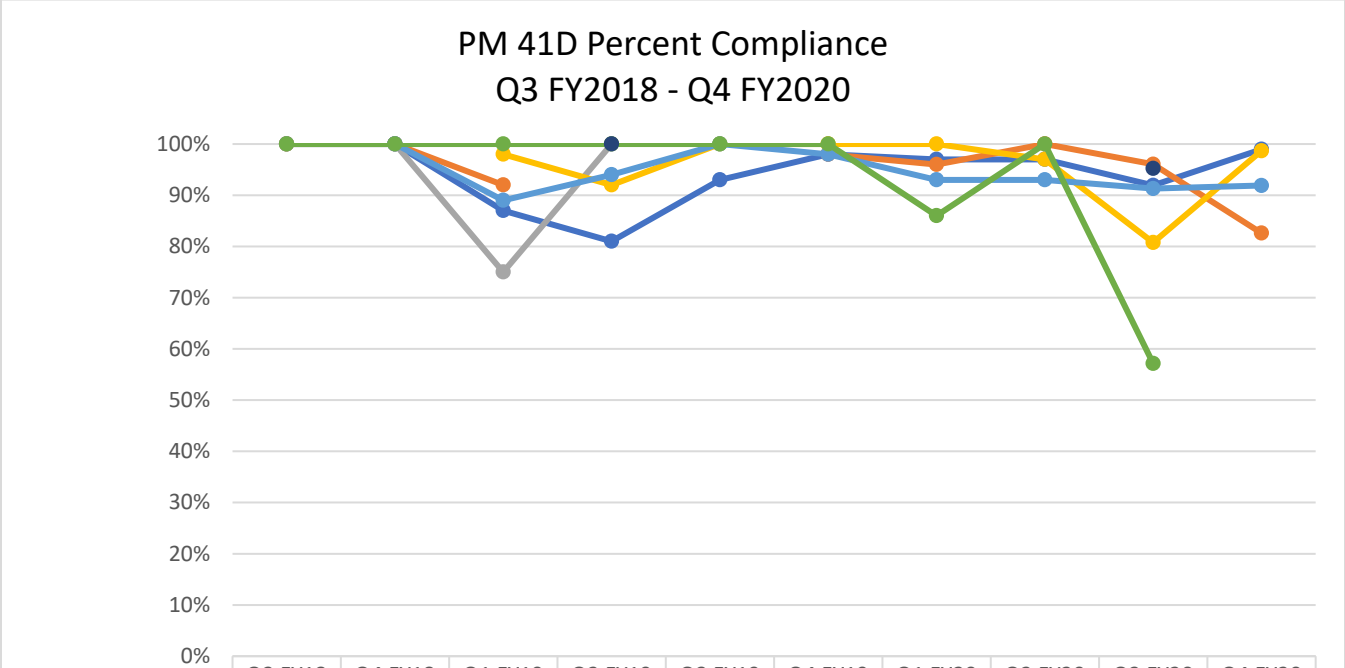


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL		100%	100%	100%	100%	100%	100%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	94%	100%	100%
Harmony										
IlliniCare	0%		100%	100%	100%	100%	100%	100%	93%	100%
Meridian	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%						100%	100%		
NextLevel									100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 41D - The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B.13 – Measure 41D

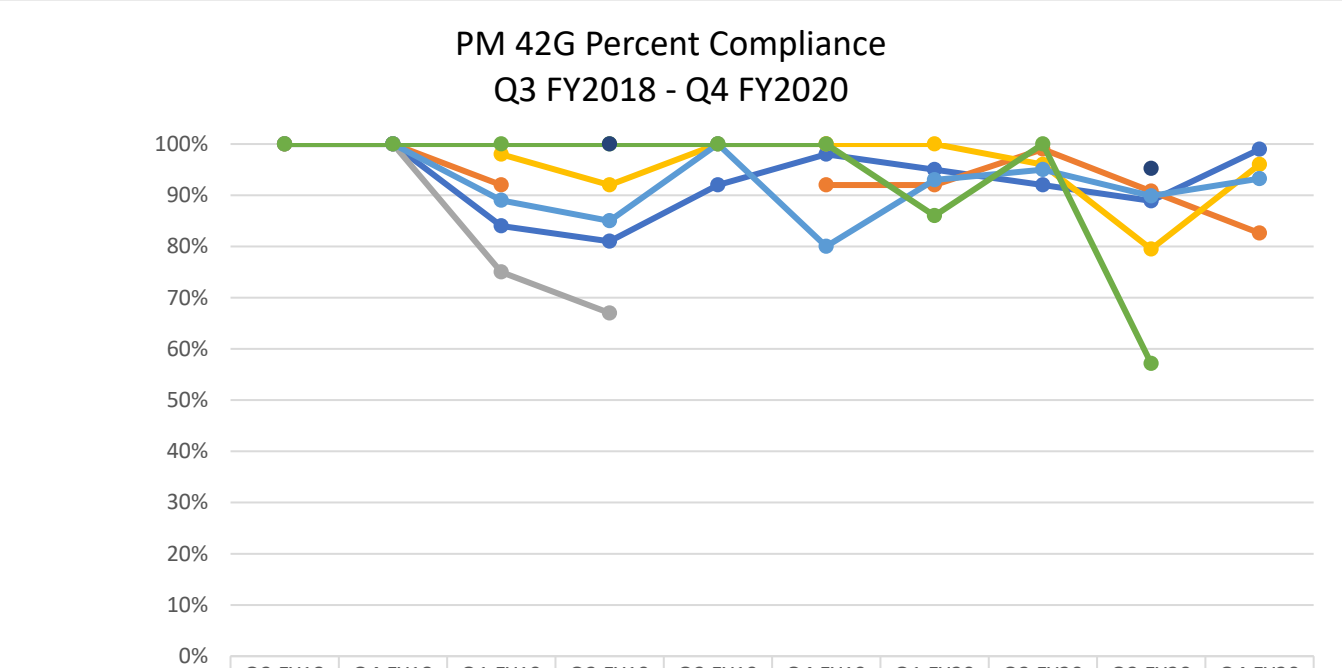


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	87%	81%	93%	98%	97%	97%	92%	99%
CountyCare	100%	100%	92%			98%	96%	100%	96%	83%
Harmony		100%	75%	100%						
IlliniCare	100%		98%	92%	100%	100%	100%	97%	81%	99%
Meridian	100%	100%	89%	94%	100%	98%	93%	93%	91%	92%
Molina	100%	100%	100%	100%	100%	100%	86%	100%	57%	
NextLevel				100%					95%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 42G - The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B.14 – Measure 42G

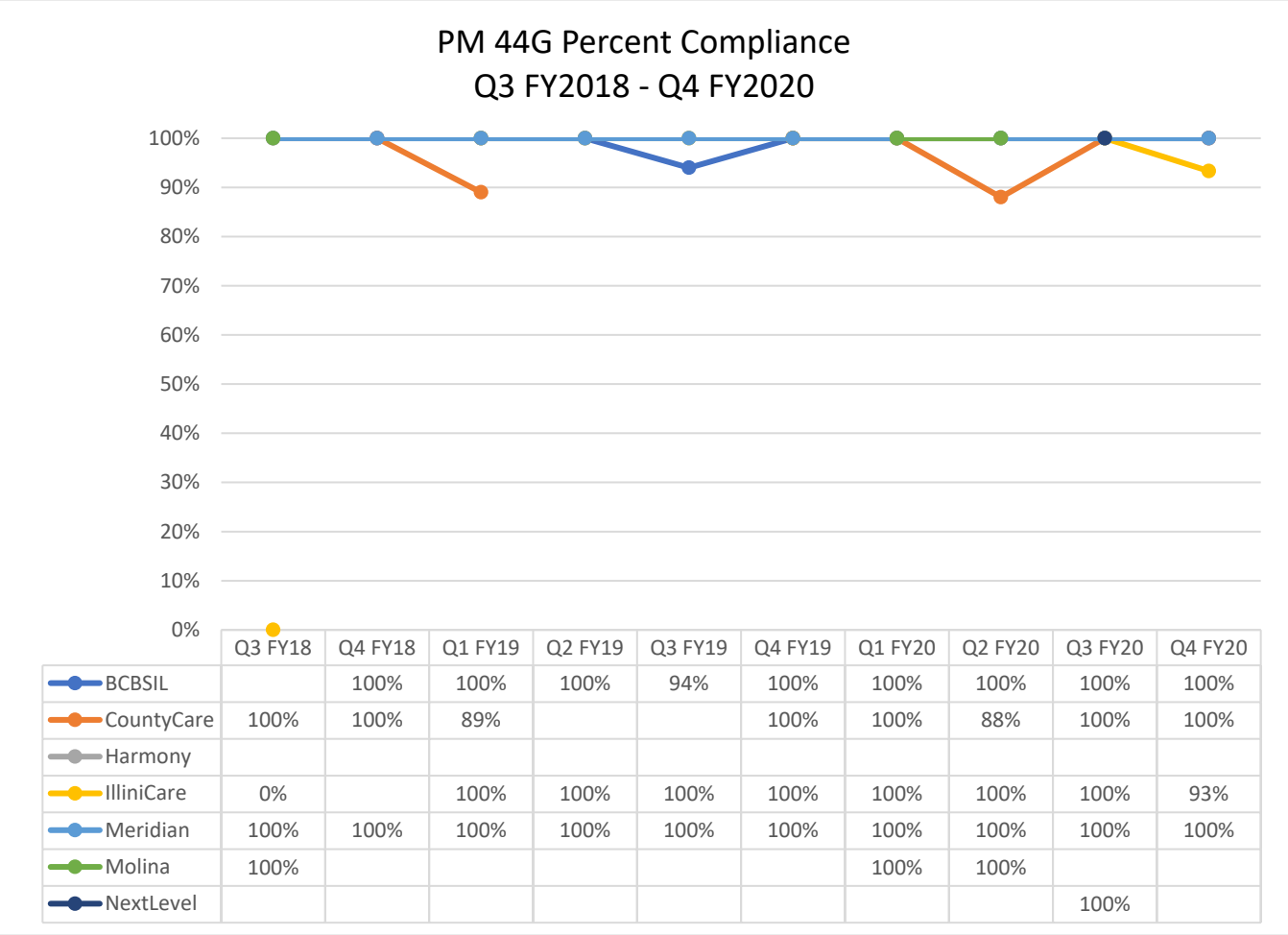


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	100%	100%	84%	81%	92%	98%	95%	92%	89%	99%
CountyCare	100%	100%	92%			92%	92%	99%	91%	83%
Harmony		100%	75%	67%						
IlliniCare	100%		98%	92%	100%	100%	100%	96%	79%	96%
Meridian	100%	100%	89%	85%	100%	80%	93%	95%	90%	93%
Molina	100%	100%	100%	100%	100%	100%	86%	100%	57%	
NextLevel				100%					95%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.15 – Measure 44G



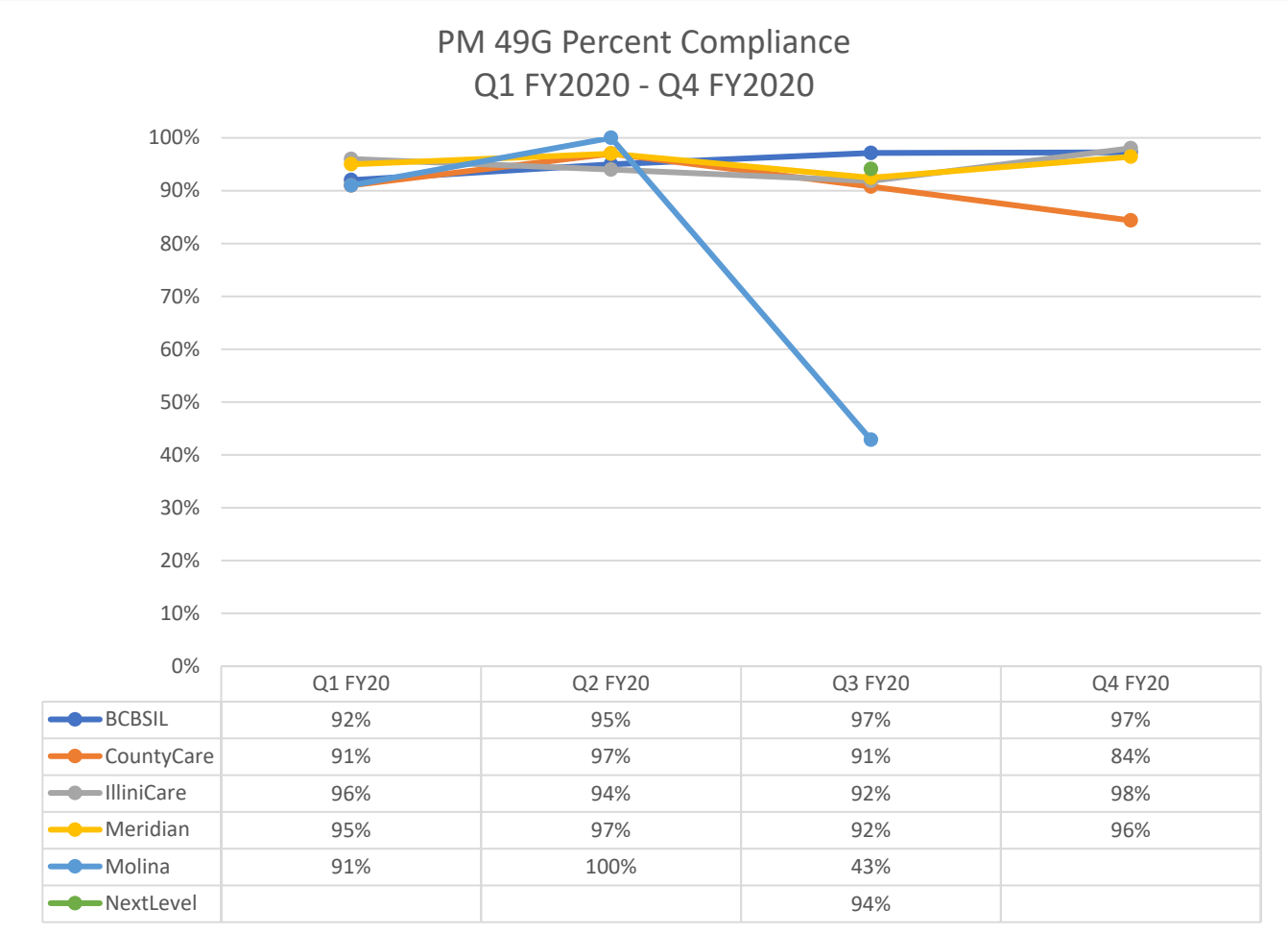
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL		100%	100%	100%	94%	100%	100%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	88%	100%	100%
Harmony										
IlliniCare	0%		100%	100%	100%	100%	100%	100%	100%	93%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%						100%	100%		
NextLevel									100%	

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 49G - The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV, PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.16 – Measure 49G



	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20
BCBSIL	92%	95%	97%	97%
CountyCare	91%	97%	91%	84%
IlliniCare	96%	94%	92%	98%
Meridian	95%	97%	92%	96%
Molina	91%	100%	43%	
NextLevel			94%	

Note: Blank cells represent quarters in which the health plan was not reviewed.

Appendix C. Health Plan Performance by Measure by Quarter – MLTSS

Table C.1 displays health plan compliance per performance measure by quarter.

Table C.1—Waiver Performance Measure Findings

MLTSS Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44G**	**49G**
BCBSIL															
Q3 2018	0%	100%	100%	100%		100%	50%	67%	100%	0%		100%	100%		100%
Q4 2018		100%	100%	100%	100%	100%		100%	0%	50%	100%	100%	100%	100%	
Q1 2019	40%	90%	90%	90%	100%	90%	70%	60%	85%	56%	100%	87%	84%	100%	88%
Q2 2019	13%	83%	85%	83%	100%	86%	81%	73%	87%	54%	100%	81%	81%	100%	76%
Q3 2019	8%	80%	95%	95%	94%	92%	77%	78%	76%	62%	100%	93%	92%	94%	78%
Q4 2019	29%	81%	94%	98%	100%	94%	89%	87%	79%	77%	100%	98%	98%	100%	94%
Q1 2020	13%	95%	94%	96%	100%	98%	94%	89%	91%	84%	100%	97%	95%	100%	92%
Q2 2020	29%	96%	99%	99%	100%	98%	91%	90%	90%	81%	100%	97%	92%	100%	95%
Q3 2020	0%	92%	92%	93%	100%	92%	89%	89%	100%	90%	100%	92%	89%	100%	97%
Q4 2020		97%	97%	98%	100%	96%	91%	98%	100%	76%	100%	99%	99%	100%	97%
CountyCare															
Q3 2018	0%	100%	100%	100%	100%	100%	80%	83%	100%	17%	100%	100%	100%	100%	100%
Q4 2018	0%	100%	100%	100%	100%	100%	100%	50%		50%	100%	100%	100%	100%	100%
Q1 2019	0%	92%	96%	96%	89%	88%	79%	96%	67%	44%	89%	92%	92%	89%	87%
Q2 2019															
Q3 2019															
Q4 2019	88%	96%	100%	100%	100%	100%	85%	86%	87%	45%	100%	98%	92%	100%	96%
Q1 2020	10%	95%	91%	92%	100%	95%	65%	80%	96%	51%	100%	96%	92%	100%	91%
Q2 2020	33%	100%	100%	100%	94%	94%	71%	81%	91%	57%	94%	100%	99%	88%	97%
Q3 2020	23%	99%	99%	96%	100%	97%	80%	78%	95%	67%	100%	96%	91%	100%	91%

Table C.1—Waiver Performance Measure Findings

MLTSS Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44G**	**49G**
Q4 2020	0%	94%	93%	91%	100%	96%	86%	91%	86%	66%	100%	83%	83%	100%	84%
IlliniCare															
Q3 2018		100%	100%	100%	0%	100%		100%	100%	0%	0%	100%	100%	0%	
Q4 2018															
Q1 2019	40%	98%	98%	98%	100%	95%	88%	88%	100%	78%	100%	98%	98%	100%	100%
Q2 2019	31%	95%	95%	95%	100%	92%	80%	65%	100%	84%	100%	92%	92%	100%	100%
Q3 2019	40%	100%	100%	100%	100%	95%	88%	76%	50%	68%	100%	100%	100%	100%	100%
Q4 2019	50%	97%	100%	100%	100%	100%	87%	89%	100%	78%	100%	100%	100%	100%	100%
Q1 2020	83%	100%	100%	100%	100%	100%	94%	90%	90%	84%	100%	100%	100%	100%	96%
Q2 2020	40%	99%	97%	100%	87%	95%	94%	89%	87%	76%	100%	97%	96%	100%	94%
Q3 2020	0%	86%	87%	86%	93%	85%	72%	83%	92%	79%	93%	81%	79%	100%	92%
Q4 2020	40%	97%	97%	97%	100%	96%	75%	89%	100%	74%	100%	99%	96%	93%	98%
Meridian															
Q3 2018		100%	100%	100%	100%	100%	100%	100%	100%	50%	100%	100%	100%	100%	100%
Q4 2018		100%	100%	100%	100%	100%	100%	100%	100%	71%	75%	100%	100%	100%	100%
Q1 2019	9%	94%	94%	94%	100%	91%	65%	77%	79%	40%	100%	89%	89%	100%	90%
Q2 2019	30%	96%	94%	94%	100%	89%	73%	74%	86%	57%	100%	94%	85%	100%	93%
Q3 2019	13%	100%	88%	100%	100%	100%	38%	69%	100%	73%	100%	100%	100%	100%	92%
Q4 2019	25%	95%	89%	95%	100%	98%	76%	75%	85%	54%	100%	98%	80%	100%	85%
Q1 2020	33%	96%	96%	96%	100%	91%	78%	89%	95%	85%	100%	93%	93%	100%	95%
Q2 2020	0%	95%	95%	95%	100%	89%	83%	92%	84%	65%	100%	93%	95%	100%	97%
Q3 2020	13%	96%	97%	97%	100%	91%	78%	86%	100%	75%	100%	91%	90%	100%	92%
Q4 2020	17%	97%	97%	97%	100%	95%	81%	89%	100%	93%	100%	92%	93%	100%	96%
Molina															
Q3 2018		100%	100%	100%	100%	100%	100%	100%	100%	0%	100%	100%	100%	100%	100%
Q4 2018	0%	100%	100%	100%		100%	0%	0%	100%	0%		100%	100%		100%
Q1 2019		100%	100%	100%		100%	100%	100%		100%		100%	100%		100%

Table C.1—Waiver Performance Measure Findings

MLTSS Performance Measure Findings Across Health Plans Percent Compliant by Measure															
Health Plan	**Performance Measure #**														
FY Quarter	**4A**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44G**	**49G**
Q2 2019		100%	100%	100%		100%		100%		100%		100%	100%		
Q3 2019		100%	100%	100%		100%	50%	100%		100%		100%	100%		100%
Q4 2019		67%	100%	100%		100%	0%	100%	0%	100%		100%	100%		100%
Q1 2020		93%	93%	93%	100%	86%	55%	79%	100%	60%	100%	86%	86%	100%	91%
Q2 2020		100%	100%	100%	100%	89%	67%	100%	100%	89%	100%	100%	100%	100%	100%
Q3 2020	0%	43%	43%	43%		43%	86%	57%	100%	75%		57%	57%		43%
Q4 2020															
NextLevel															
Q3 2018															
Q4 2018															
Q1 2019															
Q2 2019		100%	100%	100%		100%	100%	100%		100%		100%	100%		100%
Q3 2019															
Q4 2019															
Q1 2020															
Q2 2020															
Q3 2020	0%	90%	95%	95%	100%	95%	76%	81%	83%	63%	100%	95%	95%	100%	94%
Q4 2020															
Harmony*															
Q3 2018															
Q4 2018		100%	100%	100%		100%	100%	100%	100%	0%		100%	100%		100%
Q1 2019	0%	50%	50%	50%		75%	50%	75%		25%		75%	75%		75%
Q2 2019		67%	67%	67%		100%	67%	100%		33%		100%	67%		67%

Shaded rows indicate a quarter during which a health plan was not reviewed or there were no eligible records

**Due to exiting HealthChoice Q2 FY2019, Harmony's data is displayed for historic purposes through the last quarter reviewed.*

Appendix D. Waiver Measure Performance by Quarter – MLTSS

Table D.1—MLTSS Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2020																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	89%	91%	91%	91%	93%	91%	91%	92%	89%	92%	88%	93%	91%	93%	82%	91%	94%	93%	88%	95%
4A				0%	24%	18%	15%	17%	0%	100%	0%		45%	38%	12%	25%	0%			
31D	96%	98%	100%	100%	96%	95%	93%	94%	100%	97%	94%	97%	98%	99%	86%	96%	94%	99%	91%	97%
32D	96%	98%	100%	98%	96%	96%	93%	97%	100%	100%	94%	93%	94%	100%	88%	95%	93%	97%	92%	97%
33D	96%	98%	100%	96%	97%	98%	94%	97%	100%	100%	94%	97%	94%	100%	86%	95%	95%	97%	91%	97%
34D					100%	96%	99%	100%												
35D	93%	98%	98%	100%	98%	94%	95%	94%	97%	100%	87%	100%	96%	99%	87%	97%	94%	84%	86%	90%
36D	51%	52%	52%	58%	99%	99%	96%	94%	41%	55%	55%	53%	100%	100%	89%	99%				
37D	93%	96%	94%	98%	82%	87%	86%	87%	97%	97%	94%	100%	86%	90%	75%	94%	85%	78%	79%	91%
38D	95%	89%	90%	94%	94%	85%	100%	92%	93%	100%	100%	100%	91%	88%	96%	100%			100%	
39D	79%	75%	79%	77%	68%	54%	65%	61%	71%	76%	90%	90%	64%	60%	68%	71%	100%	99%	100%	100%
40D					100%	99%	99%	100%												
41D	96%	100%	100%	100%	98%	91%	93%	92%	97%	100%	90%	100%	96%	100%	85%	87%	94%	97%	84%	96%
42G	96%	100%	98%	100%	91%	89%	93%	92%	97%	100%	90%	100%	95%	98%	80%	86%	96%	95%	79%	96%
44G					100%	97%	100%	99%												
49G	93%	95%	90%	88%	99%	99%	95%	99%	86%	97%	97%	97%	90%	93%	88%	91%				

Table D.2—MLTSS Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2019																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	83%	82%	83%	85%	87%	88%	87%	91%	85%	86%	86%	88%	81%	85%	78%	89%	81%	77%	93%	90%
4A	38%	43%	13%	56%	31%	50%	27%	20%	100%			100%	0%	0%	33%	50%	20%	14%	11%	33%
31D	100%	100%	95%	93%	96%	93%	87%	93%	93%	100%	82%	100%	92%	90%	81%	96%	86%	83%	98%	83%
32D	10%	100%	100%	100%	96%	93%	97%	97%	96%	100%	100%	95%	92%	95%	88%	96%	86%	82%	93%	89%
33D	100%	94%	100%	100%	96%	93%	97%	100%	96%	100%	100%	100%	92%	95%	88%	96%	86%	82%	100%	94%
34D					98%	100%	97%	100%												
35D	96%	100%	100%	100%	94%	93%	95%	100%	89%	100%	100%	100%	92%	100%	81%	100%	88%	78%	96%	93%
36D	42%	50%	53%	59%	94%	90%	87%	99%	54%	30%	27%	48%	88%	95%	88%	96%				
37D	67%	56%	58%	72%	73%	81%	72%	87%	89%	100%	100%	86%	83%	80%	81%	85%	73%	63%	80%	83%
38D	83%	100%	100%	89%	81%	94%	60%	83%	89%	100%	83%	86%	88%	67%	60%	90%	0%	50%		0%
39D	50%	38%	63%	59%	44%	43%	41%	44%	54%	40%	64%	57%	25%	45%	44%	52%	80%	93%	100%	98%
40D					98%	100%	100%	100%												
41D	100%	100%	100%	97%	92%	90%	100%	100%	96%	100%	100%	100%	92%	95%	81%	96%	82%	80%	98%	98%
42G	96%	100%	100%	90%	92%	88%	97%	91%	96%	90%	100%	90%	88%	95%	81%	81%	82%	75%	98%	96%
44G					98%	100%	97%	100%												
49G	100%	94%	84%	92%		50%		100%	88%	89%	91%	100%	83%	83%	90%	96%				

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated.*

Table D.3—MLTSS Waiver Performance Measure Findings

Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2018																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall			76%				86%	94%			90%				89%	85%			100%	
4A			0%					0%							0%	0%			100%	
31D			100%				100%	100%			100%				100%	100%			100%	
32D			100%				100%	100%			100%				100%	100%			100%	
33D			100%				100%	100%			100%				100%	100%			100%	
34D							80%	100%												
35D			100%				100%	100%			100%				100%	100%			100%	
36D			50%								100%				80%	80%				
37D			50%				100%	88%			100%				80%	80%			100%	
38D							100%	67%			100%				100%	100%				
39D			0%				0%	88%			0%				40%	0%			100%	
40D							0%	86%												
41D			100%				100%	100%			100%				100%	100%			100%	
42G			100%				100%	100%			100%				100%	100%			100%	
44G							80%	100%												
49G			100%								100%				100%	100%				

Data capture for MLTSS in the HealthChoice program began Q3 FY2018.

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated.*

Appendix E. Acronyms

ACA ..... Affordable Care Act
ADL ..... Activity of Daily Living
ANE ..... Abuse, Neglect, and Exploitation
ARRA ..... American Recovery and Reinvestment Act of 2009
BBA ..... Balanced Budget Act of 1997
BI ..... Persons with Brain Injury Waiver
BMC ..... Bureau of Managed Care
BQM ..... Bureau of Quality Management
CAP ..... Corrective Action Plan
CCU ..... Care Coordination Unit
CFR ..... Code of Federal Regulations
CMS ..... Centers for Medicare & Medicaid Services
DHHS ..... The United States Department of Health and Human Services
DHS ..... Department of Health Services
DOA ..... Department on Aging
DON ..... Determination of Need
DRS ..... Division of Rehabilitation Services
eCCPIS ..... Department on Aging Case Management System
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FHP ..... Family Health Plan
HCBS ..... Home and Community Based Services
HCI ..... HealthChoice Illinois
HFS ..... The Illinois Department of Healthcare and Family Services
HHS ..... Health and Human Services
HIV ..... Persons with HIV/AIDS (HIV) Waiver
IADL ..... Instrumental Activity of Daily Living
ICP ..... Integrated Care Program
IDPH ..... Illinois Department of Public Health
IHH ..... Integrated Health Home
IRR ..... Interrater Reliability
IT ..... Information Technology
LTC ..... Long Term Care

MCO ..... Managed Care Organization
MEDI ..... Medical Electronic Data Interchange
MMAI ..... Medicare-Medicaid Alignment Initiative
NCQA ..... National Committee for Quality Assurance
PA ..... Personal Assistant
PCP ..... Primary Care Physician
PD ..... Persons with Physical Disabilities Waiver
POSM ..... Participants Outcomes and Status Measures
SFY ..... State Fiscal Year
SLP ..... Persons in a Supportive Living Program Waiver
VMC ..... Voluntary Managed Care
VMCO ..... Voluntary Managed Care Organization
WebCM ..... Division of Rehabilitation Services Case Management System

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Medicare Medicaid Alignment Initiative (MMAI) Home and Community-Based Service (HCBS) Waivers

Centers for Medicare & Medicaid Services (CMS) Performance Measures

Record Reviews

of

Managed Care Plans

Summary of Findings and Recommendations

SFY20 Annual Report

October 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) and employ strategies to discover/identify problems/issues within the Home and Community-Based Services (HCBS) waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG) conduct on-site reviews of waiver beneficiary records. Health plans were required to implement systematic quality improvement efforts that result in improved care coordination, with the goal of better health outcomes, reduced costs, and higher utilization of community-based service options for HCBS waiver enrollees.

This state fiscal year (SFY) 2020 HCBS Waivers CMS Performance Measures Record Reviews Summary of Findings and Recommendations Report provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for the Medicare Medicaid Alignment Initiative (MMAI) managed care population.

Overview

This report provides an overall summary of the health plans' compliance with the HCBS CMS waiver performance measures requirements. Ongoing performance was monitored through quarterly record reviews, health plan-specific feedback, and remediation of record review findings.

The report includes a summary of trended performance across health plans during SFY 2020 and across review years, and also contains a review of remediation activities conducted within the required timeframes and a summary of technical assistance provided to the health plans by HSAG.

Methodology

HSAG conducted quarterly record reviews to determine health plan compliance to 15 CMS waiver performance measures, and additional MMAI contract measures. During SFY 2020, 1,218 records were reviewed utilizing HSAG's web-based data collection tool. As a result, 782 findings of non-compliance were identified.

A detailed description of the sampling methodology and data collection processes is provided in Section 2 of this report.

Summary of Findings

Health Plan Participation

Table 1.1 displays the health plans that were reviewed during SFY 2020.

Table 1.1—SFY 2020 MMAI Health Plans

MMAI Health Plan Name
Aetna Better Health, Inc. (Aetna)
Blue Cross Blue Shield of Illinois (BCBSIL)
Humana Health Plan, Inc. (Humana)
IlliniCare Health Plan (IlliniCare)
Meridian Health (Meridian)
Molina Healthcare of Illinois (Molina)

Successes

SFY 2020 represented the sixth year of review for the MMAI population, and several successes were identified.

☑ When compared to SFY 2019, overall performance on the CMS performance measures realized a statistically significant increase in SFY 2020.

☑ Twelve of the 15 CMS performance measures averaged over 90 percent compliance in SFY 2020.

☑ Seven of the 15 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2020 when compared to SFY 2019.

☑ Five of the six health plans averaged greater than 90 percent compliance in SFY 2020.

☑ Compared to SFY 2019, Aetna realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, BCBSIL realized a statistically significant increase in performance for seven measures in SFY 2020.

☑ Compared to SFY 2019, IlliniCare realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, IlliniCare realized a statistically significant increase in performance for three measures in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020.

☑ Compared to SFY 2019, Meridian realized a statistically significant increase in performance for one measure in SFY 2020.

☑ Compared to SFY 2019, the BI waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for three measures.

☑ Compared to SFY 2019, the ELD waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for two measures.

☑ Compared to SFY 2019, the HIV waiver realized a statistically significant increase in performance in SFY 2020 and realized a statistically significant increase for one measure.

☑ Compared to SFY 2019, the PD waiver realized a statistically significant increase in performance in SFY 2020 and realized statistically significant increases for four measures.

☑ Compared to SFY 2019, the SLP waiver realized a statistically significant increase in performance in SFY 2020.

Opportunities for Improvement

Review of SFY 2020 performance identified the following opportunities for improvement:

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 33 percent compliance in SFY 2020. All five health plans with applicable cases performed at a rate of 50 percent or less in SFY 2020. A detailed analysis related to 4A is provided in Section 3 of this report.

Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record,* averaged 75 percent and 70 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. A detailed analysis related to 36D is provided in Section 3 of this report.

Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan*, averaged 80 percent compliance in SFY 2019. A detailed analysis related to 39D is provided in Section 3 of this report.

Analysis of SFY 2020 Performance on SFY 2019 Recommendations for Improvement

The year-to-year comparative analysis revealed many improvements in performance scores. These improvements were the results of efforts made by the health plans to address HSAG recommendations following the conclusion of SFY 2019 reviews, efforts to incorporate technical assistance received during onsite reviews, and efforts to integrate HFS guidance into internal processes. Although it is not possible to definitively determine causal relationships, Table 1.2 documents the results of some of the health plan improvement efforts.

Table 1.2—Health Plan Interventions and Results

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
Plan-Specific	
Aetna performed at 90 percent or greater for 14 of the 15 CMS performance measures. The one performance measure with results less than 90 percent was 39D, which averaged 89 percent during SFY 2019, and realized a statistically significant improvement from SFY 2018 (+35 percentage points, p=<0.0001). HSAG will continue to review Aetna's SFY 2020 performance to ensure gains are sustained and identify any best practices.	39D: Aetna performed at 95 percent in SFY 2020, an increase of six percentage points from SFY 2019.

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
BCBSIL should focus efforts on measures 4A, 37D, and 39D. BCBSIL should ensure that overdue service plans are completed within 30 days of the expected date. BCBSIL may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. BCBSIL should also identify a process to validate the provision of waiver services for all enrollees. In addition, BCBSIL should focus efforts on measures 31D, 32D, and 33D, especially for SLF waiver enrollees, as those three measures demonstrated statistically significant decreases in performance in SFY 2019 when compared to SFY 2018.	4A: BCBSIL demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 31D: BCBSIL realized a statistically significant increase in performance in measure 31D, with a resulting increase of seven percentage points. 32D: BCBSIL realized a statistically significant increase in performance in measure 32D, with a resulting increase of two percentage points. 33D: BCBSIL realized a statistically significant increase in performance in measure 33D, with a resulting increase of three percentage points. 37D: BCBSIL realized a statistically significant increase in performance in measure 37D, with a resulting increase of 10 percentage points. 39D: BCBSIL realized a statistically significant increase in performance in measure 39D, with a resulting increase of 24 percentage points. HSAG noted during reviews that BCBSIL had implemented the use of a standardized process to validate the provision of waiver services for all members.
Humana should focus efforts on measures 4A and 39D. Humana should ensure that overdue service plans are completed within 30 days of the expected date. Humana may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Humana should also identify a process to validate the provision of waiver services for all members.	4A: Humana demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 39D: Humana demonstrated stable performance during SFY 2020, resulting in compliance of 56 percent.
IlliniCare should focus efforts on measures 4A and 39D. IlliniCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. IlliniCare should also identify a process to validate the provision of waiver services for all members.	4A: IlliniCare demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 39D: IlliniCare realized a statistically significant increase in performance in measure 39D, with a resulting increase of 17 percentage points.

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
Meridian should focus efforts on measures 4A and 39D. Meridian should ensure that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Meridian should also identify a process to validate the provision of waiver services for all members.	4A: Meridian demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 39D: Meridian realized a statistically significant increase in performance in measure 39D, with a resulting increase of 19 percentage points.
Molina should focus efforts on measures 4A and 39D. Molina should ensure that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Molina should identify a process to validate the provision of waiver services for all members.	4A: Molina demonstrated stable performance during SFY 2020, and analysis identified that the number of overdue service plans decreased from SFY 2019 to SFY 2020. 39D: Molina demonstrated stable performance during SFY 2020, resulting in compliance of 71 percent.
Waiver-specific	
BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee at least one time a month, realized a statistically significant increase in performance from SFY 2019 to SFY 2020. Focused efforts related to measure 36D were recommended during SFY 2020 and remain as a recommendation for SFY 2021.
HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.	Performance in measure 36D, valid contact with the enrollee once a month, with a face-to-face contact bimonthly, demonstrated stable performance from SFY 2019 to SFY 2020. Focused efforts related to measure 36D were recommended during SFY 2020 and remain as a recommendation for SFY 2021.
Performance-measure specific	

SFY 2019 Recommendation	SFY 2020 Analysis of Performance
All health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.	4A: Overall performance was 33 percent in SFY 2020. 36D: Overall performance averaged 75 percent and 70 percent compliance for the BI and HIV waivers, respectively, in SFY 2020. 37D: Overall performance was 89 percent in SFY 2020, a statistically significant increase from SFY 2019 performance. 39D: Overall performance for measure 39D was 80 percent in SFY 2020, a statistically significant increase from SFY 2019 performance. Focused efforts will continue to remain as recommendations for measures 4A, 36D, and 39D.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY20. Technical assistance was provided during the on-site record reviews, as requested by health plans and following HFS approval. Technical assistance included guidance on the following:

- Validation of waiver service provision.
- Timely case reassignment for beneficiaries who require a new case manager.
- Timely completion of annual reassessments, care plan and waiver service plan.
- Timely completion of assessment, care plan and waiver service plan update for beneficiary change in condition and/or needs.
- Timely completion of the initial service plan for beneficiaries determined to be newly waiver eligible.
- Effective use of online record review result reports.

HFS Policy Guidance

As a result of HFS's efforts for continuous quality improvement for the waiver record reviews and management of waiver enrollees, HFS provided guidance via formal policies to the health plans on the following topics:

- Procedures specific to management of enrollees during COVID-19, and
- Guidance regarding determinations and documentation of waiver service validation.

Recommendations

Based on analysis of performance, as well as observations during on-site reviews, HSAG has identified recommendations to address the findings of the record reviews. In general, health plans would benefit from strengthening internal audit processes to focus on the remediation findings that result from each quarterly review. Plan-specific, waiver-specific, and performance measure-specific recommendations are identified below.

Plan-specific

Aetna performed at greater than 90 percent compliance for all 14 measures with applicable records during SFY 2020; one measure, 4A, did not have any applicable records. HSAG will continue to review Aetna's SFY 2021 performance to ensure gains are sustained and identify any best practices.

BCBSIL should focus efforts on measures 4A and 39D. BCBSIL should ensure that overdue service plans are completed within 30 days of the expected date. HSAG noted that BCBSIL implemented a process for waiver service provision, which appears to have positively impacted results for 39D; HSAG will continue to review BCBSIL's SFY 2021 performance to identify further gains.

Humana should focus efforts on measures 4A and 39D. Humana should ensure that overdue service plans are completed within 30 days of the expected date. Humana may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Humana should also identify a process to validate the provision of waiver services for all members. Humana may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

IlliniCare should focus efforts on measures 4A and 39D. IlliniCare should ensure that service plans are completed timely, and if not completed within the required timeframe, that overdue service plans are completed within 30 days of the expected date. IlliniCare may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. IlliniCare should also identify a process to validate the provision of waiver services for all members. IlliniCare may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

Meridian should focus efforts on measures 4A and 39D. Meridian should ensure that overdue service plans are completed within 30 days of the expected date. Meridian may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Meridian should also identify a process to validate the provision of waiver services for all members. Meridian may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

Molina should focus efforts on measures 4A and 39D. Molina should ensure that overdue service plans are completed within 30 days of the expected date. Molina may benefit from the use of internal audit tools to determine compliance with waiver-specific timeframes for completion of service plans. Molina should identify a process to validate the provision of waiver services for all members. Molina may

benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

Waiver-specific

BI waiver: Health plans should focus on improving documentation of valid contact with the enrollee at least one time a month. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing BI caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of BI cases, to identify timely mitigation opportunities.

HIV waiver: Health plans should focus on improving documentation of valid contact with the enrollee once a month, with a face-to-face contact bimonthly. Health plans should analyze their staffing to ensure that care managers/care coordinators have caseloads of 30 or less. Health plans should target efforts for contact to those care managers/care coordinators managing HIV caseloads to ensure contact is completed timely. Health plans should ensure that all internal auditing processes include a representative sample of HIV cases, to identify timely mitigation opportunities.

Performance measure-specific

All health plans should focus improvement efforts on measures 4A, 36D, 37D, and 39D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A and 37D, efforts might include:

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

For measure 36D, efforts might include:

- Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement.
- Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30.
- Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
- Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.

- Consider system enhancements to alert care managers/care coordinators of timeframes to contact beneficiaries.

For measure 39D, efforts might include:

- Establish a process to complete ongoing claims validation of the waiver service plan.
- Conduct root cause analysis to determine service providers who may benefit from outreach and education regarding claims submission.
- Ensure completion of education with beneficiaries related to approved hours for personal assistants.
- Conduct staff training to ensure timely follow up with beneficiaries who have a change in service provider. Training should include a component for review of claims to validate service provision and steps to ensure there are no gaps in waiver services.
- Ensure all appropriate staff are provided access and trained on navigation of waiver agency portals to review beneficiary information.
- Develop relationships with service providers to ensure timely communication to the health plan when services cannot be provided per the waiver service plan, and ensure documentation of the communication in the beneficiary's record.

Background

The Illinois Department of Healthcare and Family Services (HFS) implemented the Medicare Medicaid Alignment Initiative (MMAI) demonstration project in March 2014 for clients eligible for both Medicare and Medicaid services ("dual eligible"). MMAI voluntary enrollment began in March 2014, passive enrollment began in June 2014, and enrollment concluded in December 2014.

All waiver beneficiaries enrolled in MMAI receive care management services. This person-centered, team-based approach supports care coordination across the continuum of care, promoting improved health outcomes, increased beneficiary satisfaction, and improved coordination and integration of benefits.

The program was designed to ensure that beneficiaries receive assistance with clinical and nonclinical needs by assigning an accountable care manager who develops a care plan and service plan with the beneficiary, coordinates frequent personal contact to monitor the beneficiary's progress toward achieving care plan goals, and implements interventions to overcome barriers to care.

To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that Health Services Advisory Group, Inc. (HSAG), conduct on-site reviews of waiver beneficiary records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

HCBS Waiver Program Implementation and Monitoring

As the External Quality Review Organization (EQRO) for Illinois, HSAG assisted HFS in assessing the readiness of each health plan to participate in the Home and Community-Based Services (HCBS) waiver program. Prior to receiving HCBS waiver program enrollees, the health plans were required to participate in and pass a readiness review to demonstrate that the health plan was ready to provide services to HCBS waiver enrollees in a safe and efficient manner.

HSAG began on-site record reviews in SFY 2015 to monitor MMAI health plan performance on the HCBS waiver performance measures.

Waiver Programs and Performance Measures Included in Reviews

The following HCBS Waiver Programs were included in the Centers for Medicare & Medicaid Services (CMS) performance measures record reviews:

- **Persons with Physical Disabilities (PD)**: Individuals with disabilities who are under age 60 at the time of application, are at risk of placement in a nursing facility and can be safely maintained in the

home or community-based setting with the services provided in the plan of care. Individuals 60 years or older, who began services before age 60, may choose to remain in this waiver.

- **Persons with HIV/AIDS (HIV)**: Persons of any age who are diagnosed with Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) and are at risk of placement in a nursing facility.
- **Persons with Brain Injury (BI)**: Persons with brain injury, of any age, who are at risk of nursing facility placement due to functional limitations resulting from the brain injury.
- **Persons who are Elderly (ELD)**: Persons 60 years of age or older who are at risk of nursing facility placement. Target groups are those who are aged 65 and older, and those who are physically disabled, ages 60 through 64.
- **Persons in a Supportive Living Program (SLP)**: Affordable assisted living model that offers housing with services for the elderly (65 and older) or persons with disabilities (22 and older).

Performance Measures

For the state fiscal year (FY) 2020 review, HFS identified 15 CMS waiver performance measures for review. These performances measures were aligned with the state approved 1915(c) waiver applications for the waiver types listed above. For FY 2020, the following changes were identified from FY 2019 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2020 to exclude the BI and SLP waivers (previously captured for all waivers).
- Measure 37D, the most recent service plan is in the record and completed in a timely manner, was revised for FY 2020 to incorporate annual renewal for the BI waiver (previously required every six months).
- Measure 49G, most recent service plan includes a backup plan that includes the name of the backup, was revised to include the ELD waiver (previously captured for BI, HIV, and PD waivers only).

The listing of CMS performance measures collected during the record reviews is included as Appendix A.

Record Review Activities and Technical Methods of Data Collection

Sampling Methodology

HSAG developed a sampling methodology based on the waiver requirements approved by HFS. HSAG conducted a single-stage, proportional random sample for each population group by waiver program and stratified by health plan. Using the finite population correction to account for small population sizes, HSAG first selected a proportional random sample by waiver program based on the distribution of health plans for each population group. The overall sample sizes within each population group were

determined based on the number of eligible members in each waiver program. Once the required sample sizes were identified, a proportional random sample was selected based on the distribution of the health plans' population within each designated waiver program. Each sample was selected to ensure a 95 percent confidence level and five percent margin of error at the waiver program level, with a maximum sample population of 5,000 cases across the HealthChoice Illinois (HealthChoice), Managed Long Term Services and Supports (MLTSS), and MMAI waiver enrollees. Additionally, a ten percent oversample based on the proportional distribution of enrollees across health plans was selected to replace ineligible cases. The samples were selected in April 2019 and included waiver members enrolled as of March 1, 2019. Table 2.1 displays the FY 2020 record review sample size by health plan and waiver program for MMAI.

Table 2.1—MMAI Sample Size by Health Plan and Waiver

Health Plan	Eligible Population	Sample Size	Waiver Program				
			ELD	BI	HIV	PD	SLP
Aetna	969	127	36	16	24	25	26
BCBSIL	4,839	581	171	61	38	140	171
Humana	1,411	133	60	13	3	30	27
IlliniCare	1,076	143	36	22	14	41	30
Meridian	1,164	144	41	20	11	43	29
Molina	673	94	19	10	5	33	27
Statewide Total	**10,132**	**1,222**	**363**	**142**	**95**	**312**	**310**

Limitations to the sampling methodology included known variables such as beneficiary disenrollment from waiver services or from the health plan, beneficiary death, beneficiary waiver type change, or beneficiary program participation change (e.g. previously enrolled as MMAI and transferred to MLTSS).

In addition, to be included in the sample, a beneficiary must meet the following criteria:

1. Continuously enrolled with the health plan for at least six months as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.
2. At least three months of continuous HCBS waiver coverage during the most recent six months of enrollment as of the first calendar day of the month that precedes the month of the first scheduled audit during the review quarter.

Upon receipt of the sample, health plans are expected to review the cases to ensure they meet the above eligibility criteria, notifying HSAG of any cases that should be excluded. Health plans will also notify HSAG of any of the following, who may be excluded from the sample:

- Beneficiaries who have disenrolled from the health plan.
- Beneficiaries who have expired.

- Beneficiaries who have Operating Agency-confirmed waiver case closure.
- Beneficiaries whose current waiver type is different from the waiver type identified on the sample.
- Beneficiaries whose current program (HealthChoice, MLTSS, or MMAI) is different from the program type identified on the sample.
- Beneficiaries in long-term care.

HSAG conducted quarterly record reviews and worked with HFS and the health plans to monitor remediation and quality improvement efforts to improve performance on the HCBS waiver performance measures. Data presented in this report, including tables and graphs, reflect the quarters in which the health plans were reviewed. The six-month look back periods during SFY 2020 consisted of the following:

- Quarter 1, SFY 2020: December 1, 2018 – May 31, 2019
- Quarter 2, SFY 2020: March 1, 2019 – August 31, 2019
- Quarter 3, SFY 2020: June 1, 2019 – November 30, 2019
- Quarter 4, SFY 2020: September 1, 2019 – February 29, 2020

Web-Based Abstraction Tool and Scoring Methodology

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

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

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

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

Interrater Reliability—(IRR)

In order to ensure accuracy of the reviews, HSAG conducted IRR on all review team members. The IRR reviews were conducted by the HSAG Senior Project Manager for 10% of all records completed by each individual reviewer, via over-read of cases to ensure consistency of responses on all scored elements. An accuracy rate of 95% was required, with retraining completed if required. Reviews were completed across all review quarters, waivers, program types, and health plans to ensure continued compliance to the 95% accuracy rate standard. All members of the HSAG review team maintained a rate above 95% during SFY20.

Remediation Actions & Tracking

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

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

Remediation Validation

HFS was committed to ensuring that remediation actions were completed and that the health, safety, and welfare of enrollees was maintained. HSAG will complete remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. The results of the remediation validation reviews are reported in Section 3 of this report.

3. MMAI Overall Summary of Record Review Findings for SFY20

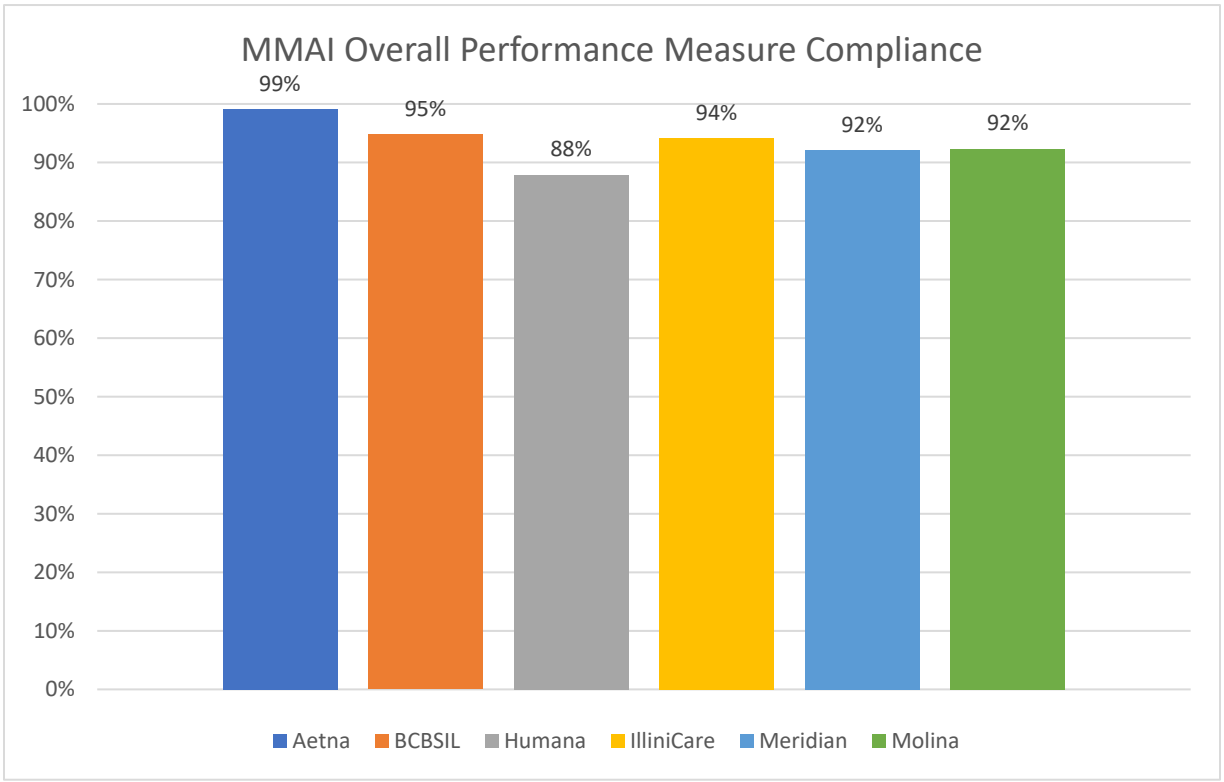
Overall Performance

Overall Health Plan Performance and Comparisons

Six health plans were reviewed during SFY 2020. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG) during SFY 2020. Displaying each health plan's overall average on the 15 Home and Community-Based Services (HCBS) CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans.

Five of the six health plans averaged greater than 90 percent overall compliance in SFY 2020. There was an 11-percentage point difference (88% to 99%) among health plans.

Figure 3.1 – Overall Compliance



Statistical significance testing was also performed to compare each health plan's average overall compliance against all other health plans, and the following differences were identified:

- Aetna performed at a statistically significant higher rate than all other health plans.
- Humana performed at a statistically significant lower rate than all other health plans.
- BCBSIL performed at a statistically significant higher rate than Meridian and Molina.
- IlliniCare performed at a statistically significant higher rate than Meridian.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Health plan-specific performance on all performance measures by quarter is included in Appendix C. Individual health plan performance analysis identified the following.

Aetna Better Health (Aetna)

Aetna demonstrated stable overall performance from Q1 to Q4 SFY 2019. Compared to SFY 2019, Aetna realized a statistically significant increase in overall performance in SFY 2020 (+1 percentage point, p=0.0087).

Analysis identified that Aetna performed at greater than 90 percent compliance for all 14 measures with applicable records during SFY 2020; one measure, 4A, did not have any applicable records. Aetna also performed at greater than 90 percent compliance for 14 of 15 measures in SFY 2019. Data will continue to be monitored to ensure performance is sustained.

Blue Cross Blue Shield of Illinois (BCBSIL)

BCBSIL demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in overall performance in SFY 2020 (+6 percentage points, p=<0.0001). BCBSIL also realized statistically significant increases in seven measures from SFY 2019 to SFY 2020.

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 21 percent (7 of 33 records). BCBSIL also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 87 percent; BCBSIL realized a statistically significant increase in performance for measure 39D, with a resulting increase of 24 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Humana Health Plan, Inc. (Humana)

Humana realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, Humana demonstrated stable overall performance in SFY 2020.

Analysis identified that Humana's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 35 percent (6 of 17 records). Humana also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 56 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

IlliniCare Health Plan, Inc. (IlliniCare)

IlliniCare demonstrated a statistically significant decrease in overall performance from Q1 to Q4 SFY 2020, but realized a statistically significant improvement from SFY 2019 to SFY 2020 (+5 percentage points, p=<0.0001). IlliniCare also realized statistically significant increases in three measures, and demonstrated a statistically significant decrease in three measures, from SFY 2019 to SFY 2020.

Analysis identified that IlliniCare's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 36 percent (4 of 11 records). IlliniCare also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 77 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Meridian Health Plan, Inc. (Meridian)

Meridian realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, Meridian realized a statistically significant increase in overall performance in SFY 2020 (+2 percentage points, p=0.0286). Meridian also realized a statistically significant increase in one measure from SFY 2019 to SFY 2020.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 50 percent (8 of 16 records). Meridian also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 73 percent, which demonstrated performance of 80 percent; Meridian realized a statistically significant increase in performance for measure 39D, with a resulting increase of 19 percentage points year-over-year. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Molina Healthcare of Illinois, Inc. (Molina)

Molina demonstrated a statistically significant decrease in overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, Molina demonstrated stable overall performance in SFY 2020. Molina also demonstrated a statistically significant decrease in one measure from SFY 2019 to SFY 2020.

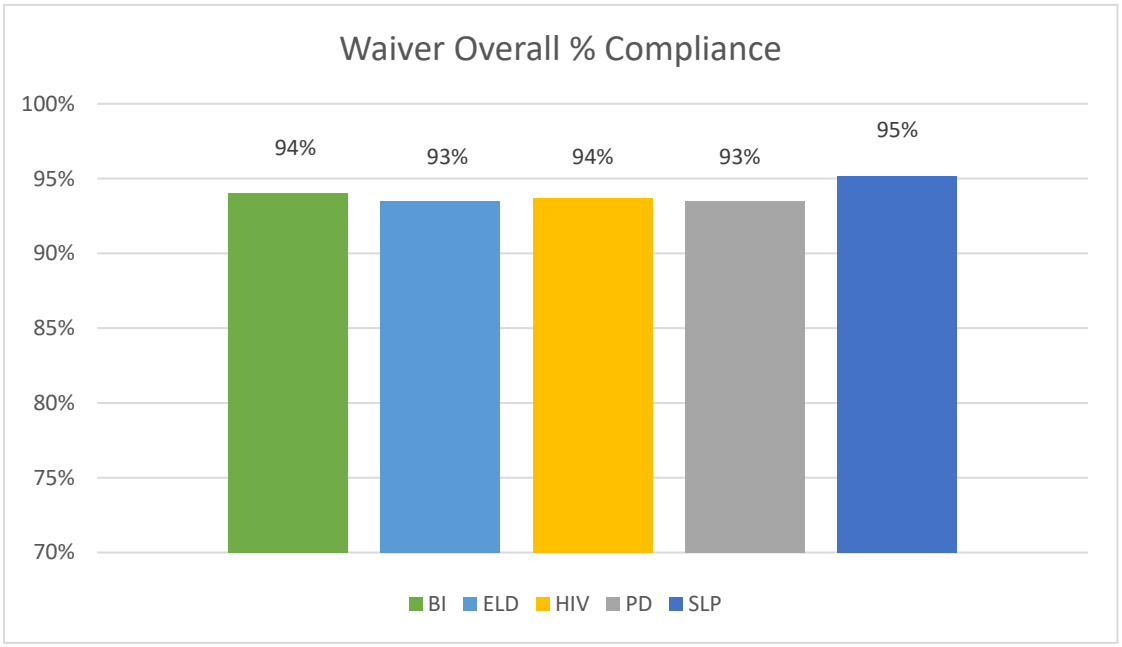
Analysis identified that Molina's greatest opportunity for improvement related to measure 4A, overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 43 percent (3 of 7 records). Molina also had opportunity for improvement in measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which demonstrated performance of 71 percent. Further analysis related to these measures is included in the analysis of lowest-performing measure in this report section.

Performance by Waiver Type

Comparisons were also analyzed by waiver type, to determine differences and improvement opportunities that may be waiver-specific, as opposed to health plan-specific. Appendix D displays waiver compliance per performance measure by quarter.

As Figure 3.2 displays below, all five waiver types averaged greater than 90 percent overall compliance in SFY 2020.

Figure 3.2—Overall Compliance Across Waiver Types



Statistical significance testing was also performed to compare each waiver's average overall compliance against all other waiver types, and the following differences were noted:

- The SLP waiver performed at a statistically significant higher rate than the ELD and PD waivers.

Differences between some waiver types may be attributable to different waiver requirements:

- BI, HIV, and PD waiver records are applicable to 12 of the 15 performance measures.
- SLP waiver records are applicable to 10 of the 15 performance measures.
- The ELD and PD waivers have different requirements for contact (annual) than the BI and HIV waivers (monthly), which may result in different performance in measure 36D.

Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver type's overall compliance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020. Individual waiver performance analysis identified the following.

BI Waiver

The BI waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the BI waiver realized a statistically significant increase in overall performance in SFY 2020 (+8 percentage points, p=<0.0001). The BI waiver also realized a statistically significant increase in three measures in SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 36D, the case manager made valid contact with the enrollee once a month or valid justification is documented in the enrollee's record, which performed at a rate of 75 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 82 percent compliance.

ELD Waiver

The ELD waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the ELD waiver realized a statistically significant increase in overall performance in SFY 2020 (+2 percentage points, p=<0.0001). The ELD waiver also realized statistically significant increases in two measures in SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 40 percent compliance.

- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 68 percent compliance.

HIV Waiver

The HIV waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the HIV waiver realized a statistically significant increase in overall performance in SFY 2020 (+4 percentage points, p=0.0013). The HIV waiver also realized a statistically significant increase in one measure in SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 0 (0 of 2 records) percent compliance.
- Measure 36D, the case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record, which performed at a rate of 70 percent compliance.

PD Waiver

The PD waiver realized a statistically significant increase in overall performance from Q1 to Q4 SFY 2020, as well as from SFY 2019 to SFY 2020 (+4 points, p=<0.0001). The PD waiver also realized a statistically significant decrease in four following measures from SFY 2019 to SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 27 percent compliance.
- Measure 39D, services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan, which performed at a rate of 72 percent compliance.

SLP Waiver

The SLP waiver demonstrated stable overall performance from Q1 to Q4 SFY 2020. Compared to SFY 2019, the SLP waiver realized a statistically significant increase in overall performance in SFY 2020 (+2 percentage points, p=0.0059). The SLP waiver demonstrated a statistically significant decrease in one measure in SFY 2020.

Analysis identified that the greatest opportunities for improvement related to:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, which performed at a rate of 0 percent compliance (0 of 1 record).
- Measure 37D, the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 85 percent compliance.

Performance was analyzed for the subset of SLP waiver members enrolled in the dementia care program. Results are identified in Table 3.1.

Table 3.1—SLP Dementia Care: Compliance with CMS Performance Measures

Measure	Measure Text	FY2019	FY2020
4A	*Overdue service plan was completed within 30 days of expected renewal.*	NA (0/0)	NA (0/0)
31D	*The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)
32D	*The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)
33D	*The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.*	100% (11/11)	100% (8/8)
35D	*The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	91% (10/11)	100% (8/8)
37D	*The most recent service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)*	100% (11/11)	63% (5/8)
38D	*The service plan was updated when the enrollee needs changed.*	0% (0/1)	NA (0/0)
39D	*Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	100% (11/11)	100% (8/8)
41D	*The enrollee has been given the opportunity to participate in choosing types of services and providers.*	100% (11/11)	100% (8/8)
42G	*The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	100% (11/11)	88% (7/8)

Performance by Measure

Comparisons were also analyzed by performance measure. Trending analysis graphs are included in Appendix B.

Table 3.2—Analysis of CMS Performance Measure Compliance

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis**
4A *Overdue service plan was completed within 30 days of expected renewal.*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. The ELD waiver realized a statistically significant	Compared to SFY 2019, this measure demonstrated stable performance in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis**
	increase in performance from Q1 to Q4. This measure was the lowest-performing, averaging 33% over SFY 2019.	
31D *The most recent care/service plan includes all enrollee goals as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the ELD and PD waiver realized a statistically significant increase in this measure in SFY 2020.
32D *The most recent care/service plan includes all enrollee needs as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. BCBSIL realized a statistically significant increase in this measure from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020.
33D *The most recent care/service plan includes all enrollee risks as identified in the comprehensive assessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4. BCBSIL realized a statistically significant increase in this measure from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020.
34D *(ELD waiver)* *The enrollee reported he/she received the services he/she needed when he/she needed them.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable performance in SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis**
35D *The most recent care/service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure demonstrated stable performance in SFY 2020. Compared to SFY 2019, Molina demonstrated a statistically significant decrease in this measure in SFY 2020. Compared to SFY 2019, the SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2020.
36D *PD and ELD Waiver – The case manager made annual contact with the enrollee or there is valid justification in the record.* *HIV Waiver—The case manager made valid contact with the enrollee once a month, with a face-to-face contact bi-monthly, or valid justification is documented in the enrollee's record. (after March 2014)** *BI Waiver—The case manager made valid contact with the enrollee at least once a month, or valid justification is documented in the enrollee's record.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and IlliniCare realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the BI and PD waiver realized a statistically significant increase in this measure in SFY 2020.
37D *PD, HIV, ELD, and SLF Waivers—The most recent care/service plan is in the record and completed in a timely manner. (Completed within 12 months from review date)* *BI Waiver—The most recent care/service plan is in the record and completed in a timely manner. (Completed within six months from review date)*	Overall, this measure demonstrated stable performance from Q1 to Q4. The SLP waiver demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL and IlliniCare realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the BI and PD waiver realized a statistically significant increase in this measure in SFY 2020.
38D *The care/service plan was updated when the enrollee needs changed.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Overall, this measure demonstrated stable performance from SFY 2019 to SFY 2020.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2020 Analysis**	**Trend Analysis**
39D *Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. Meridian realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL, IlliniCare, and Meridian realized a statistically significant increase in this measure in SFY 2020. Compared to SFY 2019, the BI, ELD, HIV, and PD waiver realized a statistically significant increase in this measure in SFY 2020.
40D *(ELD waiver)* *The enrollee reported he/she received all services listed in the plan of care.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Overall, this measure demonstrated stable performance from SFY 2019 to SFY 2020.
41D *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Overall, this measure demonstrated stable performance from SFY 2019 to SFY 2020.
42G *The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Overall, this measure demonstrated stable performance from SFY 2019 to SFY 2020.
44G *(ELD waiver)* *The enrollee reported he/she was being treated well by direct support staff.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Overall, this measure demonstrated stable performance from SFY 2019 to SFY 2020.
49G *(BI, HIV, PD Waivers)* *The most recent care/service plan includes the name of the backup personal assistant (PA) service (if receiving PA).*	Overall, this measure demonstrated stable performance from Q1 to Q4. BCBSIL realized a statistically significant increase in performance from Q1 to Q4. Molina demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2019, this measure realized a statistically significant increase in overall performance in SFY 2020. Compared to SFY 2019, BCBSIL realized a statistically significant increase in this measure in SFY 2020.

Analysis of Lowest-Performing Measure

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

- Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, which averaged 33 percent compliance during SFY 2020.
- Measure 39D, *services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan*, which averaged 80 percent compliance during SFY 2020.

Health plans also had opportunity for improvement in the BI and HIV waivers related to measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, which averaged 75 percent and 70 percent compliance, respectively, during SFY 2020.

Measure 4A

This measure is only applicable to records in which there was an overdue service plan. Health plans should make efforts to ensure that overdue service plans are completed within 30 days of expected renewal.

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing waiver service plan renewals in a timely manner. Health plans should also make efforts to ensure that overdue service plans are completed within 30 days of expected renewal. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals.

Measure 39D

During record review, measure 39D was collected by validating the services identified on the waiver service plan against claims.

Performance during SFY 2020 was analyzed to determine any health plan-specific differences, and the following were identified:

- Aetna performed at a statistically significant higher rate than all other health plans.
- BCBSIL performed at a statistically significant higher rate than Humana, IlliniCare, Meridian, and Molina.
- Humana performed at a statistically significant lower rate than all other health plans.

Performance was also analyzed across waiver types:

- The SLP waiver performed at a statistically significant higher rate than all other waiver types. Higher performance is expected for the SLP waiver, as claims review validates that the beneficiary maintains the SLP as his/her permanent residence.
- The BI and HIV waivers performed at a statistically significant higher rate than the ELD and PD waivers.

Analysis was performed to determine if there were any waiver service types that contributed to performance on measure 39D. Of the non-compliant records, non-compliant homemaker services and non-compliant personal assistant services represented the greatest opportunity for improvement.

The health plans were encouraged to ensure that they had a process to complete waiver service validation on an ongoing basis. Health plans may consider focusing on beneficiaries with homemaker and personal assistant services to ensure that waiver services are provided per the service plan and that homemaker agencies and personal assistants are appropriately educated to ensure compliance to the service plan.

Measure 36D

Performance on measure 36D was stable during SFY 2020 and when SFY 2020 performance is compared against SFY 2019. During SFY 2020, performance on measure 36D for the BI waiver resulted in a rate of 75 percent. Performance related to the HIV waiver resulted in a rate of 70 percent.

Each waiver type has a different requirement for contact, ranging from once a month to annually. A health plan may be more successful maintaining annual contact rather than monthly contact; as a result, performance in 36D can be significantly different across waivers. The greater frequency of contact for the BI and HIV waivers may result in lower performance.

Health plans should conduct root cause analysis on their HIV and BI cases to determine opportunities to affect change in this measure. Analyses should include significant input from case managers/care coordinators managing HIV and BI waiver caseloads.

Remediation and Remediation Validation

Remediation

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

Remediation actions were defined in the MMAI and were specific to each CMS waiver performance measure. The timeframe for remediation of findings was 60 days, except for two measures, 42G and 49G, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. Compliance with timely remediation of these findings was monitored by HSAG through review of completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2020, all health plans demonstrated full compliance with completion of remediation action documentation for all non-compliant performance measures within 30 and 60 days, as required.

Remediation Validation

HSAG completed remediation validation semi-annually to determine if remediation actions were completed appropriately by the health plans. A random sample was drawn in two groupings: by health plan and by performance measure using only members for whom remediation actions were completed. For health plans with an initial sample of 32 cases or greater, a validation sample of 16 cases was completed. For health plans with an initial sample of less than 32 cases, the full validation sample was completed. Table 3.3 indicates the number of cases reviewed per health plan.

Table 3.3— Health Plans Remediation Validation Review Totals

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
Aetna	9/9	7/7
BCBSIL	17/17	10/10
Humana	32/32	28/32
IlliniCare	14/16	1/6
Meridian	14/14	5/5
Molina	20/20	13/13

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

Overall remediation validation among the six MMAI health plans cases averaged 94 percent. Four of the six health plans demonstrated 100 percent compliance with remediation validation. Humana and

IlliniCare did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database, did not demonstrate sufficient training content to validate completion of remediation actions, or documentation was unable to be located to validate remediation. HSAG provided technical assistance regarding expectations for correct entry of remediation dates and for training content specific to the performance measures.

Remediation validation reviews will continue in SFY 2021 and will include review of any records that were found to be not fully remediated during the SFY 2020 reviews.

Appendix A. CMS Performance Measures Description

Table A.1 provides a description of each Centers for Medicare & Medicaid Services (CMS) performance measure, including the identification of waiver-specific measures.

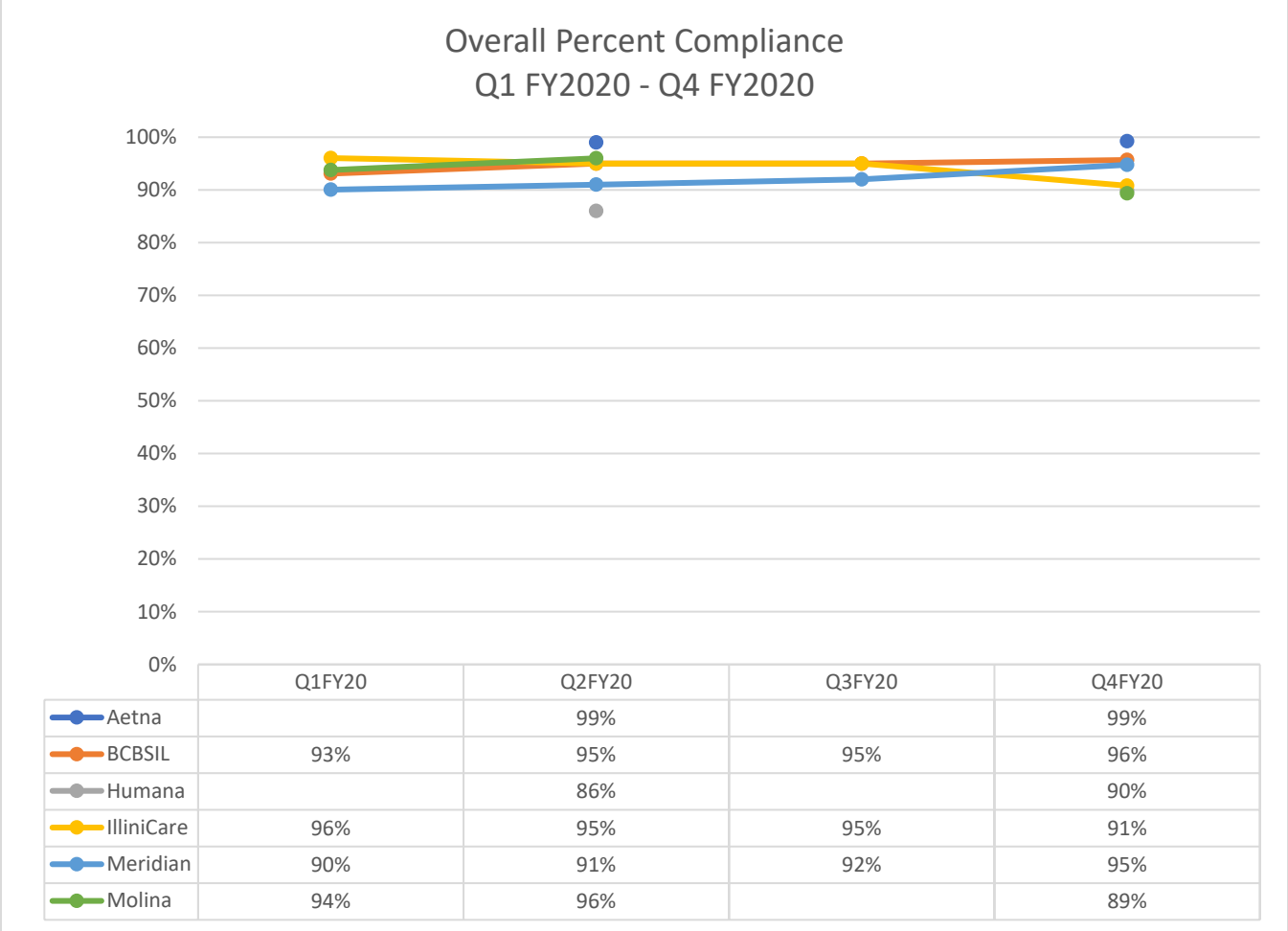
Table A.1—CMS Waiver Performance Measure Descriptions

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

Overall Trend Performance

Figure B.1 displays a computed average of the performance achieved by each health plan on all 15 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.1 – Overall Compliance



	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna		99%		99%
BCBSIL	93%	95%	95%	96%
Humana		86%		90%
IlliniCare	96%	95%	95%	91%
Meridian	90%	91%	92%	95%
Molina	94%	96%		89%

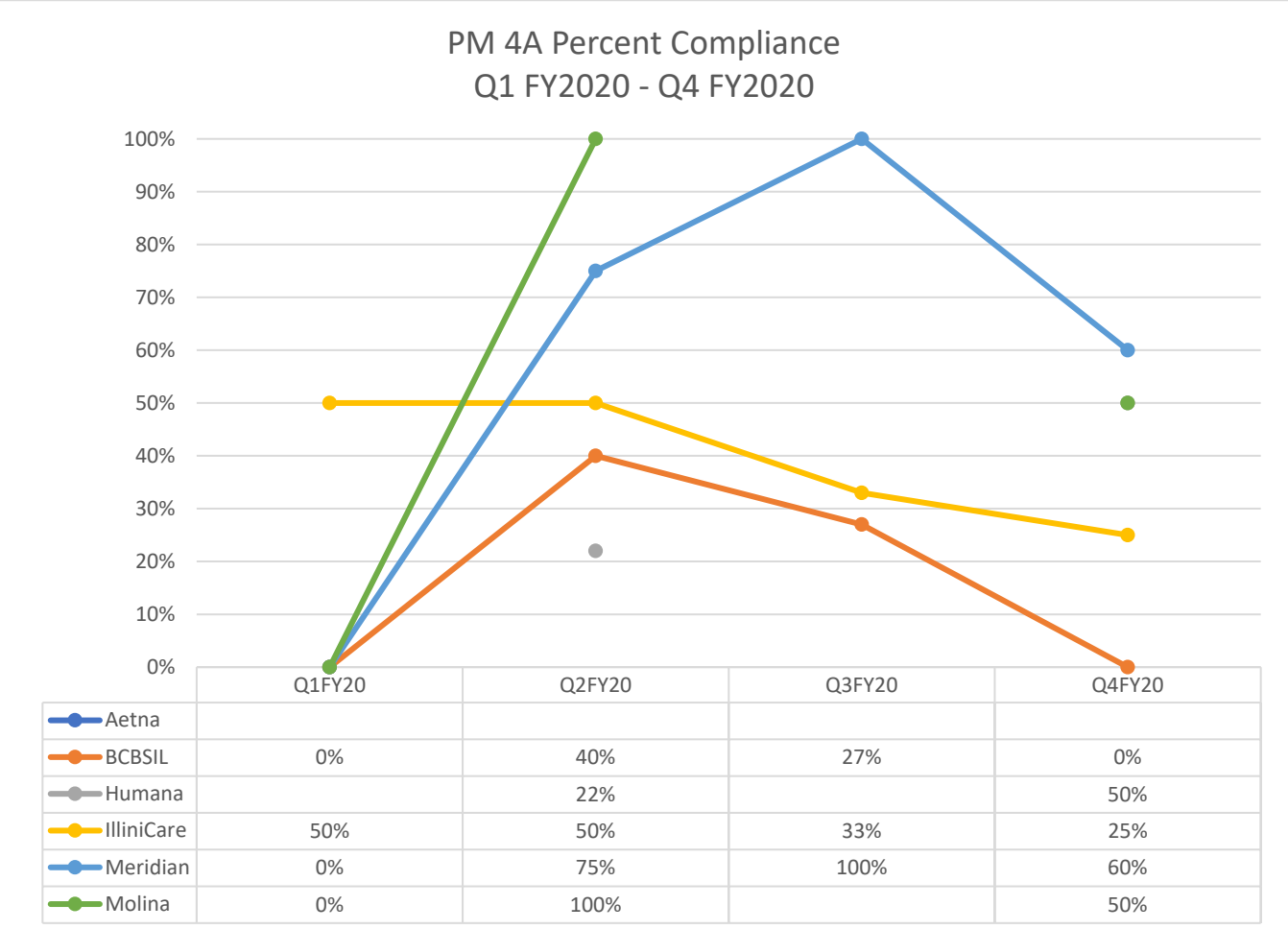
Note: Blank cells represent quarters in which the health plan was not reviewed.

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal. (ELD, HIV, and PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.2 – Measure 4A

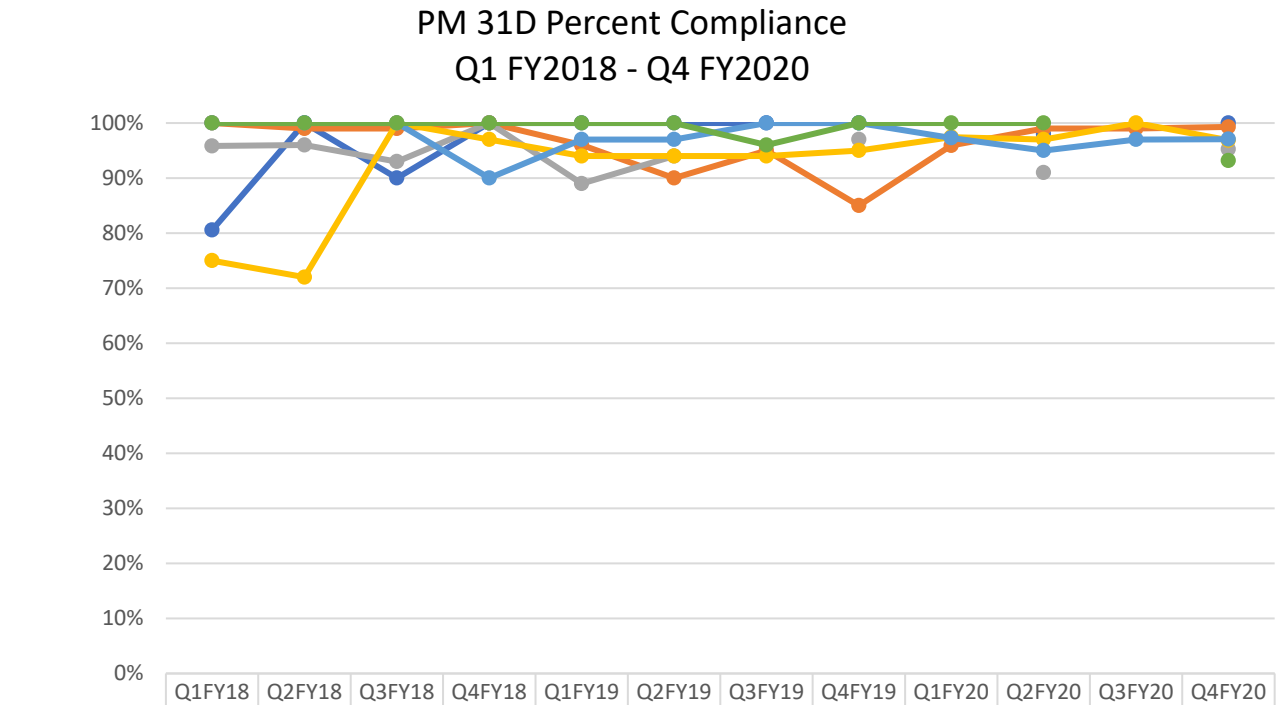


	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna				
BCBSIL	0%	40%	27%	0%
Humana		22%		50%
IlliniCare	50%	50%	33%	25%
Meridian	0%	75%	100%	60%
Molina	0%	100%		50%

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 31D - The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.

Figure B.3 – Measure 31D

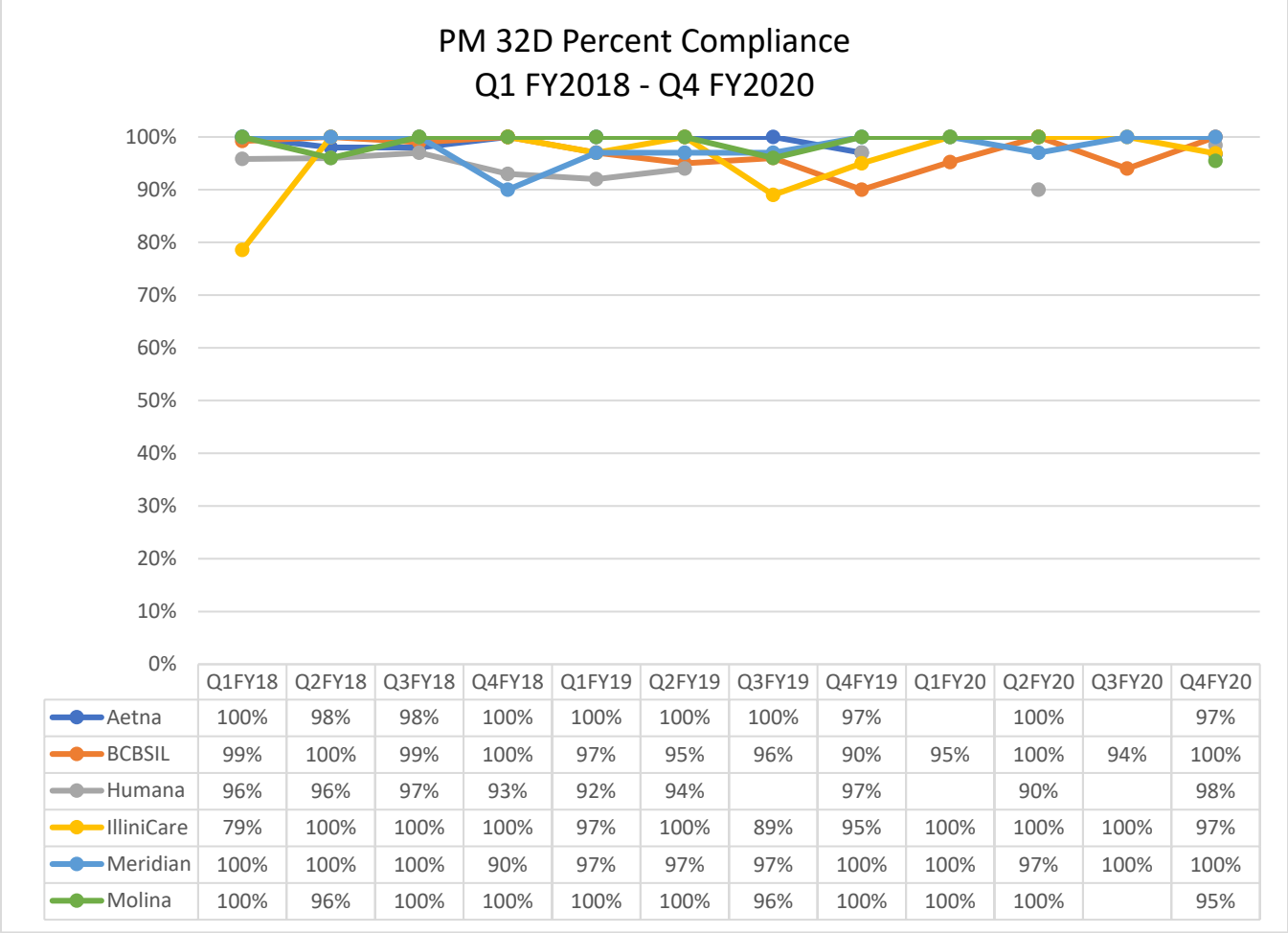


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	81%	100%	90%	100%	100%	100%	100%	100%		98%		100%
BCBSIL	100%	99%	99%	100%	96%	90%	95%	85%	96%	99%	99%	99%
Humana	96%	96%	93%	100%	89%	94%		97%		91%		95%
IlliniCare	75%	72%	100%	97%	94%	94%	94%	95%	97%	97%	100%	97%
Meridian	100%	100%	100%	90%	97%	97%	100%	100%	97%	95%	97%	97%
Molina	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%		93%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 32D - The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.

Figure B.4 – Measure 32D

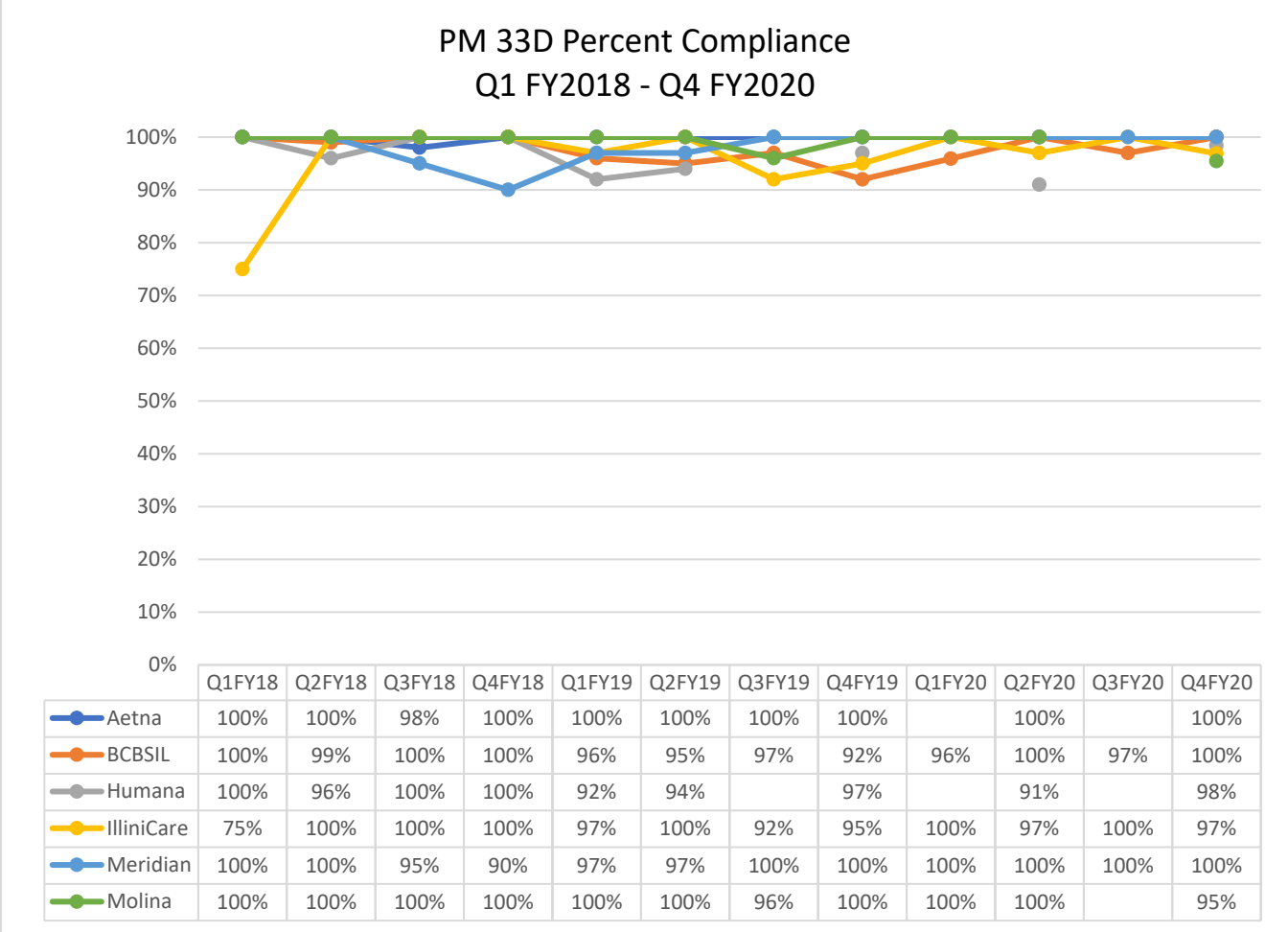


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	98%	98%	100%	100%	100%	100%	97%		100%		97%
BCBSIL	99%	100%	99%	100%	97%	95%	96%	90%	95%	100%	94%	100%
Humana	96%	96%	97%	93%	92%	94%		97%		90%		98%
IlliniCare	79%	100%	100%	100%	97%	100%	89%	95%	100%	100%	100%	97%
Meridian	100%	100%	100%	90%	97%	97%	97%	100%	100%	97%	100%	100%
Molina	100%	96%	100%	100%	100%	100%	96%	100%	100%	100%		95%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 33D - The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.

Figure B.5 – Measure 33D

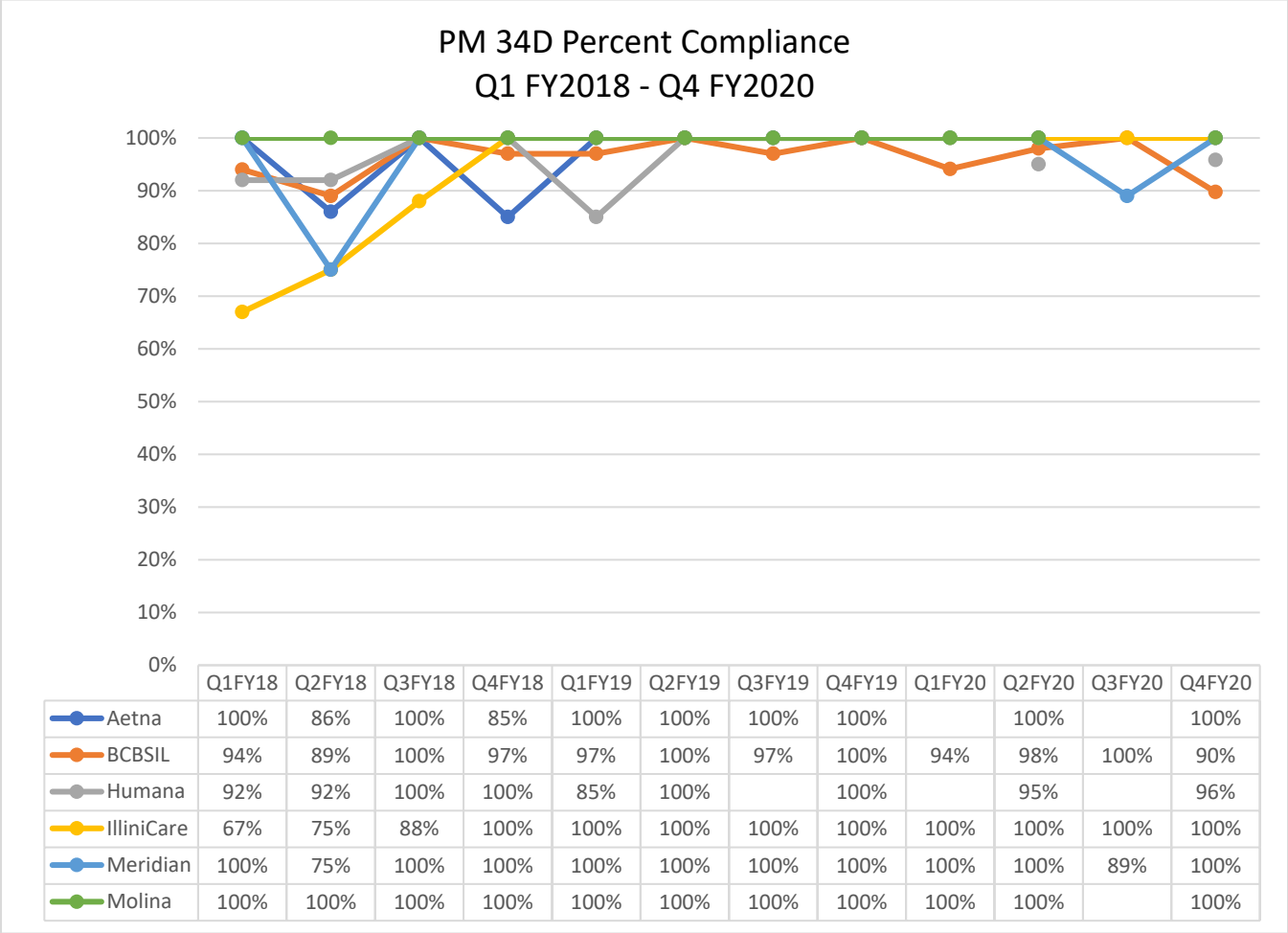


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	100%	98%	100%	100%	100%	100%	100%		100%		100%
BCBSIL	100%	99%	100%	100%	96%	95%	97%	92%	96%	100%	97%	100%
Humana	100%	96%	100%	100%	92%	94%		97%		91%		98%
IlliniCare	75%	100%	100%	100%	97%	100%	92%	95%	100%	97%	100%	97%
Meridian	100%	100%	95%	90%	97%	97%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%		95%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 34D - The enrollee reported he/she received the services he/she needed when he/she needed them. (ELD waiver only)

Figure B.6 – Measure 34D

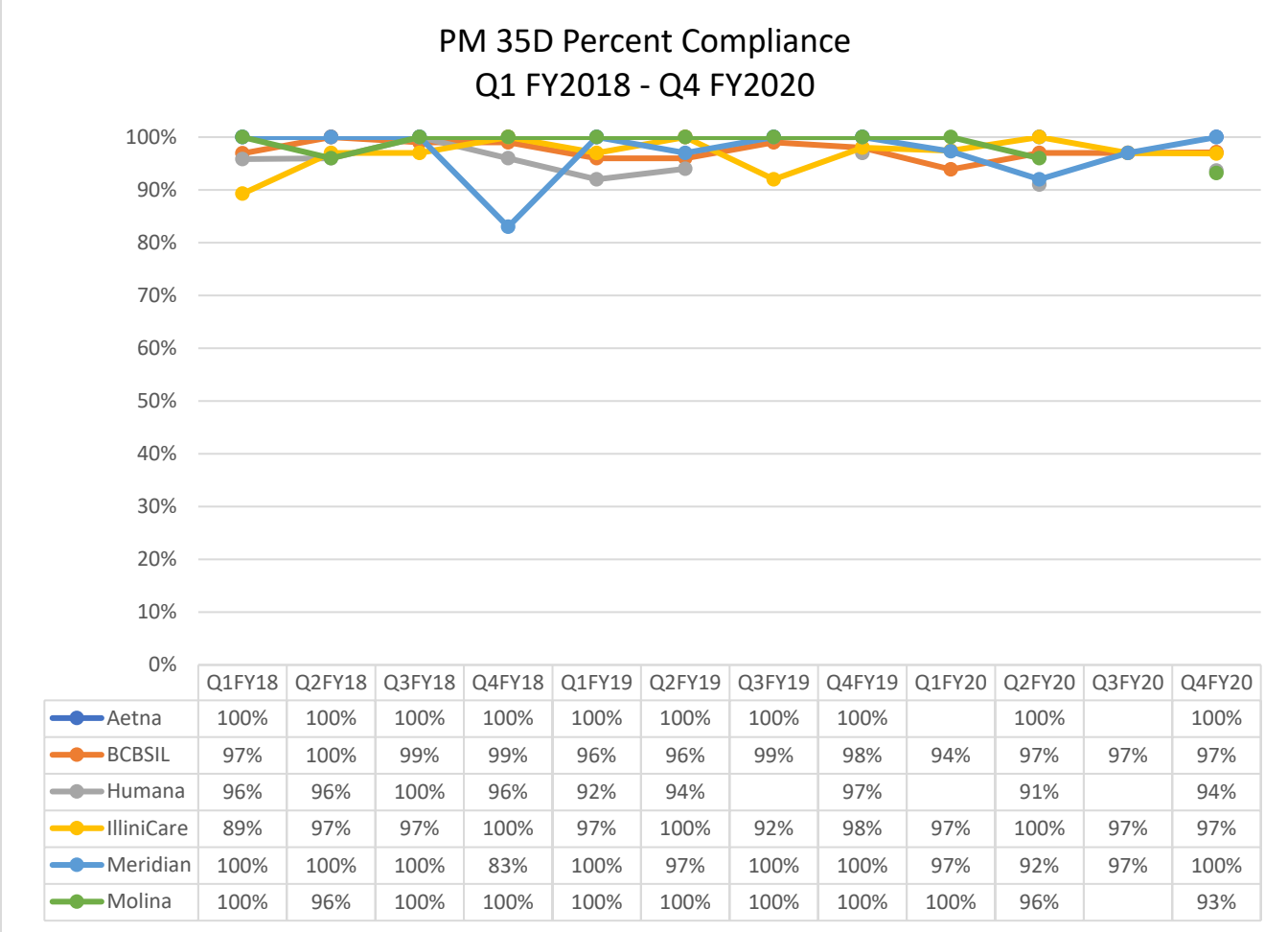


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	86%	100%	85%	100%	100%	100%	100%		100%		100%
BCBSIL	94%	89%	100%	97%	97%	100%	97%	100%	94%	98%	100%	90%
Humana	92%	92%	100%	100%	85%	100%		100%		95%		96%
IlliniCare	67%	75%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Meridian	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 35D - The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.

Figure B.7 – Measure 35D



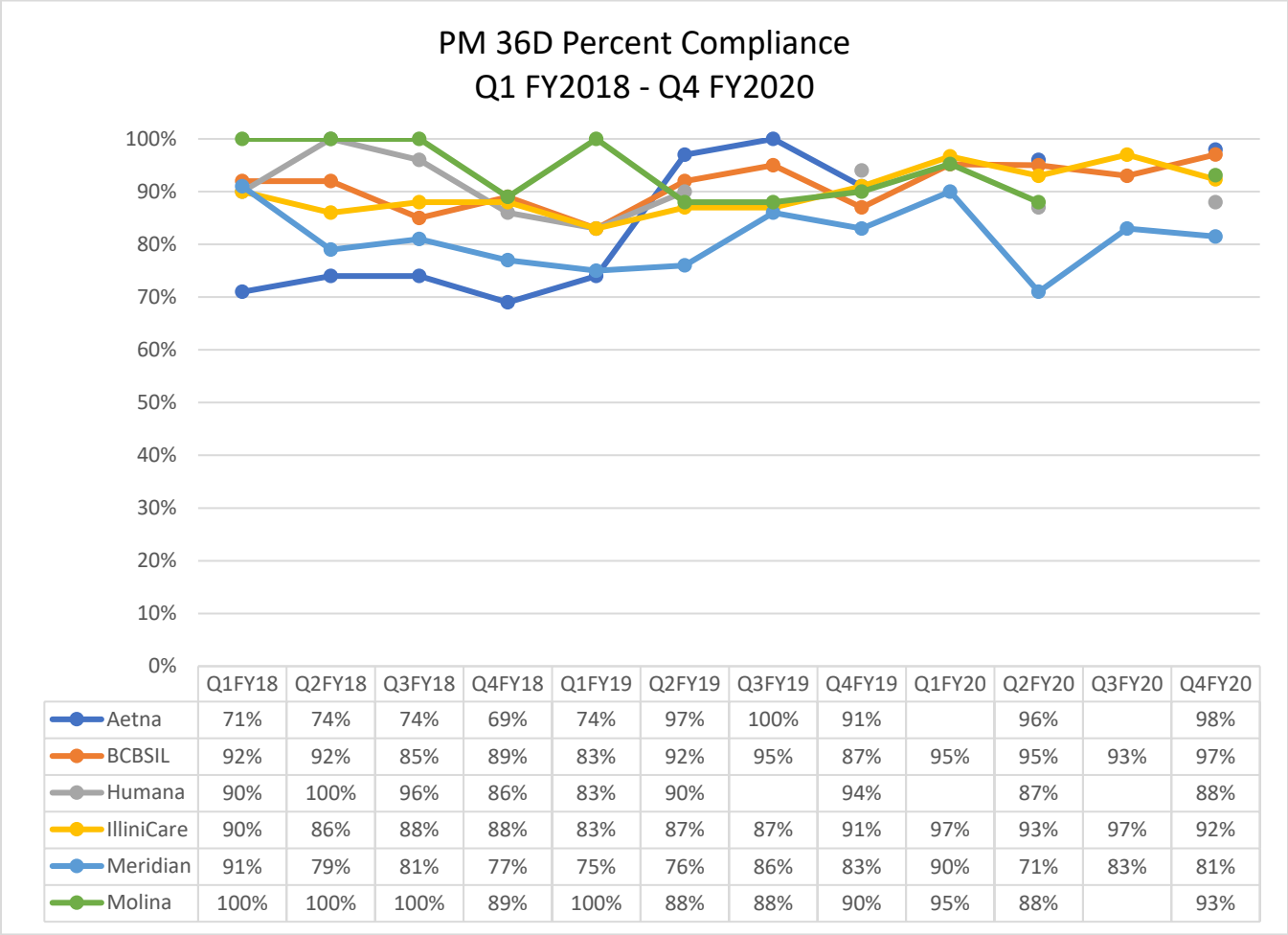
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	100%	100%	100%	100%	100%	100%	100%		100%		100%
BCBSIL	97%	100%	99%	99%	96%	96%	99%	98%	94%	97%	97%	97%
Humana	96%	96%	100%	96%	92%	94%		97%		91%		94%
IlliniCare	89%	97%	97%	100%	97%	100%	92%	98%	97%	100%	97%	97%
Meridian	100%	100%	100%	83%	100%	97%	100%	100%	97%	92%	97%	100%
Molina	100%	96%	100%	100%	100%	100%	100%	100%	100%	96%		93%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 36D - the Case Manager made valid timely contact or valid justification is documented in the enrollee's record.

HIV: One contact per month, with one contact face-to-face bi-monthly.
BI: Monthly contact.
PD: Annual contact.
ELD: Annual contact
SLP records are not eligible for this measure

Figure B.8 – Measure 36D



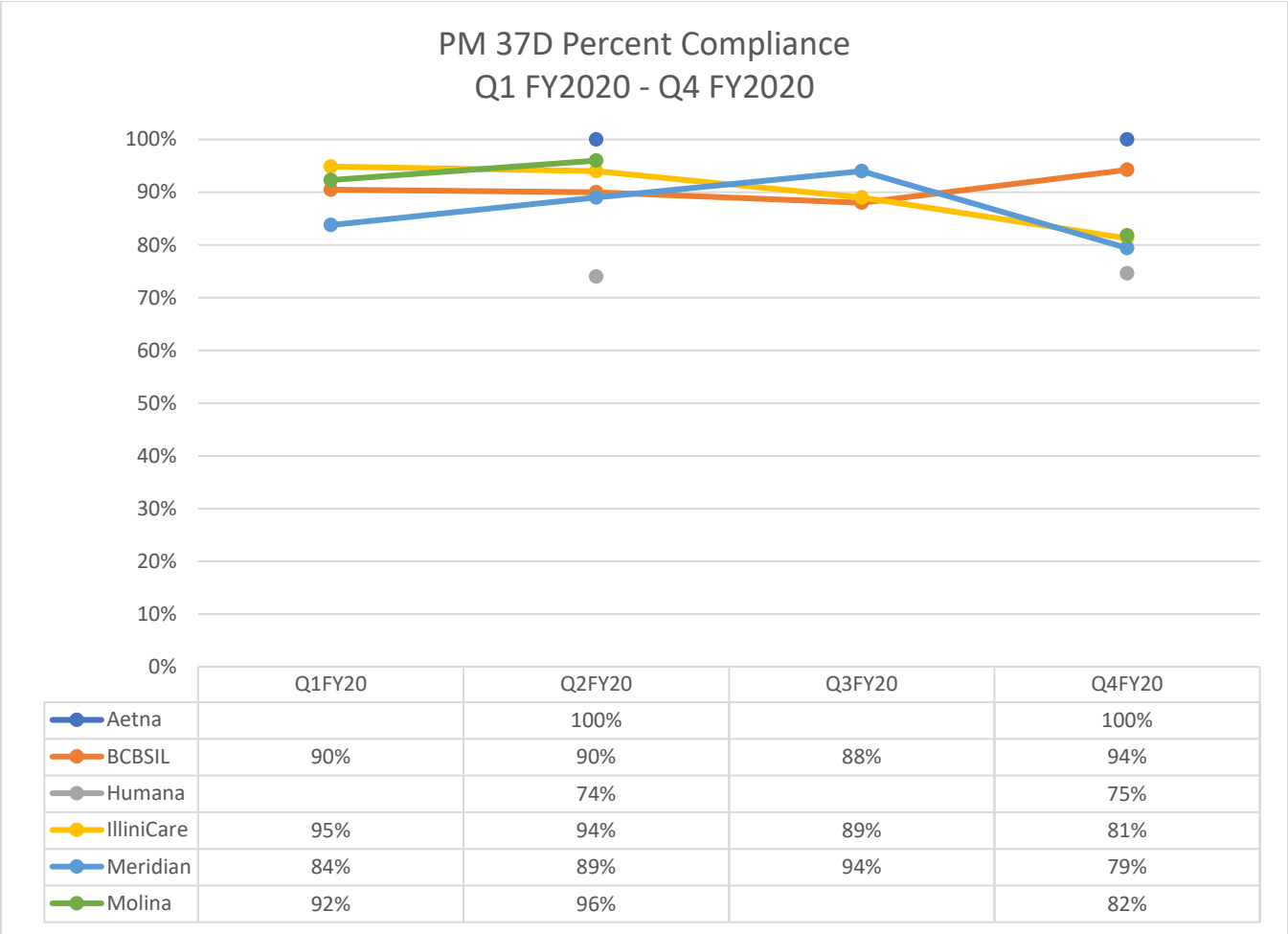
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	71%	74%	74%	69%	74%	97%	100%	91%		96%		98%
BCBSIL	92%	92%	85%	89%	83%	92%	95%	87%	95%	95%	93%	97%
Humana	90%	100%	96%	86%	83%	90%		94%		87%		88%
IlliniCare	90%	86%	88%	88%	83%	87%	87%	91%	97%	93%	97%	92%
Meridian	91%	79%	81%	77%	75%	76%	86%	83%	90%	71%	83%	81%
Molina	100%	100%	100%	89%	100%	88%	88%	90%	95%	88%		93%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 37D - The most recent service plan is in the record and completed in a timely manner (annually).

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.9 – Measure 37D

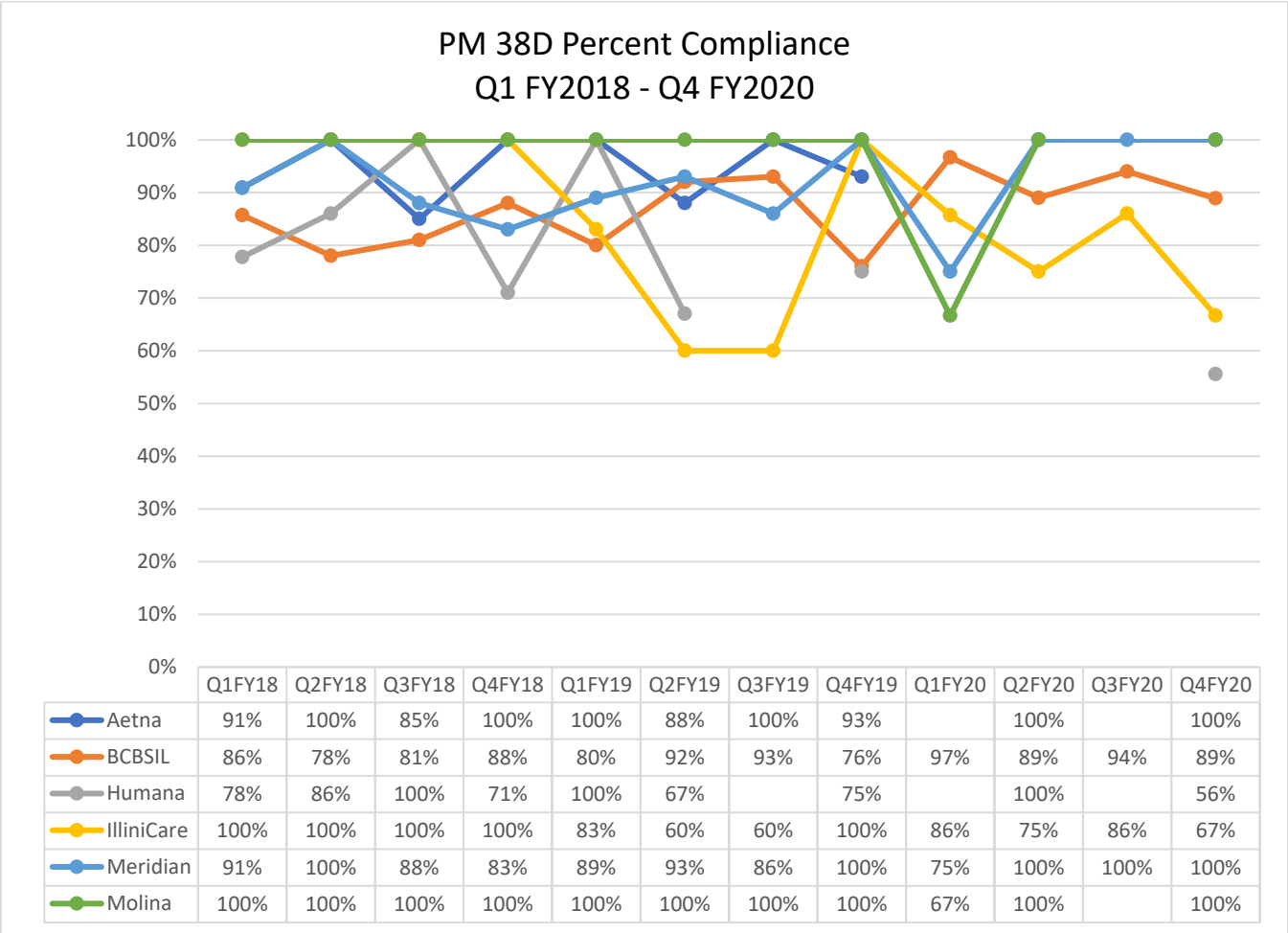


	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna		100%		100%
BCBSIL	90%	90%	88%	94%
Humana		74%		75%
IlliniCare	95%	94%	89%	81%
Meridian	84%	89%	94%	79%
Molina	92%	96%		82%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 38D - The service plan was updated when the enrollee needs changed.

Figure B.10 – Measure 38D

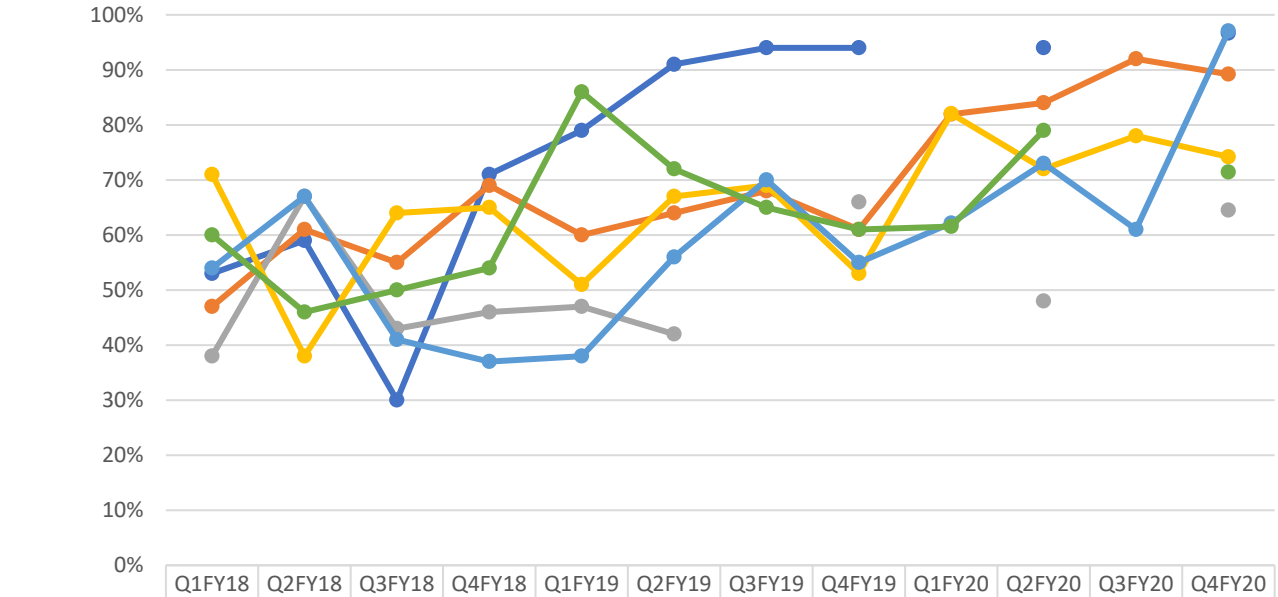


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	91%	100%	85%	100%	100%	88%	100%	93%		100%		100%
BCBSIL	86%	78%	81%	88%	80%	92%	93%	76%	97%	89%	94%	89%
Humana	78%	86%	100%	71%	100%	67%		75%		100%		56%
IlliniCare	100%	100%	100%	100%	83%	60%	60%	100%	86%	75%	86%	67%
Meridian	91%	100%	88%	83%	89%	93%	86%	100%	75%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%		100%

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.
Data prior to FY2018 available in previous years' reports.

Measure 39D - Services were delivered in accordance with the waiver service plan, including the type, amount, frequency and scope specified in the waiver service plan.

Figure B.11 – Measure 39D

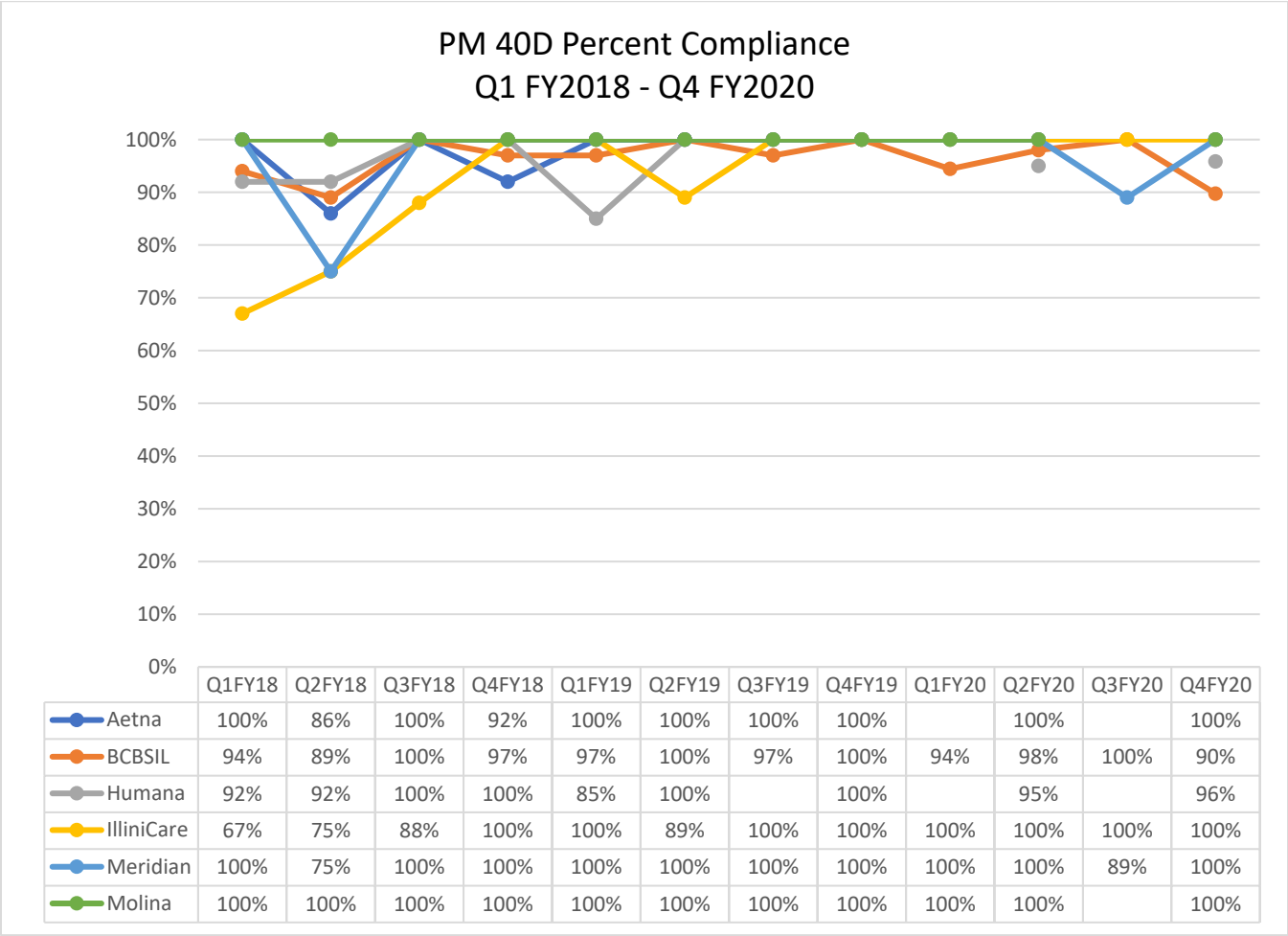


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	53%	59%	30%	71%	79%	91%	94%	94%		94%		97%
BCBSIL	47%	61%	55%	69%	60%	64%	68%	61%	82%	84%	92%	89%
Humana	38%	67%	43%	46%	47%	42%		66%		48%		65%
IlliniCare	71%	38%	64%	65%	51%	67%	69%	53%	82%	72%	78%	74%
Meridian	54%	67%	41%	37%	38%	56%	70%	55%	62%	73%	61%	97%
Molina	60%	46%	50%	54%	86%	72%	65%	61%	62%	79%		71%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 40D – The enrollee reported he/she received all services listed in the plan of care. (ELD waiver only)

Figure B.12 – Measure 40D

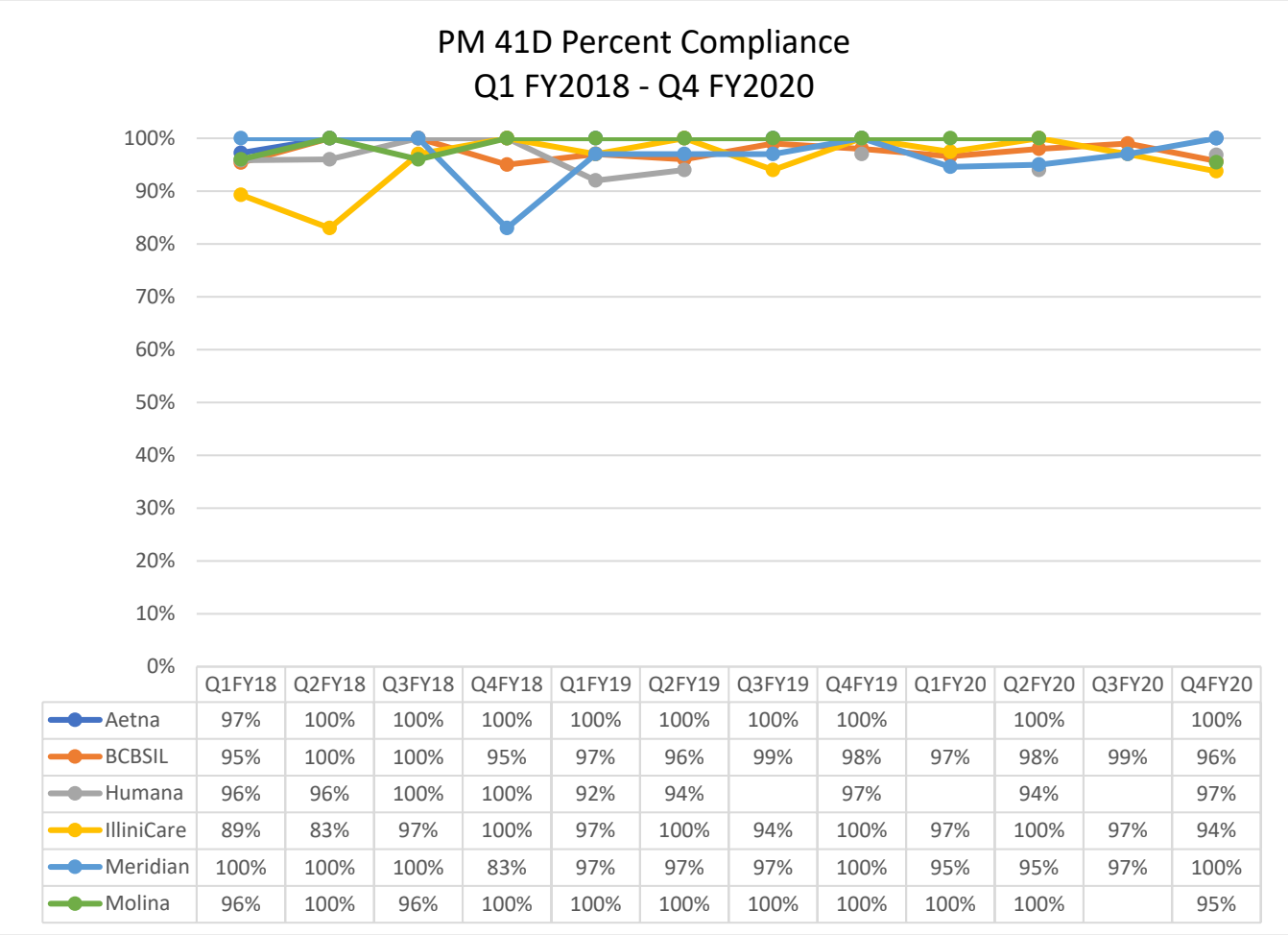


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	86%	100%	92%	100%	100%	100%	100%		100%		100%
BCBSIL	94%	89%	100%	97%	97%	100%	97%	100%	94%	98%	100%	90%
Humana	92%	92%	100%	100%	85%	100%		100%		95%		96%
IlliniCare	67%	75%	88%	100%	100%	89%	100%	100%	100%	100%	100%	100%
Meridian	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 41D - The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B.13 – Measure 41D

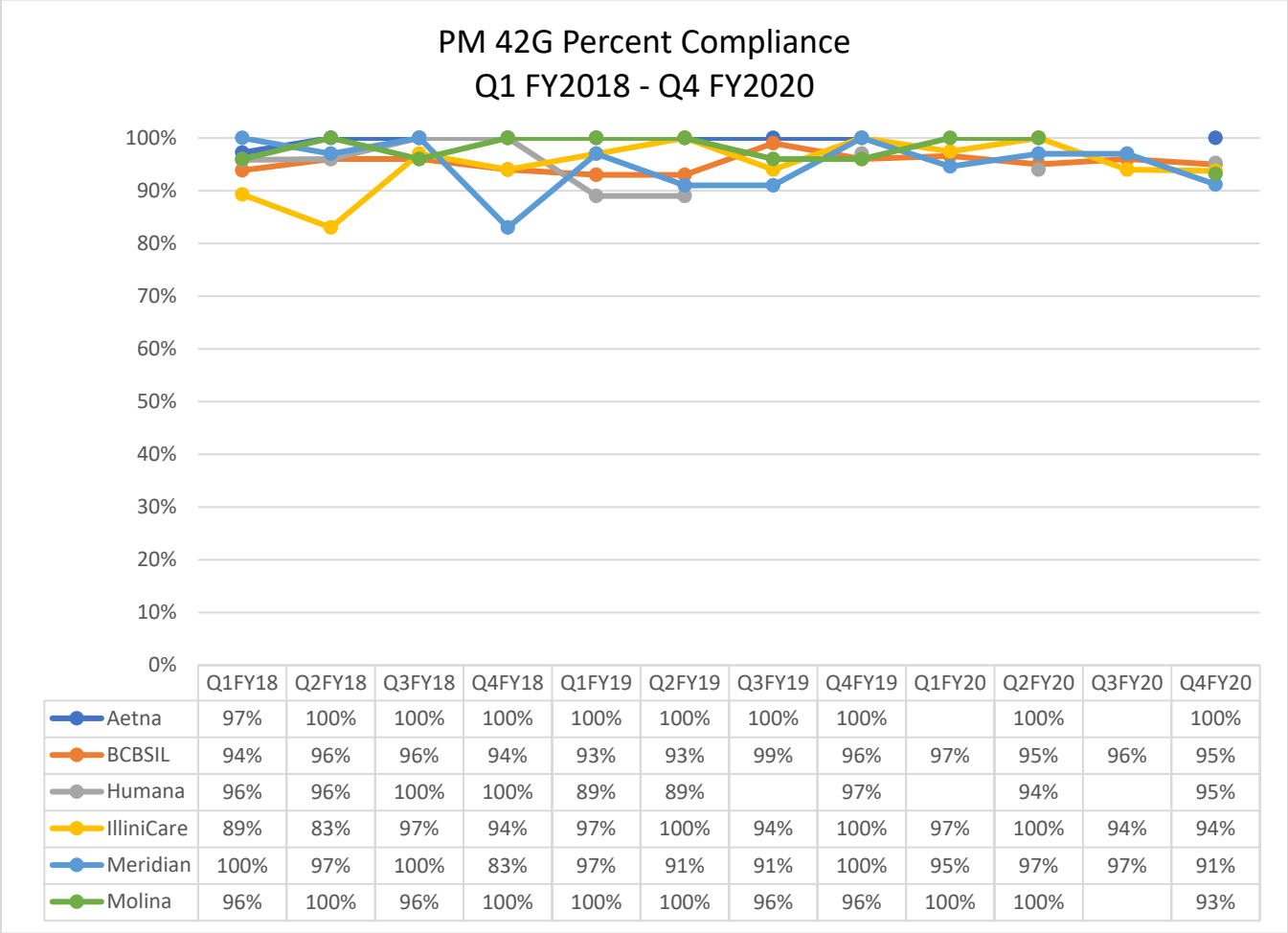


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	97%	100%	100%	100%	100%	100%	100%	100%		100%		100%
BCBSIL	95%	100%	100%	95%	97%	96%	99%	98%	97%	98%	99%	96%
Humana	96%	96%	100%	100%	92%	94%		97%		94%		97%
IlliniCare	89%	83%	97%	100%	97%	100%	94%	100%	97%	100%	97%	94%
Meridian	100%	100%	100%	83%	97%	97%	97%	100%	95%	95%	97%	100%
Molina	96%	100%	96%	100%	100%	100%	100%	100%	100%	100%		95%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 42G - The enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment.

Figure B.14 – Measure 42G

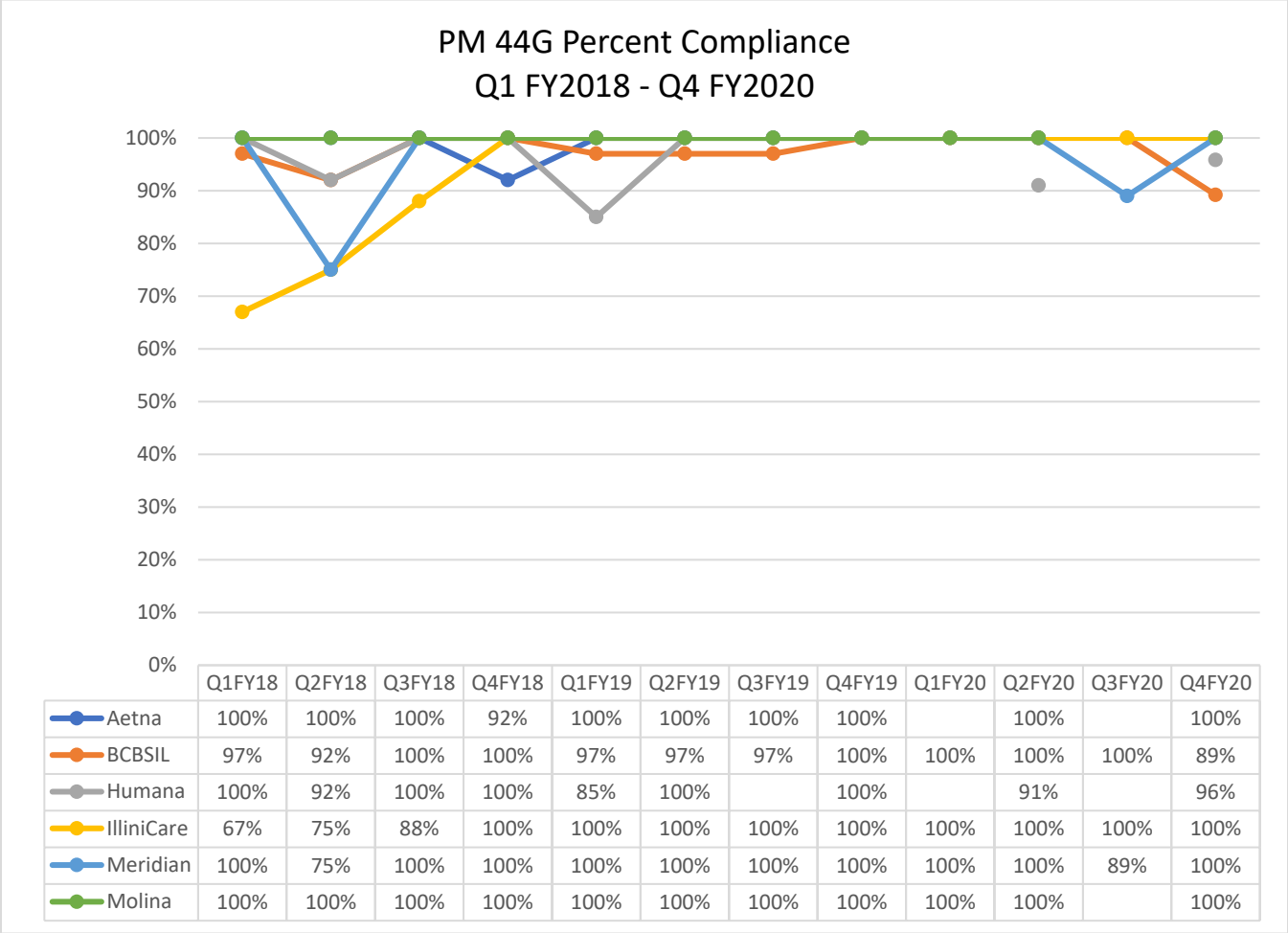


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	97%	100%	100%	100%	100%	100%	100%	100%		100%		100%
BCBSIL	94%	96%	96%	94%	93%	93%	99%	96%	97%	95%	96%	95%
Humana	96%	96%	100%	100%	89%	89%		97%		94%		95%
IlliniCare	89%	83%	97%	94%	97%	100%	94%	100%	97%	100%	94%	94%
Meridian	100%	97%	100%	83%	97%	91%	91%	100%	95%	97%	97%	91%
Molina	96%	100%	96%	100%	100%	100%	96%	96%	100%	100%		93%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.15 – Measure 44G



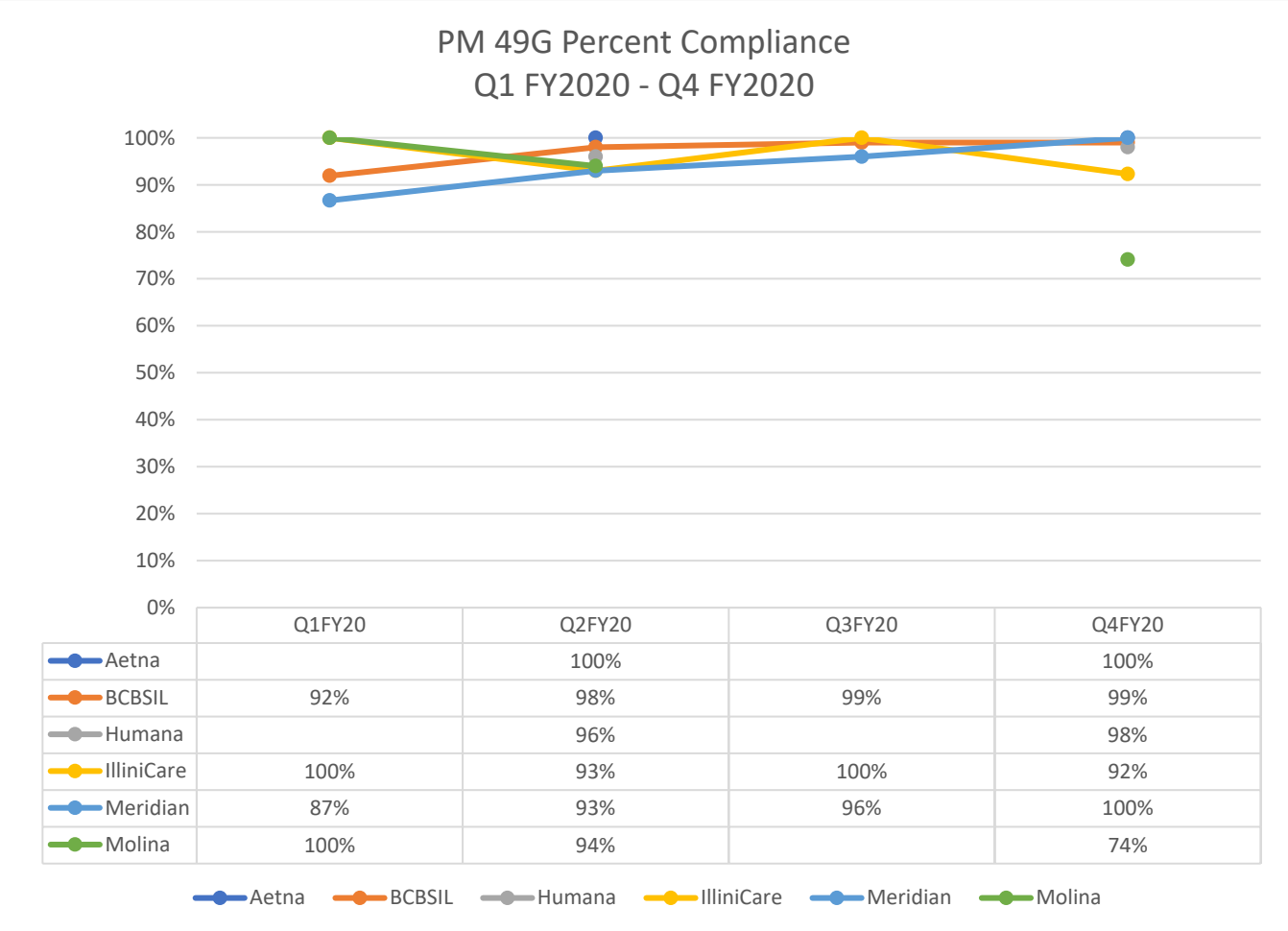
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna	100%	100%	100%	92%	100%	100%	100%	100%		100%		100%
BCBSIL	97%	92%	100%	100%	97%	97%	97%	100%	100%	100%	100%	89%
Humana	100%	92%	100%	100%	85%	100%		100%		91%		96%
IlliniCare	67%	75%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Meridian	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 49G - The most recent service plan includes a backup plan that includes the name of the backup. (ELD, BI, HIV, PD waivers only)

Due to changes in performance measure definitions in FY 2020, historic data is not comparable and only FY 2020 data is displayed.

Figure B.16 – Measure 49G



	Q1FY20	Q2FY20	Q3FY20	Q4FY20
Aetna		100%		100%
BCBSIL	92%	98%	99%	99%
Humana		96%		98%
IlliniCare	100%	93%	100%	92%
Meridian	87%	93%	96%	100%
Molina	100%	94%		74%

Note: Blank cells represent quarters in which the health plan was not reviewed.

Appendix C. Health Plan Performance by Measure by Quarter – MMAI

Table C.1 displays health plan compliance per performance measure by quarter.

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Aetna																
Q1 2015		N/A	36%	73%	91%		9%	100%	100%	N/A			82%	82%		50%
Q2 2015		100%	44%	58%	73%		0%	100%	100%	N/A			87%	87%		0%
Q3 2015		N/A	63%	88%	79%		92%	100%	100%	100%			88%	88%		100%
Q4 2015		100%	70%	75%	83%		91%	100%	98%	100%			94%	92%		83%
Q1 2016		100%	94%	87%	96%		87%	88%	96%	100%			94%	92%		96%
Q2 2016		100%	100%	97%	100%		100%	67%	100%	N/A			100%	100%		100%
Q3 2016		100%	92%	96%	96%		96%	90%	96%	100%			96%	96%		95%
Q4 2016		100%	100%	100%	97%		100%	96%	100%	100%			97%	97%		100%
Q1 2017		100%	100%	100%	100%		100%	74%	100%	100%			100%	100%		100%
Q2 2017		94%	97%	97%	100%		100%	77%	97%	100%			97%	95%		100%
Q3 2017		69%	97%	90%	100%		100%	81%	100%	100%			100%	100%		95%
Q4 2017		100%	100%	97%	97%		97%	80%	100%	100%			100%	100%		100%
Q1 2018	0%		81%	100%	100%	100%	100%	71%	92%	91%	53%	100%	97%	97%	100%	100%
Q2 2018	N/A		100%	98%	100%	86%	100%	74%	100%	100%	59%	86%	100%	100%	100%	100%
Q3 2018	43%		90%	98%	98%	100%	100%	74%	85%	85%	30%	100%	100%	100%	100%	96%
Q4 2018	33%		100%	100%	100%	85%	100%	69%	93%	100%	71%	92%	100%	100%	92%	95%
Q1 2019	100%		100%	100%	100%	100%	100%	74%	97%	100%	79%	100%	100%	100%	100%	100%
Q2 2019	N/A		100%	100%	100%	100%	100%	97%	100%	88%	91%	100%	100%	100%	100%	100%
Q3 2019	N/A		100%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%	100%
Q4 2019	N/A		100%	97%	100%	100%	100%	91%	100%	93%	94%	100%	100%	100%	100%	100%

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q1 2020																
Q2 2020			98%	100%	100%	100%	100%	96%	100%	100%	94%	100%	100%	100%	100%	100%
Q3 2020																
Q4 2020			100%	97%	100%	100%	100%	98%	100%	100%	97%	100%	100%	100%	100%	100%
BCBSIL																
Q4 2015		100%	91%	80%	90%		88%	85%	95%	75%			95%	93%		78%
Q1 2016		100%	84%	84%	83%		96%	85%	95%	100%			93%	97%		94%
Q2 2016		90%	95%	87%	91%		96%	97%	91%	100%			96%	95%		100%
Q3 2016		100%	100%	100%	100%		99%	84%	99%	80%			97%	100%		95%
Q4 2016		100%	95%	98%	97%		96%	76%	98%	75%			97%	99%		96%
Q1 2017		100%	99%	96%	99%		99%	89%	97%	100%			100%	100%		100%
Q2 2017		100%	95%	95%	96%		99%	87%	96%	33%			98%	97%		100%
Q3 2017		100%	97%	97%	95%		100%	82%	98%	60%			96%	96%		100%
Q4 2017		100%	89%	96%	96%		94%	76%	99%	67%			96%	98%		97%
Q1 2018	34%		100%	99%	100%	94%	97%	92%	79%	86%	47%	94%	95%	94%	97%	88%
Q2 2018	35%		99%	100%	99%	89%	100%	92%	87%	78%	61%	89%	100%	96%	92%	84%
Q3 2018	40%		99%	99%	100%	100%	99%	85%	86%	81%	55%	100%	100%	96%	100%	100%
Q4 2018	33%		100%	100%	100%	97%	99%	89%	82%	88%	69%	97%	95%	94%	100%	85%
Q1 2019	33%		96%	97%	96%	97%	96%	83%	81%	80%	60%	97%	97%	93%	97%	90%
Q2 2019	23%		90%	95%	95%	100%	96%	92%	82%	92%	64%	100%	96%	93%	97%	81%
Q3 2019	30%		95%	96%	97%	97%	99%	95%	86%	93%	68%	97%	99%	99%	97%	88%
Q4 2019	40%		85%	90%	92%	100%	98%	87%	77%	76%	61%	100%	98%	96%	100%	91%
Q1 2020	0%		96%	95%	96%	94%	94%	95%	90%	97%	82%	94%	97%	97%	100%	92%
Q2 2020	40%		99%	100%	100%	98%	97%	95%	90%	89%	84%	98%	98%	95%	100%	98%
Q3 2020	27%		99%	94%	97%	100%	97%	93%	88%	94%	92%	100%	99%	96%	100%	99%
Q4 2020	0%		99%	100%	100%	90%	97%	97%	94%	89%	89%	90%	96%	95%	89%	99%
Humana																

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q1 2015		N/A	95%	90%	75%		93%	100%	100%	N/A			93%	93%		100%
Q2 2015																
Q3 2015		N/A	83%	95%	98%		100%	75%	100%	100%			100%	100%		75%
Q4 2015		N/A	94%	94%	94%		100%	100%	94%	N/A			100%	100%		100%
Q1 2016		50%	100%	99%	99%		99%	100%	94%	N/A			96%	96%		100%
Q2 2016																
Q3 2016		100%	96%	100%	100%		96%	76%	90%	100%			93%	97%		100%
Q4 2016		91%	100%	100%	100%		95%	79%	100%	N/A			100%	100%		100%
Q1 2017		100%	100%	100%	100%		100%	89%	100%	50%			100%	100%		100%
Q2 2017		80%	100%	100%	97%		93%	80%	100%	100%			100%	100%		90%
Q3 2017		100%	100%	100%	100%		97%	100%	97%	100%			100%	100%		100%
Q4 2017		83%	100%	100%	100%		97%	78%	100%	N/A			100%	100%		100%
Q1 2018	67%		96%	96%	100%	92%	96%	90%	88%	78%	38%	92%	96%	96%	100%	100%
Q2 2018	50%		96%	96%	96%	92%	96%	100%	78%	86%	67%	92%	96%	96%	92%	100%
Q3 2018	33%		93%	97%	100%	100%	100%	96%	90%	100%	43%	100%	100%	100%	100%	100%
Q4 2018	29%		100%	93%	100%	100%	96%	86%	75%	71%	46%	100%	100%	100%	100%	100%
Q1 2019	20%		89%	92%	92%	85%	92%	83%	86%	100%	47%	85%	92%	89%	85%	90%
Q2 2019	14%		94%	94%	94%	100%	94%	90%	81%	67%	42%	100%	94%	89%	100%	92%
Q3 2019																
Q4 2019	25%		97%	97%	97%	100%	97%	94%	80%	75%	66%	100%	97%	97%	100%	90%
Q1 2020																
Q2 2020	22%		91%	90%	91%	95%	91%	87%	74%	100%	48%	95%	94%	94%	91%	96%
Q3 2020																
Q4 2020	50%		95%	98%	98%	96%	94%	88%	75%	56%	65%	96%	97%	95%	96%	98%
IlliniCare																
Q1 2015																
Q2 2015																

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q3 2015		100%	69%	97%	100%		86%	100%	100%	N/A			100%	100%		67%
Q4 2015		100%	83%	100%	100%		90%	100%	95%	N/A			95%	93%		100%
Q1 2016		67%	94%	91%	86%		83%	83%	91%	N/A			91%	94%		100%
Q2 2016		100%	100%	67%	0%		100%	100%	100%	N/A			100%	100%		100%
Q3 2016		100%	100%	100%	100%		100%	100%	100%	N/A			100%	100%		100%
Q4 2016		100%	100%	100%	100%		100%	100%	100%	N/A			100%	100%		100%
Q1 2017		100%	100%	100%	100%		90%	90%	100%	N/A			95%	95%		90%
Q2 2017		100%	80%	100%	100%		93%	100%	88%	100%			94%	94%		100%
Q3 2017		89%	100%	92%	96%		92%	100%	92%	100%			100%	100%		100%
Q4 2017		100%	100%	92%	100%		92%	82%	80%	N/A			100%	100%		100%
Q1 2018	17%		75%	79%	75%	67%	89%	90%	71%	100%	71%	67%	89%	89%	67%	100%
Q2 2018	0%		72%	100%	100%	75%	97%	86%	69%	100%	38%	75%	83%	83%	75%	100%
Q3 2018	78%		100%	100%	100%	88%	97%	88%	73%	100%	64%	88%	97%	97%	88%	100%
Q4 2018	33%		97%	100%	100%	100%	100%	88%	81%	100%	65%	100%	100%	94%	100%	100%
Q1 2019	13%		94%	97%	97%	100%	97%	83%	80%	83%	51%	100%	97%	97%	100%	100%
Q2 2019	43%		94%	100%	100%	100%	100%	87%	81%	60%	67%	89%	100%	100%	100%	95%
Q3 2019	13%		94%	89%	92%	100%	92%	87%	78%	60%	69%	100%	94%	94%	100%	100%
Q4 2019	18%		95%	95%	95%	100%	98%	91%	73%	100%	53%	100%	100%	100%	100%	100%
Q1 2020	50%		97%	100%	100%	100%	97%	97%	95%	86%	82%	100%	97%	97%	100%	100%
Q2 2020	50%		97%	100%	97%	100%	100%	93%	94%	75%	72%	100%	100%	100%	100%	93%
Q3 2020	33%		100%	100%	100%	100%	97%	97%	89%	86%	78%	100%	97%	94%	100%	100%
Q4 2020	25%		97%	97%	97%	100%	97%	92%	81%	67%	74%	100%	94%	94%	100%	92%
Meridian																
Q1 2015		N/A	100%	100%	100%		100%	N/A	100%	N/A			100%	100%		N/A
Q2 2015		N/A	98%	90%	98%		92%	100%	100%	N/A			92%	92%		100%
Q3 2015		N/A	0%	100%	100%		100%	N/A	100%	N/A			100%	100%		N/A
Q4 2015		N/A	83%	80%	87%		80%	100%	100%	100%			83%	83%		100%

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q1 2016		60%	99%	85%	95%		85%	72%	97%	67%			96%	91%		82%
Q2 2016		100%	100%	63%	88%		100%	44%	88%	N/A			100%	100%		89%
Q3 2016		80%	100%	94%	89%		94%	54%	50%	N/A			89%	72%		100%
Q4 2016		100%	100%	100%	100%		100%	60%	87%	N/A			100%	100%		100%
Q1 2017		88%	96%	96%	96%		100%	75%	92%	100%			100%	100%		100%
Q2 2017		0%	100%	100%	93%		100%	100%	100%	0%			100%	93%		100%
Q3 2017		100%	100%	100%	100%		100%	85%	97%	N/A			100%	100%		100%
Q4 2017		92%	100%	100%	100%		100%	79%	100%	N/A			100%	100%		100%
Q1 2018	71%		100%	100%	100%	100%	100%	91%	75%	91%	54%	100%	100%	100%	100%	100%
Q2 2018	17%		100%	100%	100%	75%	100%	79%	80%	100%	67%	75%	100%	97%	75%	100%
Q3 2018	33%		100%	100%	95%	100%	100%	81%	95%	88%	41%	100%	100%	100%	100%	100%
Q4 2018	13%		90%	90%	90%	100%	83%	77%	70%	83%	37%	100%	83%	83%	100%	93%
Q1 2019	0%		97%	97%	97%	100%	100%	75%	92%	89%	38%	100%	97%	97%	100%	96%
Q2 2019	25%		97%	97%	97%	100%	97%	76%	82%	93%	56%	100%	97%	91%	100%	94%
Q3 2019	0%		100%	97%	100%	100%	100%	86%	76%	86%	70%	100%	97%	91%	100%	100%
Q4 2019	50%		100%	100%	100%	100%	100%	83%	86%	100%	55%	100%	100%	100%	100%	100%
Q1 2020	0%		97%	100%	100%	100%	97%	90%	84%	75%	62%	100%	95%	95%	100%	87%
Q2 2020	75%		95%	97%	100%	100%	92%	71%	89%	100%	73%	100%	95%	97%	100%	93%
Q3 2020	100%		97%	100%	100%	89%	97%	83%	94%	100%	61%	89%	97%	97%	89%	96%
Q4 2020	60%		97%	100%	100%	100%	100%	81%	79%	100%	97%	100%	100%	91%	100%	100%
Molina																
Q1 2015																
Q2 2015																
Q3 2015		N/A	64%	74%	98%		91%	100%	100%	N/A			100%	100%		100%
Q4 2015		100%	85%	100%	100%		98%	100%	100%	100%			100%	100%		100%
Q1 2016		100%	96%	87%	100%		96%	93%	97%	67%			100%	99%		100%
Q2 2016		100%	100%	94%	100%		100%	93%	89%	N/A			100%	100%		93%

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q3 2016																
Q4 2016		100%	100%	97%	100%		97%	79%	100%	N/A			100%	100%		100%
Q1 2017		100%	100%	100%	100%		95%	90%	100%	100%			97%	95%		100%
Q2 2017		93%	100%	94%	100%		100%	100%	100%	NA			100%	100%		100%
Q3 2017		100%	100%	86%	100%		100%	94%	100%	50%			100%	100%		100%
Q4 2017		100%	100%	100%	100%		95%	95%	100%	100%			100%	100%		100%
Q1 2018	86%		100%	100%	100%	100%	100%	100%	72%	100%	60%	100%	96%	96%	100%	100%
Q2 2018	29%		100%	96%	100%	100%	96%	100%	73%	100%	46%	100%	100%	100%	100%	100%
Q3 2018	0%		100%	100%	100%	100%	100%	100%	89%	100%	50%	100%	96%	96%	100%	93%
Q4 2018	67%		100%	100%	100%	100%	100%	89%	88%	100%	54%	100%	100%	100%	100%	100%
Q1 2019	67%		100%	100%	100%	100%	100%	100%	89%	100%	86%	100%	100%	100%	100%	100%
Q2 2019	100%		100%	100%	100%	100%	100%	88%	96%	100%	72%	100%	100%	100%	100%	100%
Q3 2019	63%		96%	96%	96%	100%	100%	88%	65%	100%	65%	100%	100%	96%	100%	100%
Q4 2019	33%		100%	100%	100%	100%	100%	90%	79%	100%	61%	100%	100%	96%	100%	89%
Q1 2020	0%		100%	100%	100%	100%	100%	95%	92%	67%	62%	100%	100%	100%	100%	100%
Q2 2020	100%		100%	100%	100%	100%	96%	88%	96%	100%	79%	100%	100%	100%	100%	94%
Q3 2020																
Q4 2020	50%		93%	95%	95%	100%	93%	93%	82%	100%	71%	100%	95%	93%	100%	74%
Cigna-HealthSpring***																
Q1 2015		100%	81%	66%	56%		0%	100%	100%	N/A			97%	97%		33%
Q2 2015		100%	89%	84%	94%		89%	92%	100%	100%			89%	90%		92%
Q3 2015		100%	60%	84%	81%		84%	100%	96%	100%			88%	88%		80%
Q4 2015		N/A	68%	82%	75%		82%	N/A	93%	N/A			93%	96%		N/A
Q1 2016		100%	98%	94%	95%		99%	95%	99%	67%			95%	99%		95%
Q2 2016		100%	67%	81%	85%		96%	89%	100%	N/A			100%	100%		100%
Q3 2016		90%	100%	100%	100%		100%	75%	96%	100%			96%	96%		100%
Q4 2016		100%	100%	100%	100%		95%	69%	95%	N/A			100%	100%		100%

Table C.1—Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Health Plans Percent Compliant by Measure																
Health Plan	**Performance Measure #**															
FY Quarter	**4A[+1]**	**26C[^]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44G[+]**	**49G[1]**
Q1 2017		83%	100%	100%	100%		100%	93%	100%	100%			100%	100%		100%
Q2 2017		100%	97%	100%	100%		97%	82%	100%	100%			100%	100%		100%
Q3 2017		100%	100%	100%	100%		100%	80%	100%	100%			100%	100%		100%
Q4 2017		100%	100%	100%	100%		100%	86%	97%	100%			100%	100%		100%
Q1 2018	0%		100%	100%	100%	100%	100%	95%	95%	100%	64%	100%	100%	100%	100%	100%
Q2 2018	0%		96%	100%	96%	89%	100%	85%	96%	83%	52%	89%	100%	91%	89%	100%
HAC**																
Q3 2015		100%	84%	96%	93%		94%	100%	98%	100%			95%	96%		89%
Q4 2015		100%	91%	99%	96%		97%	88%	100%	N/A			99%	96%		100%
Q1 2016		100%	93%	96%	100%		96%	91%	95%	75%			99%	100%		88%
Q2 2016		100%	100%	90%	100%		97%	90%	88%	100%			100%	94%		100%

**Shaded rows indicate a quarter during which a health plan was not reviewed or data was not collected*

*** Health Alliance Connect exited the MMAI demonstration project effective December 31, 2015. Historic data provided for information and comparison.*

****Cigna-HealthSpring exited the MMAI demonstration project effective December 31, 2017. Historic data provided for information and comparison.*

[+]*New measure effective Q1 FY2018.*

[++]*Revised measure effective Q1 FY2018.*

[^]*Measure 26C retired as of Q1 FY2018.*

[1]*Revised measure effective Q1 FY2020.*

Appendix D. Waiver Measure Performance by Quarter – MMAI

Table D.1—MMAI Waiver Performance Measure Findings

MMAI Performance Measure Findings Across Waivers Percent Compliant by Measure FY 2020																				
PM	BI				ELD				HIV				PD				SLP			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Overall	92%	94%	95%	95%	93%	93%	94%	94%	95%	92%	92%	95%	91%	93%	95%	94%	96%	95%	96%	94%
4A					0%	44%	38%	53%		0%		0%	10%	43%	38%	25%	0%			
31D	97%	100%	100%	95%	99%	97%	98%	97%	100%	94%	100%	100%	95%	97%	100%	99%	95%	96%	96%	97%
32D	97%	98%	100%	100%	99%	99%	92%	98%	100%	94%	100%	100%	97%	99%	96%	98%	95%	97%	98%	98%
33D	97%	100%	100%	100%	99%	99%	97%	99%	100%	97%	100%	100%	98%	98%	98%	99%	95%	97%	98%	98%
34D					97%	98%	98%	95%												
35D	93%	100%	96%	98%	94%	95%	97%	98%	100%	97%	94%	100%	97%	98%	98%	98%	95%	95%	98%	92%
36D	87%	69%	77%	73%	99%	98%	100%	99%	76%	67%	56%	77%	100%	100%	100%	100%				
37D	93%	100%	100%	100%	90%	83%	89%	87%	100%	97%	100%	96%	85%	93%	86%	92%	92%	86%	86%	77%
38D	100%	93%	86%	100%	85%	90%	95%	89%	86%	89%	100%	50%	88%	97%	96%	84%				0%
39D	79%	81%	77%	86%	62%	64%	74%	73%	76%	91%	81%	96%	69%	63%	86%	76%	100%	100%	100%	100%
40D					97%	98%	98%	95%												
41D	93%	100%	100%	100%	96%	96%	98%	97%	100%	97%	94%	96%	97%	98%	98%	98%	98%	99%	98%	95%
42G	93%	100%	100%	95%	97%	97%	94%	94%	100%	97%	94%	96%	95%	98%	98%	97%	98%	94%	95%	95%
44G					100%	98%	98%	95%												
49G	87%	98%	100%	98%	95%	98%	100%	97%	100%	97%	100%	100%	92%	95%	96%	93%				

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated.*

Table D.2 – MMAI Waiver Performance Measure Findings: BI Waiver

MMAI Performance Measure Findings: BI Waiver Percent Compliance by Measure FY 2015 - FY 2019					
Performance Measure	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Overall**	89%	93%	96%	83%	86%
4A***				54%	35%
26C[1]	100%	97%	99%		
31D	89%	98%	97%	96%	97%
32D	89%	95%	96%	99%	99%
33D	89%	97%	98%	99%	99%
34D					
35D	93%	99%	99%	100%	99%
36D**	78%	68%	73%	58%	63%
37D	81%	78%	97%	63%	72%
38D	100%	86%	100%	93%	90%
39D**	93%	99%	97%	34%	56%
40D					
41D	89%	98%	99%	99%	99%
42G	93%	100%	100%	98%	99%
44G					
49G	86%	97%	100%	92%	95%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected*

***Changes in performance measure definitions and evaluation criteria effective SFY2018. Historic data not comparable.*

****New measure SFY2018*

[1]Measure retired at end of SFY2017

Table D.3 – MMAI Waiver Performance Measure Findings: ELD Waiver

MMAI Performance Measure Findings: ELD Waiver Percent Compliance by Measure FY 2015 - FY 2019					
Performance Measure	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Overall**	87%	93%	96%	89%	91%
4A***				28%	23%
26C[1]					
31D	78%	93%	95%	95%	94%
32D	86%	88%	96%	98%	96%
33D	88%	93%	97%	99%	96%
34D***				94%	99%
35D	81%	94%	97%	97%	97%
36D**				99%	98%
37D	98%	95%	97%	83%	84%
38D	90%	77%	77%	85%	92%
39D**	81%	96%	98%	37%	52%
40D***				94%	98%
41D	93%	94%	97%	97%	97%
42G	92%	96%	97%	95%	96%
44G***				96%	98%
49G				93%	88%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected*

***Changes in performance measure definitions and evaluation criteria effective SFY2018. Historic data not comparable.*

****New measure SFY2018*

[1]Measure retired at end of SFY2017

Table D.4 – MMAI Waiver Performance Measure Findings: HIV Waiver

MMAI Performance Measure Findings: HIV Waiver Percent Compliance by Measure FY 2015 - FY 2019					
Performance Measure	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Overall**	86%	93%	95%	88%	90%
4A***				40%	63%
26C[1]	100%	94%	97%		
31D	80%	93%	98%	100%	95%
32D	93%	91%	98%	100%	96%
33D	87%	91%	100%	100%	98%
34D					
35D	80%	98%	100%	100%	99%
36D**	93%	66%	56%	45%	58%
37D	93%	99%	100%	90%	92%
38D	100%	100%	100%	100%	90%
39D**	73%	95%	96%	54%	69%
40D					
41D	93%	99%	100%	98%	99%
42G	93%	98%	99%	98%	99%
44G					
49G	64%	97%	98%	95%	95%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected*

***Changes in performance measure definitions and evaluation criteria effective SFY2018. Historic data not comparable.*

****New measure SFY2018*

[1]Measure retired at end of SFY2017

Table D.5 – MMAI Waiver Performance Measure Findings: PD Waiver

MMAI Performance Measure Findings: PD Waiver Percent Compliance by Measure FY 2015 - FY 2019					
Performance Measure	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Overall**	91%	96%	98%	90%	89%
4A***				26%	30%
26C[1]	100%	97%	94%		
31D	84%	96%	98%	97%	94%
32D	91%	93%	97%	98%	96%
33D	94%	95%	100%	98%	96%
34D					
35D	85%	96%	97%	98%	97%
36D**	99%	98%	100%	99%	98%
37D	98%	97%	99%	85%	83%
38D	100%	90%	89%	89%	84%
39D**	86%	96%	99%	43%	50%
40D					
41D	94%	96%	99%	96%	97%
42G	93%	96%	99%	96%	96%
44G					
49G	86%	97%	99%	97%	92%

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected*

***Changes in performance measure definitions and evaluation criteria effective SFY2018. Historic data not comparable.*

****New measure SFY2018*

[1]Measure retired at end of SFY2017

Table D.2 – MMAI Waiver Performance Measure Findings: SLP Waiver

MMAI Performance Measure Findings: SLP Waiver Percent Compliance by Measure FY 2015 - FY 2019					
Performance Measure	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**
Overall**	85%	97%	99%	96%	93%
4A***				35%	29%
26C[1]					
31D	73%	96%	100%	98%	93%
32D	71%	96%	98%	98%	94%
33D	78%	98%	98%	99%	95%
34D					
35D	85%	94%	98%	99%	98%
36D**					
37D	100%	100%	98%	90%	85%
38D		75%	71%	100%	25%
39D**	100%			98%	99%
40D					
41D	92%	98%	100%	98%	98%
42G	94%	97%	99%	96%	94%
44G					
49G					

**Shaded cells reflect quarters in which there were no records in the sample eligible for the measure indicated or the measure was not collected*

***Changes in performance measure definitions and evaluation criteria effective SFY2018. Historic data not comparable.*

****New measure SFY2018*

[1]Measure retired at end of SFY2017

Appendix E. Acronyms

ACA ..... Affordable Care Act
ADL ..... Activity of Daily Living
ANE ..... Abuse, Neglect, and Exploitation
ARRA ..... American Recovery and Reinvestment Act of 2009
BBA ..... Balanced Budget Act of 1997
BI ..... Persons with Brain Injury Waiver
BMC ..... Bureau of Managed Care
BQM ..... Bureau of Quality Management
CAP ..... Corrective Action Plan
CCU ..... Care Coordination Unit
CFR ..... Code of Federal Regulations
CMS ..... Centers for Medicare & Medicaid Services
DHHS ..... The United States Department of Health and Human Services
DHS ..... Department of Health Services
DOA ..... Department on Aging
DON ..... Determination of Need
DRS ..... Division of Rehabilitation Services
eCCPIS ..... Department on Aging Case Management System
EQR ..... External Quality Review
EQRO ..... External Quality Review Organization
FHP ..... Family Health Plan
HCBS ..... Home and Community Based Services
HCI ..... HealthChoice Illinois
HHS ..... Health and Human Services
HIV ..... Persons with HIV/AIDS (HIV) Waiver
IADL ..... Instrumental Activity of Daily Living
ICP ..... Integrated Care Program
IDPH ..... Illinois Department of Public Health
IRR ..... Interrater Reliability
IT ..... Information Technology
LTC ..... Long Term Care
MCO ..... Managed Care Organization
MEDI ..... Medical Electronic Data Interchange

MLTSS..... Managed Long Term Services and Supports
MMAI .....Medicare-Medicaid Alignment Initiative
NCQA .....National Committee for Quality Assurance
PA .....Personal Assistant
PCP .....Primary Care Physician
PD .....Persons with Physical Disabilities Waiver
POSM.....Participants Outcomes and Status Measures
SFY (FY) .....State Fiscal Year
SLP.....Persons in a Supportive Living Program Waiver
VMC ..... Voluntary Managed Care
VMCO..... Voluntary Managed Care Organization
WebCM..... Division of Rehabilitation Services Case Management System

Appendix C. Administrative and Compliance Processes Methodologies

This section presents a description of the methodologies and additional information related to external quality review activities conducted to comply with 42 CFR Part 438 Subpart E.

Introduction

The Code of Federal Regulations (CFR) at 42 CFR §438.358 describes activities related to compliance with standards, one of three federally mandated activities for Medicaid managed care plans (health plans). States are required to conduct a compliance review of each health plan, within the previous three-year period, to determine health plan compliance with federal regulatory provisions, State standards, and contract requirements. The Illinois Department of Healthcare and Family Services (HFS) has an annual monitoring process in place to ensure the Code of Federal Regulations (CFR) and The Balanced Budget Act of 1997, Public Law 105-33 (BBA) requirements are met over a three-year period.

Since June 2002, Health Services Advisory Group, Inc. (HSAG), has served as the EQRO for HFS. In state fiscal year (SFY) 2020, the first year of a new three-year review cycle, HSAG conducted an Administrative Processes and Compliance Review (Compliance Review). The Compliance Review, in accordance with §438.358, evaluated a subset of standards selected by HFS for the six health plans serving HealthChoice Illinois. In SFY 2021, HSAG will complete the review by assessing the remaining standards.

Throughout preparation for the Compliance Review and performance of the activities to complete the review, HSAG worked closely with HFS and the health plans to ensure a coordinated and supportive approach to completing the required activities.

This section describes the methodology HSAG utilized to complete the Compliance Review. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[C-1]

Objectives for Conducting the Administrative Review

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

[C-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html.

Compliance Review Activities

Activity One: Establish Compliance Thresholds

HSAG performed a series of pre-planning steps to define levels of compliance for use throughout the compliance review, as shown in Table C-1 below.

Table C-1—Activity One: Establish Compliance Thresholds

<table>
<tr><th>For this step,</th><th colspan="2">HSAG…</th></tr>
<tr><td>Step 1:</td><td colspan="2">Collected information from HFS</td></tr>
<tr><td></td><td colspan="2">Worked with HFS to define the scope of the review to include applicable federal and State regulations and laws and the requirements set forth in the Medicaid Model Contract, as they relate to the scope of the review.</td></tr>
<tr><td>Step 2:</td><td colspan="2">Determined review standards.</td></tr>
<tr><td></td><td colspan="2">The Compliance Review included requirements that addressed the operational areas listed below.</td></tr>
<tr><td></td><td>SFY 2020 Subset</td><td>SFY 2021 Subset</td></tr>
<tr><td></td><td>Access
Standard III—Coordination and Continuity of Care
Standard IV—Coverage and Authorization
Standard VI—Children’s Behavioral Health
Structure and Operations
Standard XI—Grievance and Appeal System
Standard XII—Organization and Governance
Standard XV—Subcontractual Relationships
Measurement and Improvement
Standard XVIII—Quality Assessment and Performance Improvement Program</td><td>Access
Standard I—Availability of Services
Standard II—Assurance of Adequate Capacity and Services
Standard V—Credentialing and Re-Credentialing
Structure and Operations
Standard VIII —Enrollee Information/Enrollee Rights
Standard IX—Confidentiality
Standard X—Enrollment and Disenrollment
Measurement and Improvement
Standard XIV—Health Information Systems
Standard XVI—Critical Incidents
Standard XVII—Practice Guidelines and Required Minimums
Program Integrity
Standard XIII—Fraud, Waste, and Abuse</td></tr>
</table>

For this step,	HSAG…
Step 3:	**Prepared the data collection tools for reviewing the standards.**
	As a mechanism to assess the health plans compliance with the standards under the scope of the review, HSAG, in collaboration with HFS, developed hard copy compliance review tools, as well as specific file review tools. HSAG also developed a web-based application and process for the health plans to submit documentation and data for the review. This web-based application, the Illinois Compliance Review Tool, was used for documenting findings from the review. This electronic tool also has reporting capabilities.
Step 4:	**Defined levels of compliance.**
	HSAG assigned each element within the standards in the compliance monitoring tool a score of Met, Not Met, or Not Applicable (NA). HSAG used scores of Met and Not Met to indicate the degree of compliance with the requirements by the health plans. HSAG used a designation of NA when a requirement was not applicable to an organization during the period covered by the review. *Met* indicates full compliance defined as both of the following: • All documentation listed under a regulatory provision or component thereof is present. • Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation. *Not Met* indicates noncompliance defined as the following: • Not all documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
Step 5:	**Built timeline for review process.**
	HSAG worked with HFS to construct a timeline to ensure completion of all review activities and advance notice to health plans.

Activity Two: Perform Preliminary Review

HSAG performed a series of preliminary steps, including a desk review, as shown in Table C-2 below.

Table C-2—Activity Two: Perform Preliminary Review

For this step,	HSAG…
Step 1:	**Established early contact with the health plans.**
	HSAG coordinated with HFS and the health plans to set the schedule and identified members of the HSAG review team for each health plan.
Step 1a:	**Prepared and submitted the pre-assessment form to the health plans.**
	The pre-assessment form is to identify gaps in information necessary to ensure a comprehensive EQR process and efficient and productive interactions with the health plan

<table>
<tr><th>For this step,</th><th>HSAG…</th></tr>
<tr><td></td><td>during the site visit. The form required the health plans to describe their organization and its functions and contained a list of desk review documents that the health plans were required to submit prior to the on-site review, as well as a list of documents required for the on-site portion of the administrative review. In addition, the pre-assessment form provided the health plans with the purpose, timelines, and instructions for submitting the data required for sampling for the file reviews.</td></tr>
<tr><td>Step 1b:</td><td>Forwarded the review tool, file review tools, and web-based application access instructions to the health plans.</td></tr>
<tr><td></td><td>Health plan-specific tools and were provided to assist each health plan in preparing for the review.</td></tr>
<tr><td>Step 1c:</td><td>Responded to the MCOs' questions related to the review and provided additional information needed before the review.</td></tr>
<tr><td></td><td>Prior to conducting the reviews, HSAG maintained contact with the health plans as needed to answer questions and to provide information to key members of the management staff. This telephone and/or e-mail contact gave health plan representatives the opportunity to ask for clarification about the request for documentation for HSAG's desk review and on-site e review processes. HSAG communicated regularly with HFS about HSAG's discussions with the health plans and its responses to their questions.</td></tr>
<tr><td>Step 1d:</td><td>Received data files from the health plans and HFS, then selected and posted samples to HSAG's FTP site prepared for each health plan.</td></tr>
<tr><td></td><td>HSAG generated unique record review samples based on data files supplied by the health plans and HFS for each of the file reviews listed below. Specifications were also supplied for the program description reviews listed below.
<table>
<tr><th>Standard #</th><th>Standard</th><th>File Reviews</th></tr>
<tr><td colspan="3">Access Standards</td></tr>
<tr><td>III</td><td>Coordination and Continuity of Care</td><td>Care Management Record Review;
Care/Disease Management Program Description Review</td></tr>
<tr><td>IV</td><td>Coverage and Authorization</td><td>Denials;
Utilization Management Program Description Review;
Peer Review Program Review</td></tr>
<tr><td>VI</td><td>Children's Behavioral Health</td><td>Children's Behavioral Health Record Review</td></tr>
<tr><td colspan="3">Structure and Operations Standards</td></tr>
<tr><td>XI</td><td>Grievance and Appeal System</td><td>Appeals; Grievances</td></tr>
<tr><td>XII</td><td>Organization and Governance</td><td>N/A</td></tr>
<tr><td>XV</td><td>Subcontractual Relationships</td><td>Delegation; Provider Complaints</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>For this step,</th><th>HSAG…</th></tr>
<tr><td></td><td>
<table>
<tr><th colspan="3">Measurement and Improvement Standards</th></tr>
<tr><td>XVIII</td><td>Quality Assessment and Performance Improvement Program</td><td>Quality Assurance Program Description Review</td></tr>
</table>
</td></tr>
<tr><td>Step 2:</td><td>Perform a preliminary document review (desk review).</td></tr>
<tr><td></td><td>Received the health plans' documents for HSAG's desk review and evaluated the information before conducting the on-site review. HSAG reviewers used the documentation to gain insight into each health plan's processes for providing access to care for its members, its structure and operations and its quality assessment and performance improvement program. HSAG also used the documentation to begin compiling preliminary findings before the on-site portion of the review. During the desk review process, reviewers:
Documented findings from the review of the materials submitted by the health plans as evidence of their compliance with the requirements.
Identified areas and issues requiring further clarification or follow-up during the on-site interviews.
Identified information not found in the desk review documentation that HSAG would request during the on-site administrative review.</td></tr>
</table>

Activity Three: Conduct Site Visits

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

Table C-3—Activity Three: Conduct Site Visits

For this step,	HSAG…
Step 1:	**Determined the length of visit and the dates.**
	HFS determined that site visits would be scheduled for two consecutive business days with each health plan. Health plans were given scheduling options and the schedule was finalized in advance.
Step 2:	**Identify the number and types of reviewers needed.**
	The review team members that HSAG assigned were content area experts who had in-depth knowledge of that HFS' Medicaid systems and requirements, and who also have extensive experience and proven competency conducting the compliance reviews. To ensure interrater reliability, HSAG reviewers were trained on the review methodology to ensure that the determinations for each element of the review are made in the same manner. Members of HSAG's review teams were assigned specific standards, and communication and coordination were ongoing among the team members to ensure uniformity of the reviews. The team leader reviews the findings and scores for all standards to ensure accuracy and consistency of approach among reviewers. HSAG assigned the number of reviewers based on the characteristics of the health plan. Factors that are considered by HSAG include the number of Medicaid enrollees, provider network, the plan's history of compliance with required standards, and the scope of programs being contracted by the state Medicaid agency.
Step 3:	**Established an agenda for the visit.**
	The site visit agenda was developed to assist each health plan's staff in planning for participation in the on-site review, assembling requested documentation, and addressing logistical issues. The agenda set the tone, expectations, the objectives, and time frames for the review.
Step 4:	**Provided preparation instructions and guidance to the health plans.**
	HSAG representatives conducted a teleconference with the health plans and HFS to exchange information, confirm the dates for the desk and on-site review, and complete other planning activities to ensure that the Compliance Review was completed methodically and accurately. In addition, clear instructions and guidance were provided to each health plan prior to the site visit including: the scope of the assessment, how the review will be conducted, lists of required documents, instructions for the organization of document presentation; forms or other data gathering instruments that should be completed prior to arrival, reports from prior reviews and subsequent corrective actions, identification of expected interview participants and administrative needs of the reviewers and any other expectations or responsibilities.

For this step,	HSAG…
Step 5:	**Conducted onsite document review.**
	During the on-site review, health plan staff members were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information.
Step 6:	**Conducted onsite health plan interviews.**
	During the onsite review, HSAG: • Conducted interviews with health plan staff. HSAG used interviews to obtain a complete picture of compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the health plan's performance. • Reviewed information, documentation, and systems demonstrations. Throughout the on-site review process, reviewers used the administrative review tool to identify relevant information sources and to document findings regarding compliance with the standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. • Received and reviewed files designated for the file reviews. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the health plans' policies and procedures. • Summarized findings at the completion of the on-site review.
Step 7:	**Conducted exit interviews.**
	As a final step, HSAG reviewers met with staff members and HFS to provide a high-level summary of the preliminary findings from the on-site review. The purpose of the exit interview allowed HSAG to clarify its understanding of the information collected throughout the compliance review process and provided the health plans the opportunity to respond to initial compliance issues to ensure the findings were due to true non-compliance and not due to misunderstanding or misinterpretation of health plan documents and interviews.

Activity Four: Compile and Analyze Findings

HSAG documented components of the review and the final compliance determinations for each regulatory provision via the steps outlined in Table C-4 below. The documented findings served as evidence of the comprehensiveness of the EQR process and validity of the findings.

Table C-4—Activity Four: Compile and Analyze Findings

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

Activity Five: Report Results

HSAG drafted a report to HFS with the results of the review of the health plans' compliance with Federal and State requirements using the steps shown in Table C-5 below.

Table C-5—Activity Five: Report Results

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

Appendix D. PIPs Methodology

Objective

As part of the State's quality strategy, each MCO is required to conduct PIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i-iv). As one of the mandatory EQR activities required under the Balanced Budget Act of 1997 (BBA), HSAG, as the State's EQRO, validated the PIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG follows validation guidelines established in the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[D-1] Additionally, HSAG's PIP process facilitates frequent communication with the MCOs. HSAG provides written feedback after each module is validated and provides TA for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while MCOs test interventions.

HFS requires its MCOs to conduct two PIPs annually. The topics continued in SFY 2020 were:

- *Follow-Up After Hospitalization for Mental Illness Within 30 Days*
- *Transitions of Care–Patient Engagement After Inpatient Discharge*

The topics selected by HFS addressed CMS requirements related to quality outcomes—specifically, the quality and timeliness of and access to care and services.

For each PIP topic, the MCOs defined a Global and SMART Aim. The SMART Aim statement includes the narrowed population, the baseline rate, a set goal for the project, and the end date. HSAG provided the following parameters to the MCOs for establishing the SMART Aim for each PIP:

- **S**pecific: The goal of the project: What is to be accomplished? Who will be involved or affected? Where will it take place?
- **M**easurable: The indicator to measure the goal: What is the measure that will be used? What is the current data figure (i.e., count, percent, or rate) for that measure? What do you want to increase/decrease that number to?
- **A**ttainable: Rationale for setting the goal: Is the achievement you want to attain based on a particular best practice/average score/benchmark? Is the goal attainable (not too low or too high)?
- **R**elevant: The goal addresses the problem to be improved.
- **T**ime-bound: The timeline for achieving the goal.

[D-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Aug 14, 2018.

Approach to PIP Validation

In SFY 2020, HSAG obtained the data needed to conduct the PIP validation from the MCO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed.

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus on the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, FMEA, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act**: The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the health plan summarizes key findings and outcomes and presents comparisons of successful and unsuccessful interventions, lessons learned, and the plan to spread and sustain successful changes for improvement achieved.

The MCOs submitted each module according to the approved timeline. After the initial validation of each module, the MCOs received HSAG's feedback and TA and resubmitted the modules until all validation criteria were achieved. This process ensures that the methodology is sound before the MCOs progress to the next phase of the PIP process.

The goal of HSAG's PIP validation is to ensure that HFS and key stakeholders have confidence that any reported improvement is related to and can be directly linked to the quality improvement strategies and activities the MCO conducted during the PIP. HSAG's scoring methodology evaluates whether the MCO executed a methodologically sound improvement project and confirmed that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the MCO.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* Any validation criteria not applicable (*NA*) were not scored. As the PIP progresses, and at the completion of Module 5, HSAG will use the validation findings from modules 1 through 5 for each PIP to determine a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested, and the MCO accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the MCO accurately summarized the key findings. However, some, but not all, quality improvement processes conducted and/or intervention(s) tested were clearly linked to the demonstrated improvement.
- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Appendix E1. Validation of Network Adequacy Methodologies

This section describes the methodologies used in the activities HSAG conducted to validate and monitor the health plans' network adequacy during the preceding state fiscal year.

Post-Implementation Monitoring Methodology

In SFY 2019–2020, HSAG continued network monitoring activities as follow-up to the HealthChoice Illinois Post-Implementation Reviews. The methodology for the monitoring process is detailed below.

Network Data Submission Process

HSAG developed a *Provider Network Data Submission Instruction Manual* (manual) to provide health plans with detailed guidance for the completion and quarterly submission of accurate network capacity data. The health plans were required to follow the instructions and definitions for provider types within the manual to submit network capacity data in a standardized Provider File Layout (PFL), MS Excel workbook. The manual included the following sections:

- Section 1—Introduction, describes the purpose of the manual and its organization and provides an overview of the PFL
- Section 2—PFL Instruction, provides detailed guidance on properly completing the PFL, including the file naming conventions, provider type specifications and definitions, and a description of the data submission elements needed to complete each field of the PFL
- Section 3—Submission Process, describes the procedure MCOs follow to submit the provider network data
- Appendix A—Data Dictionary, contains definitions for all provider types required for submission
- Appendix B—HCBS Waiver Definitions, defines HCBS service types required for submission
- Appendix C—PFL MS Excel workbook template

Health plans were required to upload their provider network data files to a secure HSAG file transfer protocol site. These files included PCPs, specialists, pediatric providers, dental providers, hospitals, facilities, pharmacies, HCBS and MLTSS providers (including substance abuse providers), FQHCs, CMHCs, RHCs, nursing facilities, supportive living facilities, exceptional care providers, and transportation providers within each managed care service area.

Data Validation Process

Following the receipt of the health plans' provider network data, HSAG conducted a validation process that included:

- Review of the accuracy and completeness of required data fields.
- Identification of duplicate data.
- Verification of provider contract status.
- Categorization of providers to the correct provider group.
- Verification of open and closed panel status.

- Comparison of the number of data records between the prior and current data submissions.
- Verification of provider types.

After completion of HSAG's validation checks, the health plan provider data was loaded to a secure MS Access database containing programmed queries that generated network reports. As an additional validation check, the data generated by the source programming code was validated against the health plan data files to verify the accuracy of the network reports.

HSAG produced health plan-specific and comparative network reports to identify the number of provider types within each county statewide. These reports also included contracted providers within specific out-of-state counties neighboring the service regions.

Reporting and Communication

During the post-implementation reviews, HSAG maintained ongoing communication with the health plans and HFS regarding any findings and recommendations identified during HSAG's analysis of the health plans' provider networks. HSAG monitored and reported to HFS the plans' compliance towards establishing an adequate provider network. Network gaps were communicated to HFS and health plans were required to respond to all identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps.

Monitoring Network Adequacy for HealthChoice Illinois

HSAG collaborated with HFS to develop quarterly provider network capacity reports to ensure compliance with HFS' specifications. The provider network capacity reports included:

- Regional Dashboard Report—review of the health plans' contracting status with hospitals, FQHCs, CMHCs, and RHCs in the services regions, as well as contiguous counties, if applicable.
- Hospital Analysis Report—hospitals listed by name and region to show contracted and pended hospitals across health plans.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.

Appendix E2. Network Adequacy Regional Comparison

IL2020 Provider Network - HealthChoice IL
Region 1 - Northwest Counties
Current Network (Contracted and Loaded Providers)
Health Plan Provider Data Submitted on May 15, 2020

Health Plan	BCBS	IlliniCare	Meridian	Molina
Enrollment as of April 1, 2020	19,185	72,616	130,326	44,575

Health Plan	BCBS	IlliniCare	Meridian	Molina
Practitioners (# of unique NPIs)*				
Primary Care Providers (PCPs)	602	1,254	881	927
Pediatric Primary Care Providers (PCPs)	538	1,064	470	1,031
Mid-Level Practitioners (Adult)	317	1,476	935	1,279
Mid-Level Practitioners (Children)	263	1,423	859	1,252
Adult Specialty Providers	1,447	2,170	1,648	1,616
Pediatric Specialists	551	1,115	757	1,172
Gynecology, OB/GYN	118	207	172	197
Dental Providers (Adult)	313	480	293	267
Pediatric Dentistry	294	464	303	261
Behavioral Health Providers (Adult)	255	553	407	544
Behavioral Health Providers (Children)	41	391	136	229
Facilities (# of locations)*				
CMHC/FQHC/RHC	97	191	191	175
Skilled Nursing Facilities	121	150	153	95
Supportive Living Facilities	20	25	19	21
Pharmacies	206	275	422	265
Other Facilities	215	489	790	340

Health Plan	BCBS	IlliniCare	Meridian	Molina
Hospitals (# of locations)*				
Hospitals	24	30	26	27

IL2020 Provider Network - HealthChoice IL
Region 2 - Central Counties
Current Network (Contracted and Loaded Providers)
Health Plan Provider Data Submitted on May 15, 2020

Health Plan	BCBS	IlliniCare	Meridian	Molina
Enrollment as of April 1, 2020	27,862	46,874	133,108	53,918

Health Plan	BCBS	IlliniCare	Meridian	Molina
Practitioners (# of unique NPIs)*				
Primary Care Providers (PCPs)	564	1,048	1,011	861
Pediatric Primary Care Providers (PCPs)	514	876	567	938
Mid-Level Practitioners (Adult)	356	1,794	1,221	1,426
Mid-Level Practitioners (Children)	316	1,751	1,118	1,386
Adult Specialty Providers	1,728	2,163	1,602	1,789
Pediatric Specialists	583	1,205	821	1,183
Gynecology, OB/GYN	103	202	165	192
Dental Providers (Adult)	199	204	190	189
Pediatric Dentistry	189	198	191	184
Behavioral Health Providers (Adult)	309	481	468	562
Behavioral Health Providers (Children)	65	277	165	217
Facilities (# of locations)*				
CMHC/FQHC/RHC	150	297	292	251
Skilled Nursing Facilities	119	159	151	93
Supportive Living Facilities	26	27	18	27
Pharmacies	220	292	447	274
Other Facilities	235	478	758	404

Health Plan	BCBS	IlliniCare	Meridian	Molina
Hospitals (# of locations)*				
Hospitals	28	35	31	30

Summary Notes

*Provider counts were based on a count of unique NPIs for practitioners and a count of provider locations for Facilities & Hospitals. All providers included in the summary above were reported by the health plans as Medicaid Contracted and Loaded. Providers reported as "Pending" for Medicaid Contracted and/or Loaded were not included.

PCP Specialties

- Adult – Family Practice, General Practice, Internal Medicine, Nurse Practitioner, Physician Assistant
- Pediatric – Pediatric Medicine, Pediatric Nurse Practitioner, Pediatric Physician Assistant
- PCP providers were reported by the health plans as "Yes" for the PCP (Y/N) column.

Behavioral Health Specialties

- Adult – Alcohol and Substance Abuse Rehab. Services, Licensed Professional/Licensed Clinical Counselor, Psychiatrist, Psychologist, Social Worker, Other Behavioral Health Services
- Pediatric – Pediatric Psychiatrist, Pediatric Psychologist, Mental Health Counselor, Qualified Mental Health Professional, Licensed Practitioner of the Healing Arts

Cook Only Health Plans

- CountyCare & NextLevel

IL2020 Provider Network - HealthChoice IL
Region 3 - Southern Counties
Current Network (Contracted and Loaded Providers)
Health Plan Provider Data Submitted on May 15, 2020

Health Plan	BCBS	IlliniCare	Meridian	Molina
Enrollment as of April 1, 2020	17,116	45,283	78,040	42,901

Health Plan	BCBS	IlliniCare	Meridian	Molina
Practitioners (# of unique NPIs)*				
Primary Care Providers (PCPs)	444	768	799	710
Pediatric Primary Care Providers (PCPs)	421	661	483	804
Mid-Level Practitioners (Adult)	344	972	815	964
Mid-Level Practitioners (Children)	278	946	751	911
Adult Specialty Providers	1,099	1,306	921	1,129
Pediatric Specialists	296	698	458	775
Gynecology, OB/GYN	68	106	106	138
Dental Providers (Adult)	128	95	105	91
Pediatric Dentistry	109	94	109	92
Behavioral Health Providers (Adult)	136	298	209	295
Behavioral Health Providers (Children)	39	187	61	107
Facilities (# of locations)*				
CMHC/FQHC/RHC	151	312	308	241
Skilled Nursing Facilities	84	135	116	66
Supportive Living Facilities	26	23	17	24
Pharmacies	202	247	385	240
Other Facilities	259	356	656	388

Health Plan	BCBS	IlliniCare	Meridian	Molina
Hospitals (# of locations)*				
Hospitals	32	37	33	32

IL2020 Provider Network - HealthChoice IL
Region 4 - Cook County
Current Network (Contracted and Loaded Providers)
Health Plan Provider Data Submitted on May 15, 2020

Health Plan	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Enrollment as of April 1, 2020	245,751	95,178	217,494	63,862	320,365	55,052

Health Plan	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Practitioners (# of unique NPIs)*						
Primary Care Providers (PCPs)	2,025	2,092	2,587	1,708	1,911	1,023
Pediatric Primary Care Providers (PCPs)	1,528	1,600	1,076	2,075	468	193
Mid-Level Practitioners (Adult)	1,003	2,890	2,720	1,921	2,040	1,211
Mid-Level Practitioners (Children)	789	2,778	2,641	1,953	314	2
Adult Specialty Providers	6,340	5,685	6,248	2,967	6,902	1,789
Pediatric Specialists	3,163	3,633	3,671	2,226	514	63
Gynecology, OB/GYN	537	650	672	483	612	363
Dental Providers (Adult)	1,360	1,315	1,119	813	1,187	52
Pediatric Dentistry	1,283	1,318	1,142	814	40	1
Behavioral Health Providers (Adult)	1,093	1,824	1,543	1,609	1,106	791
Behavioral Health Providers (Children)	122	1,201	788	802	181	64
Facilities (# of locations)*						
CMHC/FQHC/RHC	452	571	658	533	1,166	603
Skilled Nursing Facilities	204	244	224	138	215	139
Supportive Living Facilities	28	37	42	28	39	21
Pharmacies	661	882	1,335	815	438	697
Other Facilities	621	1,186	2,131	551	864	170

Health Plan	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Hospitals (# of locations)*						
Hospitals	54	56	55	42	60	31

IL2020 Provider Network - HealthChoice IL
Region 5 - Collar Counties
Current Network (Contracted and Loaded Providers)
Health Plan Provider Data Submitted on May 15, 2020

Health Plan	BCBS	IlliniCare	Meridian	Molina
Enrollment as of April 1, 2020	147,037	68,230	169,407	16,127

Health Plan	BCBS	IlliniCare	Meridian	Molina
Practitioners (# of unique NPIs)*				
Primary Care Providers (PCPs)	1,133	786	1,357	407
Pediatric Primary Care Providers (PCPs)	963	613	653	463
Mid-Level Practitioners (Adult)	528	1,138	1,672	660
Mid-Level Practitioners (Children)	435	1,035	1,557	681
Adult Specialty Providers	3,159	1,855	3,469	757
Pediatric Specialists	1,583	1,079	2,028	561
Gynecology, OB/GYN	298	187	398	88
Dental Providers (Adult)	845	923	672	423
Pediatric Dentistry	782	927	683	421
Behavioral Health Providers (Adult)	452	818	769	605
Behavioral Health Providers (Children)	72	601	298	214
Facilities (# of locations)*				
CMHC/FQHC/RHC	209	295	285	167
Skilled Nursing Facilities	107	140	127	64
Supportive Living Facilities	22	26	26	21
Pharmacies	412	567	931	518
Other Facilities	353	594	1,483	275

Health Plan	BCBS	IlliniCare	Meridian	Molina
Hospitals (# of locations)*				
Hospitals	26	14	25	7

Appendix E3. MLTSS Network Monitoring

HealthChoice Illinois
2020 MLTSS Network Monitoring
Statewide Expansion
Provider Network Data submitted on 5/15/20

Methodology:

HSAG completed the following HCBS & MLTSS network analysis for the Northwestern, Central, Southern, Cook County and Collar Regions. HSAG reviewed the health plan provider network data to identify the number of contracted and loaded Medicaid (HealthChoice IL) providers reported for each county/region.

The analysis in the excel workbook details the following:

- Count of unique providers based on the Tax IDs reported by the health plans for each county/region.

IL2020 HCBS & MLTSS Network Monitoring
Statewide Summary - Contracted Providers
Provider Network Data submitted on 5/15/20

Region / Health Plan	HCBS Enrollment as of April 2020		Provider Coverage by Service Region															Region Coverage (Yes/No)
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS	MLTSS Transportation
Northwestern Counties			**Region 1 – 24 Counties**																
BCBS	**113**	**1,229**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
IlliniCare	**584**	**906**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Meridian	**702**	**890**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Molina	**356**	**517**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Central Counties			**Region 2 – 35 Counties**																
BCBS	**294**	**1,330**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
IlliniCare	**273**	**798**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Meridian	**787**	**840**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Molina	**386**	**503**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Southern Counties			**Region 3 – 34 Counties**																
BCBS	**193**	**1,643**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
IlliniCare	**260**	**1,111**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Meridian	**475**	**995**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+	**Yes**
Molina	**323**	**628**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Collar Counties			**Region 5 – 8 Counties**																
BCBS	**1,184**	**1,432**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
IlliniCare	**636**	**980**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Meridian	**1,046**	**880**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Molina	**81**	**169**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Cook County			**Region 4 – One County**																
BCBS	**3,854**	**5,088**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
IlliniCare	**2,476**	**3,047**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Meridian	**2,147**	**3,275**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
Molina	**276**	**517**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
CountyCare	**4,233**	**4,472**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	**Yes**
NextLevel	**428**	**800**	3+	3+	3+	1	2	3+	3+	3+	3+	3+	1	3+	1	3+	3+	3+	**Yes**

Notes:
• The table also shows the number of unique providers that were identified by the health plans as contracted and loaded.
The figures included in the grid identify the following:
• "3+" - three (3) or more contracted providers (shaded green)
• "2" - two (2) contracted providers (shaded green)
•"1" - one (1) contracted provider (shaded yellow/orange)
•"0" - no contracted/loaded providers were identified in the health plan network data.
• See the Transportation tab for additional information regarding statewide coverage.
• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

IL2020 HCBS & MLTSS Network Monitoring
Region 1 - Northwest Counties: Contracted Providers
Provider Network Data submitted on 5/15/20

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Metro Counties																		
Boone																		
BCBS	**0**	**40**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**24**	**56**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**12**	**31**	3+	2	1	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**0**	**8**	0	0	2	1	0	1	1	0	3+	3+	3+	1	3+	0	0	0
DeKalb																		
BCBS	**14**	**69**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**12**	**34**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**47**	**70**	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**3**	**18**	2	1	3+	1	2	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2
Peoria																		
BCBS	**8**	**134**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	2	2	3+	3+	3+
IlliniCare	**55**	**109**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**129**	**87**	3+	2	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**172**	**82**	1	1	1	1	2	3+	3+	2	3+	3+	3+	2	3+	3+	3+	1
Rock Island																		
BCBS	**2**	**142**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**53**	**95**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**83**	**64**	3+	2	2	3+	2	2	3+	0	1	3+	0	3+	0	2	3+	1
Molina	**4**	**33**	1	1	1	1	0	1	2	0	3+	3+	0	2	3+	3+	3+	1
Tazewell																		
BCBS	**2**	**55**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**21**	**36**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**46**	**44**	3+	2	2	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**59**	**41**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	2	2	0
Winnebago																		
BCBS	**25**	**345**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**284**	**312**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**201**	**183**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**18**	**148**	2	1	3+	2	1	2	3+	2	3+	3+	1	3+	3+	3+	3+	2
Micro Counties																		
Henry																		
BCBS	**0**	**25**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**11**	**18**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**5**	**23**	3+	3+	2	3+	2	2	3+	3+	3+	3+	0	3+	2	3+	3+	3+
Molina	**3**	**6**	0	0	0	1	0	1	1	0	3+	3+	1	2	3+	3+	3+	0
Knox																		
BCBS	**2**	**23**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**14**	**19**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**25**	**28**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**41**	**23**	1	1	1	1	1	2	3+	3+	3+	3+	1	3+	3+	3+	3+	2
La Salle																		
BCBS	**9**	**59**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**21**	**44**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**17**	**60**	3+	3+	3+	3+	2	1	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**7**	**27**	2	1	2	1	2	3+	3+	2	3+	3+	2	3+	3+	2	2	2
Ogle																		
BCBS	**8**	**35**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
IlliniCare	**12**	**18**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**20**	**19**	3+	2	1	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**3**	**12**	0	0	0	1	0	1	1	0	3+	3+	1	1	3+	1	1	0
Stephenson																		
BCBS	**5**	**22**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**13**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**39**	**103**	2	2	1	3+	2	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**8**	**32**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Whiteside																		
BCBS	**18**	**90**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**17**	**43**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**26**	**40**	3+	3+	2	3+	2	2	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**8**	**28**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	1	1	0
Woodford																		
BCBS	**1**	**16**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**5**	**12**	2	3+	1	1	2	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Meridian	**2**	**3**	3+	2	2	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**7**	**5**	0	0	0	1	1	1	1	0	3+	3+	1	1	3+	2	3+	0
Rural Counties																		
Bureau																		
BCBS	**4**	**28**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**6**	**13**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**6**	**18**	1	1	1	3+	2	2	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**9**	0	0	0	1	0	1	1	0	3+	3+	1	1	3+	0	0	0
Carroll																		
BCBS	**2**	**11**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
IlliniCare	**0**	**7**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	2
Meridian	**8**	**13**	1	1	1	3+	2	2	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**2**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Fulton																		
BCBS	**2**	**53**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**10**	**28**	3+	3+	2	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**13**	**34**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**14**	**17**	0	0	0	1	0	2	2	1	3+	3+	1	3+	3+	2	2	1
Henderson																		
BCBS	**1**	**3**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**2**	**1**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**11**	2	1	1	3+	2	2	1	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**2**	1	1	1	2	1	2	2	1	2	3+	0	2	3+	2	2	1
Jo Daviess																		
BCBS	**1**	**10**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**2**	**3**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Meridian	**3**	**6**	1	1	1	3+	2	1	2	1	2	3+	0	2	1	3+	3+	3+
Molina	**2**	**2**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Lee																		
BCBS	**5**	**29**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**9**	**18**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**9**	**12**	3+	2	2	3+	3+	2	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**2**	**11**	0	0	0	1	0	1	1	0	3+	3+	1	1	3+	2	2	0
Marshall																		
BCBS	**2**	**8**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**2**	**3**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**4**	3+	2	1	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Molina	**1**	**5**	1	1	1	2	1	2	2	1	3+	3+	1	2	3+	1	1	1

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level															
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Mercer																		
BCBS	**0**	**12**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**6**	**12**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**0**	**11**	3+	2	2	3+	2	1	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**1**	**0**	0	0	0	1	0	1	1	0	3+	3+	1	1	3+	1	1	0
Putnam																		
BCBS	**2**	**0**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**1**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**0**	**1**	1	1	1	3+	2	1	2	3+	3+	3+	0	2	1	3+	3+	3+
Molina	**0**	**0**	0	0	0	1	0	1	1	0	1	3+	1	1	3+	0	0	0
Stark																		
BCBS	**0**	**2**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**3**	2	2	2	1	1	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Meridian	**2**	**1**	3+	2	2	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**1**	**1**	0	0	0	1	1	1	1	0	2	3+	2	1	3+	2	2	0
Warren																		
BCBS	**0**	**18**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**13**	**8**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**24**	3+	1	1	3+	2	3+	2	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**2**	**5**	0	0	0	1	0	1	2	0	2	3+	1	1	3+	1	0	0

Notes:

• This report includes the number of unique providers that were reported by the health plans within each regional county. Note - counties that were identified with "zero" (0) providers do not necessarily indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded for the identified county.

The figures included in the grid identify the following:

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted/loaded providers were identified in the health plan provider data

• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

IL2020 HCBS & MLTSS Network Monitoring
Region 2 - Central Counties: Contracted Providers
Provider Network Data submitted on 5/15/20

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Metro Counties																		
Champaign																		
BCBS	**3**	**62**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
IlliniCare	**6**	**54**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**42**	**25**	3+	3+	1	3+	3+	1	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**105**	**47**	1	1	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Coles																		
BCBS	**8**	**62**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**16**	**75**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**23**	**52**	2	1	1	3+	2	2	3+	2	3+	3+	1	3+	1	2	2	2
Molina	**7**	**24**	1	1	1	1	1	2	2	1	3+	3+	1	1	3+	2	2	1
Macon																		
BCBS	**49**	**158**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**59**	**90**	2	2	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**57**	**90**	3+	3+	2	3+	2	1	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Molina	**20**	**54**	0	0	1	2	1	2	2	1	3+	3+	3+	1	3+	3+	3+	1
McLean																		
BCBS	**4**	**29**	0	0	0	0	0	0	0	0	0	3+	0	0	0	0	0	0
IlliniCare	**11**	**23**	2	2	3+	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**15**	**22**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**53**	**34**	1	1	0	2	0	2	2	1	3+	3+	3+	0	3+	3+	3+	1
Sangamon																		
BCBS	**112**	**298**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**37**	**96**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**108**	**168**	3+	2	2	3+	2	2	3+	3+	3+	3+	1	3+	0	3+	3+	3+
Molina	**16**	**81**	0	0	0	1	0	1	1	0	3+	3+	3+	0	3+	3+	2	0
Micro Counties																		
Adams																		
BCBS	**14**	**89**	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	2	2	3+	3+	3+
IlliniCare	**10**	**54**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**26**	**49**	2	2	1	3+	2	1	3+	1	1	3+	1	3+	1	2	3+	1
Molina	**16**	**33**	0	0	1	1	1	3+	2	1	3+	3+	0	1	3+	3+	3+	1
Jersey																		
BCBS	**3**	**38**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**12**	**19**	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**8**	**12**	3+	2	1	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+	3+
Molina	**5**	**11**	1	2	1	1	2	2	2	1	1	3+	2	1	3+	2	3+	1
Macoupin																		
BCBS	**10**	**52**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**9**	**36**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**18**	**29**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**9**	**15**	1	1	1	1	1	1	1	0	3+	3+	3+	0	3+	2	1	0
McDonough																		
BCBS	**0**	**21**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**10**	**22**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**15**	**51**	3+	2	1	3+	2	3+	2	3+	3+	3+	0	3+	1	3+	3+	3+

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Molina	**3**	**11**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	1	0
Morgan																		
BCBS	**16**	**71**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	2	3+	3+	3+
IlliniCare	**12**	**37**	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**32**	**64**	3+	3+	2	3+	2	2	3+	3+	3+	3+	1	3+	1	3+	3+	3+
Molina	**2**	**16**	0	0	0	1	0	1	1	0	3+	3+	1	0	3+	0	0	0
Vermilion																		
BCBS	**5**	**42**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**33**	1	2	1	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**47**	**20**	3+	3+	1	3+	3+	1	3+	1	3+	3+	0	3+	1	3+	3+	3+
Molina	**92**	**48**	0	0	0	2	0	1	0	0	3+	3+	3+	0	3+	0	1	0
Rural Counties																		
Brown																		
BCBS	**3**	**3**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**0**	1	1	1	1	1	2	1	3+	3+	3+	1	3+	2	2	2	2
Meridian	**0**	**3**	1	1	1	3+	2	1	2	3+	3+	3+	1	3+	1	3+	3+	3+
Molina	**1**	**1**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	1	1	0
Calhoun																		
BCBS	**1**	**3**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**5**	**5**	1	1	1	1	1	2	2	2	2	3+	1	3+	3+	1	1	1
Meridian	**0**	**5**	3+	2	1	3+	3+	3+	3+	1	3+	3+	0	3+	1	3+	3+	3+
Molina	**2**	**3**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0
Cass																		
BCBS	**3**	**17**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**7**	**15**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**8**	**9**	3+	3+	2	3+	2	1	3+	2	3+	3+	0	3+	0	3+	3+	3+
Molina	**1**	**11**	0	0	0	1	0	1	1	0	3+	3+	1	0	3+	1	1	0
Christian																		
BCBS	**17**	**39**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**8**	**11**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**17**	**27**	3+	2	2	3+	2	1	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**2**	**9**	1	0	0	1	0	2	1	1	3+	3+	3+	1	3+	2	2	1
Clark																		
BCBS	**2**	**10**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**1**	**9**	2	3+	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2**	**6**	1	1	1	3+	2	0	2	0	1	3+	0	2	0	1	1	1
Molina	**2**	**0**	0	0	0	1	0	1	1	0	3+	3+	1	0	3+	1	0	0
Cumberland																		
BCBS	**0**	**7**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**1**	**8**	2	2	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**8**	2	1	1	3+	2	1	2	1	2	3+	0	3+	1	2	2	2
Molina	**0**	**3**	0	0	0	1	0	1	1	0	2	3+	2	0	3+	1	0	0
De Witt																		
BCBS	**2**	**10**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**10**	1	1	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**3**	**3**	3+	3+	1	3+	2	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**4**	**7**	0	0	0	1	0	1	0	0	3+	3+	1	0	3+	1	1	0
Douglas																		
BCBS	**1**	**14**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**13**	2	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**5**	**3**	2	2	1	3+	2	1	3+	0	3+	3+	0	3+	0	3+	3+	3+

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Molina	**3**	**2**	0	0	0	2	0	1	1	0	1	3+	3+	0	3+	1	1	0
Edgar																		
BCBS	**0**	**23**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**2**	**17**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2**	**14**	2	2	1	3+	2	0	3+	1	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**8**	0	0	1	2	0	1	1	0	3+	3+	3+	0	3+	1	0	0
Ford																		
BCBS	**0**	**6**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**2**	1	2	2	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**4**	**2**	3+	3+	2	3+	3+	0	2	2	3+	3+	1	3+	1	3+	3+	3+
Molina	**7**	**2**	0	0	0	2	0	1	0	0	3+	3+	3+	0	3+	1	1	0
Greene																		
BCBS	**5**	**14**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**9**	**12**	2	2	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**13**	**7**	3+	2	1	3+	2	2	3+	2	3+	3+	0	3+	1	3+	3+	3+
Molina	**4**	**5**	0	0	0	1	0	1	0	0	2	3+	0	0	3+	1	1	0
Hancock																		
BCBS	**1**	**11**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**6**	**17**	2	2	3+	2	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2**	**21**	3+	3+	1	3+	2	1	3+	0	3+	3+	0	3+	0	2	3+	2
Molina	**0**	**5**	0	0	1	1	0	1	1	0	2	3+	0	1	3+	1	1	0
Iroquois																		
BCBS	**7**	**43**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**18**	1	2	2	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**8**	**10**	3+	3+	2	3+	3+	0	2	2	3+	3+	1	3+	2	3+	3+	3+
Molina	**3**	**10**	0	1	1	1	1	1	1	1	3+	3+	0	1	3+	2	3+	1
Livingston																		
BCBS	**1**	**22**	1	1	0	1	1	1	1	1	1	3+	0	1	1	1	1	1
IlliniCare	**6**	**34**	1	1	1	1	1	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Meridian	**0**	**27**	2	2	2	3+	3+	3+	3+	2	3+	3+	1	3+	1	3+	3+	3+
Molina	**3**	**11**	0	0	0	1	0	1	0	0	3+	3+	0	0	3+	1	2	0
Logan																		
BCBS	**6**	**63**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	2	3+	3+	3+
IlliniCare	**6**	**11**	3+	3+	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**7**	**17**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Molina	**1**	**9**	0	0	0	1	0	1	1	0	3+	3+	3+	0	3+	0	0	0
Mason																		
BCBS	**1**	**17**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**5**	**8**	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**8**	**4**	3+	1	2	3+	3+	3+	3+	2	3+	3+	1	3+	2	3+	3+	3+
Molina	**6**	**8**	0	0	1	1	1	1	2	1	3+	3+	0	1	3+	1	1	1
Menard																		
BCBS	**5**	**11**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**6**	2	1	0	0	0	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Meridian	**6**	**8**	3+	2	2	3+	2	2	3+	2	3+	3+	0	3+	0	3+	3+	3+
Molina	**1**	**3**	0	0	0	1	0	1	1	0	2	3+	1	0	3+	0	0	0
Montgomery																		
BCBS	**7**	**27**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**7**	**19**	1	2	0	0	0	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**9**	**40**	3+	2	3+	3+	2	1	3+	3+	3+	3+	1	3+	0	3+	3+	2
Molina	**7**	**9**	0	0	0	1	0	1	1	0	3+	3+	3+	2	3+	1	3+	0

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Moultrie																		
BCBS	**2**	**8**	2	2	2	2	2	2	2	2	2	3+	2	2	2	2	2	2
IlliniCare	**0**	**18**	1	1	1	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2**	**4**	2	1	1	3+	2	1	2	1	2	3+	0	3+	1	3+	3+	2
Molina	**0**	**2**	0	0	0	1	0	1	0	0	2	3+	2	0	3+	1	0	0
Piatt																		
BCBS	**0**	**4**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**3**	1	1	1	1	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+
Meridian	**0**	**2**	3+	3+	1	3+	2	1	3+	2	3+	3+	0	3+	2	3+	3+	3+
Molina	**2**	**4**	0	0	0	2	0	1	0	0	3+	3+	3+	0	3+	1	1	0
Pike																		
BCBS	**3**	**24**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**13**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**18**	2	2	1	3+	2	2	3+	2	3+	3+	0	3+	1	3+	3+	3+
Molina	**8**	**11**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	1	1	0
Schuyler																		
BCBS	**0**	**11**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**0**	2	2	2	1	2	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Meridian	**3**	**6**	2	2	1	3+	2	3+	2	0	3+	3+	0	3+	0	3+	3+	3+
Molina	**0**	**2**	1	1	1	2	1	2	3+	1	2	3+	0	1	3+	1	1	1
Scott																		
BCBS	**1**	**4**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**1**	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**4**	**5**	2	1	1	3+	2	1	2	2	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**0**	0	0	0	1	0	1	1	0	1	3+	0	0	3+	0	0	0
Shelby																		
BCBS	**2**	**17**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**7**	**9**	1	2	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**287**	**9**	3+	1	1	3+	2	1	2	2	3+	3+	0	3+	1	3+	3+	3+
Molina	**1**	**4**	0	0	1	1	0	1	0	0	3+	3+	3+	0	3+	1	0	0

Notes:

• This report includes the number of unique providers that were reported by the health plans within each regional county. Note - counties that were identified with "zero" (0) providers do not necessarily indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded for the identified county.

The figures included in the grid identify the following:

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted/loaded providers were identified in the health plan provider data

• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

IL2020 HCBS & MLTSS Network Monitoring
Region 3 - Southern Counties: Contracted Providers
Provider Network Data submitted on 5/15/20

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level															
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Metro Counties																		
Jackson																		
BCBS	**15**	**119**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**36**	**65**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**31**	**35**	2	1	1	3+	2	1	3+	2	2	3+	0	3+	1	3+	3+	2
Molina	**10**	**38**	1	1	1	1	1	1	2	1	3+	3+	0	3+	3+	1	2	1
Madison																		
BCBS	**18**	**247**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
IlliniCare	**28**	**200**	3+	3+	3+	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**234**	**258**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Molina	**132**	**172**	2	2	2	2	2	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	1
Saint Clair																		
BCBS	**4**	**318**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**12**	**198**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**0**	**273**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	1	3+	1	3+	3+	3+
Molina	**105**	**170**	2	1	0	1	0	1	1	0	3+	3+	3+	1	3+	3+	3+	0
Williamson																		
BCBS	**12**	**104**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**24**	**52**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**23**	**57**	2	1	1	3+	2	1	3+	2	2	3+	1	3+	1	3+	3+	2
Molina	**3**	**23**	1	0	1	1	1	1	2	1	3+	3+	0	2	3+	2	3+	1
Micro Counties																		
Clinton																		
BCBS	**1**	**23**	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
IlliniCare	**1**	**8**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**9**	**27**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**3**	**5**	1	1	1	1	1	2	1	1	3+	3+	3+	1	3+	2	2	1
Effingham																		
BCBS	**1**	**25**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**28**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**7**	**12**	1	0	1	3+	2	2	2	2	3+	3+	0	2	1	3+	3+	3+
Molina	**1**	**5**	1	2	2	2	2	2	2	1	2	3+	1	2	3+	2	1	1
Franklin																		
BCBS	**5**	**79**	2	2	1	1	2	1	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**9**	**50**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**16**	**31**	2	1	1	3+	2	1	3+	2	2	3+	0	3+	1	3+	3+	2
Molina	**4**	**25**	1	1	2	1	1	1	2	1	2	3+	0	2	3+	1	1	1
Jefferson																		
BCBS	**13**	**82**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**14**	**49**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**13**	**18**	2	1	1	3+	2	1	3+	2	3+	3+	1	3+	1	3+	3+	2
Molina	**6**	**23**	0	0	0	1	0	1	1	0	3+	3+	1	3+	3+	2	3+	0
Marion																		
BCBS	**16**	**94**	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
IlliniCare	**8**	**56**	2	3+	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**30**	**52**	2	1	2	3+	2	2	3+	2	3+	3+	0	3+	1	3+	3+	3+

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Molina	**9**	**24**	0	0	1	1	1	1	2	1	3+	3+	2	3+	3+	2	3+	1
Massac																		
BCBS	**6**	**26**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**7**	**18**	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Meridian	**12**	**10**	0	0	1	3+	2	1	2	0	0	3+	0	0	0	0	0	0
Molina	**4**	**5**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Monroe																		
BCBS	**2**	**19**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**2**	3+	3+	2	2	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**1**	**4**	3+	3+	1	3+	3+	3+	3+	2	3+	3+	0	3+	1	3+	3+	3+
Molina	**0**	**0**	0	0	1	1	0	1	0	0	3+	3+	0	1	3+	1	1	0
Randolph																		
BCBS	**2**	**33**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**12**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**4**	**9**	3+	3+	1	3+	3+	2	3+	1	3+	3+	0	3+	0	3+	3+	3+
Molina	**8**	**8**	0	0	0	1	0	1	0	0	3+	3+	0	0	3+	1	1	0
Saline																		
BCBS	**12**	**39**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**22**	**36**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**12**	**20**	2	1	1	3+	2	1	3+	2	2	3+	0	3+	1	3+	3+	2
Molina	**2**	**16**	1	0	1	1	1	1	2	1	3+	3+	0	2	3+	3+	3+	1
Wabash																		
BCBS	**2**	**14**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**5**	**14**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**1**	**13**	1	1	1	3+	2	1	3+	2	2	3+	1	2	0	3+	3+	2
Molina	**0**	**4**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	1	0
Rural Counties																		
Alexander																		
BCBS	**16**	**26**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**4**	**17**	3+	2	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	1	1	1
Meridian	**8**	**5**	0	0	0	3+	2	1	1	0	1	3+	0	1	0	1	1	1
Molina	**1**	**10**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0
Bond																		
BCBS	**4**	**18**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**15**	2	2	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**12**	**25**	3+	2	2	3+	2	2	3+	3+	3+	3+	0	3+	0	3+	3+	3+
Molina	**1**	**4**	0	0	0	1	0	1	0	0	2	3+	3+	0	3+	1	1	0
Clay																		
BCBS	**3**	**51**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**19**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**1**	**15**	1	0	1	3+	2	2	3+	2	2	3+	0	2	1	3+	3+	2
Molina	**2**	**6**	0	0	0	1	0	1	1	0	1	3+	1	1	3+	1	1	0
Crawford																		
BCBS	**3**	**11**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**27**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**0**	**8**	0	0	0	3+	2	1	1	2	2	3+	0	0	0	3+	3+	2
Molina	**1**	**3**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Edwards																		
BCBS	**0**	**3**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**6**	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Meridian	**0**	**4**	1	1	1	3+	2	1	3+	2	2	3+	0	2	0	3+	3+	2

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level															
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Molina	**0**	**1**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Fayette																		
BCBS	**5**	**38**	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
IlliniCare	**3**	**8**	2	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**3**	**10**	2	1	0	3+	2	2	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**2**	**8**	0	0	0	1	0	1	1	0	2	3+	3+	1	3+	2	1	0
Gallatin																		
BCBS	**2**	**13**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**1**	**5**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	0	0
Meridian	**5**	**4**	0	0	0	3+	2	1	1	0	1	3+	0	0	0	1	1	1
Molina	**1**	**4**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0
Hamilton																		
BCBS	**1**	**25**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**0**	**10**	2	2	2	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Meridian	**1**	**7**	1	1	1	3+	2	1	3+	0	1	3+	0	3+	0	3+	3+	1
Molina	**0**	**2**	0	0	0	1	0	1	1	0	1	3+	0	1	3+	0	0	0
Hardin																		
BCBS	**1**	**9**	2	2	2	2	2	2	2	2	2	3+	2	2	2	2	2	2
IlliniCare	**0**	**5**	3+	2	2	2	2	3+	3+	3+	3+	3+	2	3+	3+	2	2	2
Meridian	**2**	**3**	0	0	0	3+	2	1	1	0	0	3+	0	0	0	0	0	0
Molina	**0**	**1**	1	0	1	1	1	1	2	1	1	3+	0	2	3+	1	1	1
Jasper																		
BCBS	**0**	**10**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**10**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**1**	**2**	1	1	1	3+	2	2	3+	3+	3+	3+	0	1	0	3+	3+	3+
Molina	**1**	**5**	0	0	0	1	0	1	1	0	2	3+	1	1	3+	0	0	0
Johnson																		
BCBS	**2**	**19**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**7**	**23**	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**10**	**8**	2	1	1	3+	2	1	3+	2	2	3+	0	3+	1	3+	3+	2
Molina	**2**	**4**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0
Lawrence																		
BCBS	**1**	**21**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**4**	**16**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Meridian	**2**	**7**	1	1	0	3+	2	1	2	2	2	3+	0	1	0	3+	3+	2
Molina	**2**	**6**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	0	0	0
Perry																		
BCBS	**3**	**31**	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
IlliniCare	**12**	**14**	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Meridian	**6**	**7**	3+	2	1	3+	2	1	3+	1	2	3+	0	3+	1	3+	3+	2
Molina	**5**	**8**	1	1	1	1	1	1	2	1	3+	3+	0	2	3+	1	1	1
Pope																		
BCBS	**0**	**5**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**3**	**1**	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	0	0
Meridian	**4**	**0**	0	0	1	3+	2	1	2	0	0	3+	0	0	0	0	0	0
Molina	**0**	**0**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0
Pulaski																		
BCBS	**16**	**26**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**7**	**15**	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	1	1	1
Meridian	**8**	**7**	0	0	1	3+	2	1	2	0	1	3+	0	1	0	1	1	1
Molina	**1**	**10**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	0	0	0

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Richland																		
BCBS	**3**	**24**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**8**	**32**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**5**	**20**	1	1	1	3+	2	1	3+	2	2	3+	0	2	0	3+	3+	2
Molina	**7**	**9**	1	0	1	1	1	2	2	1	3+	3+	0	2	3+	2	2	1
Union																		
BCBS	**19**	**48**	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
IlliniCare	**12**	**27**	3+	2	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	2	2	2
Meridian	**11**	**20**	2	1	1	3+	2	1	3+	2	2	3+	0	3+	1	3+	3+	2
Molina	**6**	**13**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	1	1	0
Washington																		
BCBS	**1**	**5**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**2**	**9**	2	1	0	0	0	3+	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Meridian	**0**	**9**	3+	2	2	3+	2	1	3+	1	3+	3+	0	3+	1	3+	3+	3+
Molina	**1**	**5**	0	0	0	1	0	1	0	0	2	3+	1	0	3+	1	1	0
Wayne																		
BCBS	**3**	**14**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**9**	**28**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2**	**8**	2	1	1	3+	2	1	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Molina	**2**	**6**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	1	1	0
White																		
BCBS	**1**	**24**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**6**	**36**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Meridian	**1**	**7**	1	1	1	3+	2	1	3+	0	1	3+	0	2	0	1	1	1
Molina	**1**	**5**	0	0	0	1	0	1	1	0	2	3+	0	1	3+	1	1	0

Notes:

• This report includes the number of unique providers that were reported by the health plans within each regional county. Note - counties that were identified with "zero" (0) providers do not necessarily indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded for the identified county.

The figures included in the grid identify the following:

• "3+" - three (3) or more contracted providers

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•"1" - one (1) contracted provider

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• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

IL2020 HCBS & MLTSS Network Monitoring
Region 5 - Collar Counties: Contracted Providers
Provider Network Data submitted on 5/15/20

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Large Metro																		
DuPage																		
BCBS	**436**	**328**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**171**	**188**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**312**	**218**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**26**	**40**	3+	3+	3+	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lake																		
BCBS	**148**	**273**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**142**	**292**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**205**	**123**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**9**	**27**	3+	3+	3+	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Metro Counties																		
Grundy																		
BCBS	**2**	**47**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**3**	**25**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**8**	**12**	3+	3+	3+	3+	2	2	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**0**	**3**	0	0	0	1	0	1	1	0	3+	3+	0	1	3+	1	0	0
Kane																		
BCBS	**229**	**259**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**93**	**187**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**168**	**213**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**11**	**25**	1	2	3+	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	2
Kankakee																		
BCBS	**95**	**66**	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
IlliniCare	**24**	**39**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**47**	**49**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**4**	**4**	0	1	2	1	0	1	2	0	3+	3+	0	2	3+	1	3+	0
Kendall																		
BCBS	**42**	**83**	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
IlliniCare	**5**	**27**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**18**	**18**	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Molina	**2**	**10**	1	0	3+	1	1	3+	3+	2	3+	3+	1	2	3+	1	1	1
McHenry																		
BCBS	**21**	**188**	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	2	2	3+	3+	3+
IlliniCare	**32**	**71**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**96**	**67**	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**5**	**25**	2	2	3+	1	0	3+	3+	1	3+	3+	3+	2	3+	3+	3+	1
Will																		
BCBS	**211**	**188**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**166**	**151**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**192**	**180**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**24**	**35**	1	2	3+	2	0	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level															
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS

Notes:

• This report includes the number of unique providers that were reported by the health plans within each regional county. Note - counties that were identified with "zero" (0) providers do not necessarily indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded for the identified county.

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IL2020 HCBS & MLTSS Network Monitoring
Region 4 - Cook County: Contracted Providers
Provider Network Data submitted on 5/15/20

County / Health Plan	HCBS Enrollment as of April 2020		Contracted HCBS Providers - County Level														
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS
Large Metro																		
Cook																		
BCBS	**3,854**	**5,088**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
IlliniCare	**2,476**	**3,047**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Meridian	**2,147**	**3,275**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Molina	**276**	**517**	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
CountyCare	**4,233**	**4,472**	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
NextLevel	**428**	**800**	3+	3+	3+	1	2	3+	3+	3+	3+	3+	1	3+	1	3+	3+	3+

Notes:
• This report includes the number of unique providers that were reported by the health plans within each regional county. Note - counties that were identified with "zero" (0) providers do not necessarily indicate a lack of access for members as providers in neighboring counties may have the capacity to provide the identified service. The analysis above reflects providers that were listed in the health plan data as contracted and loaded for the identified county.
The figures included in the grid identify the following:
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• Environmental Accessibility - contract section 5.7.1.5.1 states that the health plan shall ensure that this service is satisfactorily completed by a qualified provider within ninety (90) days after the health plan becomes aware of the need.

IL2020 HCBS & MLTSS Network Monitoring
Percent of Counties with Coverage - Statewide Summary
Provider Network Data submitted on 5/15/20

Region / Health Plan	HCBS Enrollment as of April 2020		Percent of Counties with Coverage															Region Coverage (Yes/No)
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS	MLTSS Transportation
Northwestern Counties										**Region 1 – 24 Counties**									
BCBS	**113**	**1,229**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
IlliniCare	**584**	**906**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
Meridian	**702**	**890**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	<70%	>90%	>90%	>90%	>90%	>90%	**Yes**
Molina	**356**	**517**	<70%	<70%	<70%	>90%	<70%	>90%	>90%	<70%	>90%	>90%	70-90%	>90%	>90%	70-90%	70-90%	<70%	**Yes**
Central Counties										**Region 2 – 35 Counties**									
BCBS	**294**	**1,330**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
IlliniCare	**273**	**798**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
Meridian	**787**	**840**	>90%	>90%	>90%	>90%	>90%	70-90%	>90%	70-90%	>90%	>90%	<70%	>90%	70-90%	>90%	>90%	>90%	**Yes**
Molina	**386**	**503**	<70%	<70%	<70%	>90%	<70%	>90%	70-90%	<70%	>90%	>90%	<70%	<70%	>90%	70-90%	70-90%	<70%	**Yes**
Southern Counties										**Region 3 – 24 Counties**									
BCBS	**193**	**1,643**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
IlliniCare	**260**	**1,111**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
Meridian	**475**	**995**	70-90%	70-90%	70-90%	>90%	>90%	>90%	>90%	70-90%	>90%	>90%	<70%	70-90%	<70%	>90%	>90%	>90%	**Yes**
Molina	**323**	**628**	<70%	<70%	<70%	>90%	<70%	>90%	70-90%	<70%	>90%	>90%	<70%	>90%	>90%	<70%	<70%	<70%	**Yes**
Collar Counties										**Region 5 – 8 Counties**									
BCBS	**1,184**	**1,432**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
IlliniCare	**636**	**980**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
Meridian	**1,046**	**880**	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	>90%	**Yes**
Molina	**81**	**169**	70-90%	70-90%	>90%	>90%	<70%	>90%	>90%	70-90%	>90%	>90%	70-90%	>90%	>90%	>90%	>90%	70-90%	**Yes**
Cook County										**Region 4 – One County**									
BCBS	**3,854**	**5,088**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**
IlliniCare	**2,476**	**3,047**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**
Meridian	**2,147**	**3,275**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**
Molina	**276**	**517**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**
CountyCare	**4,233**	**4,472**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**
NextLevel	**428**	**800**	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	**Yes**

IL2020 HCBS & MLTSS Network Monitoring
County Coverage - Contracted Providers
Provider Network Data submitted on 5/15/20

Region / Health Plan	HCBS Enrollment as of April 2020		County Coverage by Service Region															Region Coverage (Yes/No)
	HCI Program	MLTSS Program	Adult Day Services	Adult Day Services Transportation	Day Habilitation	Environmental Accessibility	Home Delivered Meals	Home Health Aide	Homemaker Services	Nursing Intermittent	Nursing Skilled	Personal Emergency Response System	Pre-vocational Services	Respite Care Services	Specialized Medical Equipment	Occupational Therapy-HCBS	Physical Therapy-HCBS	Speech Therapy-HCBS	MLTSS Transportation
Northwestern Counties			**Region 1 – 24 Counties**																
BCBS	**113**	**1,229**	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	**Yes**
IlliniCare	**584**	**906**	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	**Yes**
Meridian	**702**	**890**	24	24	24	24	24	24	24	23	24	24	10	24	23	24	24	24	**Yes**
Molina	**356**	**517**	8	8	9	24	9	24	24	8	24	24	17	24	24	18	17	9	**Yes**
Central Counties			**Region 2 – 35 Counties**																
BCBS	**294**	**1,330**	34	34	33	34	34	34	34	34	34	35	33	34	34	34	34	34	**Yes**
IlliniCare	**273**	**798**	35	35	33	33	33	35	35	35	35	35	35	35	35	35	35	35	**Yes**
Meridian	**787**	**840**	35	35	35	35	35	31	35	31	35	35	12	35	27	35	35	35	**Yes**
Molina	**386**	**503**	7	7	12	35	9	35	27	10	35	35	23	15	35	28	25	10	**Yes**
Southern Counties			**Region 3 – 34 Counties**																
BCBS	**193**	**1,643**	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	34	**Yes**
IlliniCare	**260**	**1,111**	34	34	33	33	33	34	34	34	34	34	34	34	34	32	32	32	**Yes**
Meridian	**475**	**995**	27	25	28	34	34	34	34	26	31	34	5	29	18	31	31	31	**Yes**
Molina	**323**	**628**	11	7	12	34	11	34	30	11	34	34	11	31	34	22	23	11	**Yes**
Collar Counties			**Region 5 – 8 Counties**																
BCBS	**1,184**	**1,432**	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	**Yes**
IlliniCare	**636**	**980**	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	**Yes**
Meridian	**1,046**	**880**	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	**Yes**
Molina	**81**	**169**	6	6	8	8	4	8	8	6	8	8	6	8	8	8	8	6	**Yes**
Cook County			**Region 4 – One County**																
BCBS	**3,854**	**5,088**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**
IlliniCare	**2,476**	**3,047**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**
Meridian	**2,147**	**3,275**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**
Molina	**276**	**517**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**
CountyCare	**4,233**	**4,472**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**
NextLevel	**428**	**800**	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	**Yes**

Notes:
• The grid above shows the number of counties that were identified with **at least one contracted provider.**
The figures included in the grid identify the following:
• Total number of counties within each region (shaded in dark blue) and number of counties the health plans reported with at least one contracted provider (shaded in green)
• See the Transportation tab for additional information regarding statewide coverage.

IL2020 MCO Transportation Vendors for MLTSS
Network Monitoring: Statewide Coverage

Transportation Vendors	Current Network					
Health Plan	**BCBS**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Transportation Vendors						
Logisticare	X	X				
MTM			X			
Secure Transportation				X		
First Transit					X	
PAL Transportation						X
SCR Medical						X
Car-(Catch a Ride)						X
Total	**1**	**1**	**1**	**1**	**1**	**3**

- The "X" in the grid above identifies the transportation vendor contracted with each health plan.
- Health plans reported that their transportation vendors for MLTSS have the capacity to provide statewide coverage.

IL2020 HCBS & MLTSS Network Review
HealthChoice IL
Health Plan data submitted on 5/15/20

Methodology:

HSAG completed the following HCBS & MLTSS Network review for the Northwestern, Central, Southern, Cook County and Collar Regions. To complete the HCBS & MLTSS regional review, HSAG used the MCO reported Tax IDs to identify unique providers within each managed care region. The following region specific tabs provide a comparative analysis across health plans by provider/service type.

IL2020 HCBS & MLTSS Provider Network for Northwestern Counties Region 1
Current Network: Contracted and Loaded Providers
Health Plan data submitted on 5/15/20

Enrollment	BCBS	IlliniCare	Meridian	Molina
HCBS Enrollment as of April 2020	113	584	702	356
MLTSS Enrollment as of April 2020	1,229	906	890	517

	Contracted and Loaded			
Facilities	BCBS	IlliniCare	Meridian	Molina
Exceptional Care	2	23	15	3
Skilled Nursing Facilities	104	122	117	87
Supportive Living Facilities	19	23	17	20

	Contracted and Loaded			
HCBS Providers	BCBS	IlliniCare	Meridian	Molina
Pre-vocational Services	6	39	5	15
Respite Care Services	8	201	30	14
Specialized Medical Equipment	8	69	15	22

	Contracted and Loaded			
Behavioral Health Services	BCBS	IlliniCare	Meridian	Molina
Alcohol and Substance Abuse Rehab. Services	6	12	14	13
Licensed Professional/Licensed Clinical Counselor	34	31	80	42
Other Behavioral Health Services	59	38	38	14
Psychologist	13	14	14	14
Social Worker	41	45	51	37
Targeted Case Management Services	10	24	29	25

	Contracted and Loaded			
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina
Medicar Transportation	9	33	4	16

Non-Emergency Ambulance Transportation	9	24	1	28
Other Transportation*	7	76	24	31

HSAG Notes:

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

IL2020 HCBS & MLTSS Provider Network for Central Counties Region 2
Current Network: Contracted and Loaded Providers
Health Plan data submitted on 5/15/20

Enrollment	BCBS	IlliniCare	Meridian	Molina
HCBS Enrollment as of April 2020	294	273	787	386
MLTSS Enrollment as of April 2020	1,330	798	840	503

	Contracted and Loaded			
Facilities	BCBS	IlliniCare	Meridian	Molina
Exceptional Care	0	15	8	0
Skilled Nursing Facilities	97	127	111	88
Supportive Living Facilities	26	27	16	27

	Contracted and Loaded			
HCBS Providers	BCBS	IlliniCare	Meridian	Molina
Pre-vocational Services	6	35	5	11
Respite Care Services	8	193	26	11
Specialized Medical Equipment	7	72	8	17

	Contracted and Loaded			
Behavioral Health Services	BCBS	IlliniCare	Meridian	Molina
Alcohol and Substance Abuse Rehab. Services	8	10	6	25
Licensed Professional/Licensed Clinical Counselor	33	43	63	38
Other Behavioral Health Services	73	38	23	15
Psychologist	6	15	10	13
Social Worker	37	50	42	44
Targeted Case Management Services	9	37	16	35

	Contracted and Loaded			
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina
Medicar Transportation	9	42	3	14

Non-Emergency Ambulance Transportation	6	35	0	32
Other Transportation	7	103	16	30

HSAG Notes:
*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

Health Plan Notes:
• **Meridian** reported that ambulance providers are reimbursed by Meridian for providing Non-Emergency Ambulance transportation services in the Central and Southern regions regardless of network status (contracted and non-contracted).
• Health plans will be required to verify the accuracy of their HCBS/MLTSS provider data for provider types showing as "zero" (0).

IL2020 HCBS & MLTSS Provider Network for Southern Counties Region 3
Current Network: Contracted and Loaded Providers
Health Plan data submitted on 5/15/20

Enrollment	BCBS	IlliniCare	Meridian	Molina
HCBS Enrollment as of April 2020	193	260	475	323
MLTSS Enrollment as of April 2020	1,643	1,111	995	628

	Contracted and Loaded			
Facilities	BCBS	IlliniCare	Meridian	Molina
Exceptional Care	1	20	9	1
Skilled Nursing Facilities	75	107	93	63
Supportive Living Facilities	26	23	16	24

	Contracted and Loaded			
HCBS Providers	BCBS	IlliniCare	Meridian	Molina
Pre-vocational Services	4	17	2	5
Respite Care Services	8	169	13	14
Specialized Medical Equipment	7	56	2	17

	Contracted and Loaded			
Behavioral Health Services	BCBS	IlliniCare	Meridian	Molina
Alcohol and Substance Abuse Rehab. Services	7	6	2	16
Licensed Professional/Licensed Clinical Counselor	12	20	42	19
Other Behavioral Health Services	46	18	20	15
Psychologist	3	6	5	2
Social Worker	24	33	31	33
Targeted Case Management Services	8	30	3	29

	Contracted and Loaded			
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina
Medicar Transportation	8	34	1	15

Non-Emergency Ambulance Transportation	1	27	0	25
Other Transportation	10	80	13	22

HSAG Notes:
*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

Health Plan Notes:
•**Meridian** reported that ambulance providers are reimbursed by Meridian for providing Non-Emergency Ambulance transportation services in the Central and Southern regions regardless of network status (contracted and non-contracted).

IL2020 HCBS & MLTSS Provider Network for Cook County Region 4
Current Network: Contracted and Loaded Providers
Health Plan data submitted on 5/15/20

Enrollment	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
HCBS Enrollment as of April 2020	3,854	2,476	2,147	276	4,233	428
MLTSS Enrollment as of April 2020	5,088	3,047	3,275	517	4,472	800

	Contracted and Loaded					
Facilities	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Exceptional Care	10	47	78	18	8	2
Skilled Nursing Facilities	199	227	206	137	202	134
Supportive Living Facilities	28	35	41	28	35	20

	Contracted and Loaded					
HCBS Providers	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Pre-vocational Services	61	115	7	14	35	1
Respite Care Services	85	435	73	55	7	3
Specialized Medical Equipment	85	128	33	22	80	1

	Contracted and Loaded					
Behavioral Health Services	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Alcohol and Substance Abuse Rehab. Services	30	33	24	45	87	7
Licensed Professional/Licensed Clinical Counselor	70	94	236	76	44	52
Other Behavioral Health Services	164	133	65	30	34	12
Psychologist	69	77	97	47	65	21
Social Worker	90	148	105	85	68	55
Targeted Case Management Services	86	90	56	73	82	66

	Contracted and Loaded					
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Medicar Transportation	73	76	32	27	21	2

Non-Emergency Ambulance Transportation	18	17	4	38	60	6
Other Transportation	117	105	185	47	66	0*

IL2020 HCBS & MLTSS Provider Network for Collar Counties Region 5
Current Network: Contracted and Loaded Providers
Health Plan data submitted on 5/15/20

Enrollment	BCBS	IlliniCare	Meridian	Molina
HCBS Enrollment as of April 2020	1,184	636	1,046	81
MLTSS Enrollment as of April 2020	1,432	980	880	169

	Contracted and Loaded			
Facilities	BCBS	IlliniCare	Meridian	Molina
Exceptional Care	1	17	47	4
Skilled Nursing Facilities	104	128	117	63
Supportive Living Facilities	21	26	26	20

	Contracted and Loaded			
HCBS Providers	BCBS	IlliniCare	Meridian	Molina
Pre-vocational Services	21	71	7	12
Respite Care Services	25	267	78	16
Specialized Medical Equipment	25	76	35	22

	Contracted and Loaded			
Behavioral Health Services	BCBS	IlliniCare	Meridian	Molina
Alcohol and Substance Abuse Rehab. Services	21	19	19	26
Licensed Professional/Licensed Clinical Counselor	52	61	158	33
Other Behavioral Health Services	102	73	47	16
Psychologist	30	41	49	10
Social Worker	54	59	67	38
Targeted Case Management Services	26	59	52	37

	Contracted and Loaded			
MLTSS Transportation	BCBS	IlliniCare	Meridian	Molina
Medicar Transportation	35	48	22	25

Non-Emergency Ambulance Transportation	12	17	3	40
Other Transportation	51	80	152	43

HSAG Notes:

*Other Transportation includes the following Category of Service (COS): COS 053-Taxicab Services, COS 054-Service Car, COS 055-Private Auto Transportation, COS 056-Other Transportation.

Health Plan Notes

• Health plans will be required to verify the accuracy of their HCBS/MLTSS provider data for provider types showing as "zero" (0).

IL2019 Contracted FQHCs & CMHCs
Statewide Analysis
Health Plan data submitted on 5/15/20

	Region 1 - Northwestern Counties			Region 2 - Central Counties			Region 3 - Southern Counties			Region 4 - Cook County			Region 5 - Collar Counties		
	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***	Total Facilities Available within Region* (# of facilities)	Current Network**	% Current Network over # of available facilities***
FQHCs: # of Facilities (Clinics)															
BCBS	**31**	26	84%	**47**	26	55%	**77**	30	39%	**207**	185	89%	**81**	78	96%
IlliniCare	**31**	27	87%	**47**	47	100%	**77**	60	78%	**207**	163	79%	**81**	76	94%
Meridian	**31**	30	97%	**47**	37	79%	**77**	63	82%	**207**	177	86%	**81**	45	56%
Molina	**31**	32	103.2%*	**47**	38	81%	**77**	59	77%	**207**	181	87%	**81**	23	28%
CountyCare	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**207**	530	256%*	**N/A**	N/A	N/A
NextLevel	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**207**	295	142.5%*	**N/A**	N/A	N/A
CMHCs: # of Facilities (Clinics)															
BCBS	**142**	70	49%	**180**	75	42%	**173**	81	47%	**434**	267	62%	**232**	131	56%
IlliniCare	**142**	127	89%	**180**	148	82%	**173**	142	82%	**434**	408	94%	**232**	217	94%
Meridian	**142**	143	100.7%*	**180**	182	101.1%*	**173**	149	86%	**434**	481	110.8%*	**232**	239	103%*
Molina	**142**	119	84%	**180**	138	77%	**173**	122	71%	**434**	352	81%	**232**	144	62%
CountyCare	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**434**	636	146.5%*	**N/A**	N/A	N/A
NextLevel	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**N/A**	N/A	N/A	**434**	308	71%	**N/A**	N/A	N/A

*Overall number of facilities available within the identified region.
**Number of provider locations reported by the health plans as contracted and loaded.
***Percent of contracted FQHCs and CMCHs over the number of available FQHCs/CMHCs within the identified region. Full list of available FQHCs and CMHCs is included in the HSAG provider data submission manual. Please note that an updated list was also shared via email with all health plans.
- "N/A" - not a service region for the identified health plan.

Health Plan Notes:
*HSAG will follow-up with these health plans as duplicate FQHCs and CMHCs were identified within their Facilities Data.

IL2020 MLTSS Statewide Expansion - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on May 15, 2020

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Region 1 - Northwest							
Alpine Fireside Health Center	6	6	NF not contracting	7	11		
Clayberg, The	22	Contracted	Contracted	Contracted	Contracted		
Elizabeth Nursing Home	7	Contracted	Contracted	NF not contracting	NF not contracting		
Harbor Crest Home	0	Contracted	Contracted	Contracted	Contracted		
Heritage Square	6	Contracted	Contracted	Contracted	Contracted		
Medina Nursing Center	31	NF not contracting	Contracted	Contracted	Contracted		
Pine Acres Rehab Living Center	30	Contracted	Contracted	Contracted	Contracted		
Willows Health Center	8	10	NF not contracting	8	Contracted		
Region 2 - Central							
Heartland Manor	15	Contracted	2	Contracted	Contracted		
Sunset Home	68	Contracted	Contracted	Contracted	Contracted		
Region 3 - Southern							
Bethalto Care Center	19	NF not contracting	Contracted	NF not contracting	NF not contracting		
Eunice C Smith Home	2	10	Contracted	Contracted	Contracted		
Fairview Nursing Center	21	Contracted	Contracted	Contracted	Contracted		
Faith Care Center	9	Contracted	Contracted	Contracted	NF not contracting		
Memorial Care Center	1	9	Pending	3	Contracted		
Oak Hill	22	Contracted	Contracted	Contracted	Contracted		
St Pauls Home	22	Contracted	NF not contracting	Contracted	Contracted		
Three Springs Lodge Nrsg Home	18	Contracted	Contracted	Contracted	Contracted		
Twin Willows Nursing Center	15	14	NF not contracting	6	11		
United Methodist Village North	0	Contracted	NF not contracting	Contracted	Contracted		
Region 4 - Cook							
Abington Of Glenview Nursing &	17	6	Contracted	8	15	NF not contracting	Contracted
Montgomery Place	1	NF not contracting	Contracted	Contracted	Contracted	Contracted	Contracted
Moorings Of Arlington Heights	3	7	Contracted	7	Contracted	Contracted	Contracted
Westminster Place	6	NF not contracting	Contracted	8	Contracted	Contracted	Contracted
Region 5 - Collars							
Alden Estates Cts Of Huntley	0	Contracted	Contracted	Contracted	Contracted		
Fair Oaks Health Care Center	4	8	NF not contracting	4	9		
Hearthstone Manor	10	5	Contracted	Contracted	9		
Libertyville Manor Ext Care	6	5	NF not contracting	Contracted	13		
Mercy Harvard Hospital Cr Ctr	3	NF not contracting	Contracted	Contracted	Contracted		
Radford Green	3	NF not contracting	Contracted	Contracted	NF not contracting		

IL2020 MLTSS Statewide Expansion - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on May 15, 2020

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Springs At Monarch Landing	2	NF not contracting	NF not contracting	7	9		
Valley Hi Nursing Home	49	Contracted	3	Contracted	Contracted		
Total NF Contracted by Health Plan		**15 of 32**	**21 of 32**	**21 of 32**	**21 of 32**	**3 of 4**	**4 of 4**
Percent Contracted - Statewide Health Plans		**47%**	**66%**	**66%**	**66%**		

Notes

• HSAG conducted a statewide analysis to evaluate the contracting of nursing facilities (NFs) and, therefore, determine the number of nursing facilities not contracted by any health plan. HFS directed HSAG to work with the health plans to track contracting efforts with each of the non-contracted nursing facilities identified in the grid above.

The table above shows the following information:

*HFS identified the number of enrollees assigned to each nursing facility (NF).

• Columns A and B contain information on the name of each nursing facility and the associated Medicaid enrollment that was included in the MLTSS Statewide Expansion – (a file from HFS provided this information).

• Columns C through H includes the following information:

-"Pending" shaded in blue indicates that the health plan reported that they are in the process of executing a contract with the identified nursing facility.

-"NF not contracting" cells shaded in pink/red - nursing facility has declined contract with health plan.

- "Contracted" shaded in green indicates that the health plan has contracted with the identified NF. HSAG will review the health plan provider network data submissions to verify that the contracted NFs above were accurately reflected in the data as contracted/loaded.

- Numeric values in Columns C through H represent the number outreach attempts made by the health plan to contract with the NF (i.e. health plan left messages and/or emails).

IL2019 MLTSS Statewide Expansion - Network Readiness - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on June 24, 2019

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Region 1 - Northwest							
Alpine Fireside Health Center	6	1	2	4	3		
Clayberg, The	22	2	Contracted	4	2		
Elizabeth Nursing Home	7	Contracted	3	4	NF not contracting		
Harbor Crest Home	0	1	2	Contracted	2		
Heritage Square	6	3	3	5	2		
Medina Nursing Center	31	3	2	Contracted	3		
Pine Acres Rehab Living Center	30	4	Contracted	Contracted	Contracted		
Willows Health Center	8	6	NF not contracting	4	2		
Region 2 - Central							
Heartland Manor	15	4	2	Contracted	3		
Sunset Home	68	2	3	3	Pending		
Region 3 - Southern							
Bethalto Care Center	19	1	3	2	3		
Eunice C Smith Home	2	2	2	3	1		
Fairview Nursing Center	21	2	2	Contracted	Pending		
Faith Care Center	9	2	Contracted	4	2		
Memorial Care Center	1	2	2	2	1		
Oak Hill	22	Contracted	2	Contracted	1		
St Pauls Home	22	2	3	3	2		
Three Springs Lodge Nrsg Home	18	2	3	3	1		
Twin Willows Nursing Center	15	2	2	4	2		
United Methodist Village North	0	4	2	Contracted	2		
Region 4 - Cook							
Abington Of Glenview Nursing &	17	1	3	2	1	3	Pending
Montgomery Place	1	1	1	2	1	Contracted	Contracted
Moorings Of Arlington Heights	3	2	1	2	2	Contracted	Contracted
Westminster Place	6	2	1	2	2	Contracted	Contracted
Region 5 - Collars							
Alden Estates Cts Of Huntley	0	1	Contracted	Contracted	Contracted		
Fair Oaks Health Care Center	4	5	2	2	1		
Hearthstone Manor	10	1	1	2	2		
Libertyville Manor Ext Care	6	1	2	2	3		
Mercy Harvard Hospital Cr Ctr	3	1	Contracted	2	Contracted		
Radford Green	3	1	Contracted	2	1		

IL2019 MLTSS Statewide Expansion - Network Readiness - Nursing Facilities (NFs)
Number of Outreach Attempts and Contracting Status
Health Plan Contracting Workbook Submitted on June 24, 2019

		Statewide Health Plans - # of Outreach Attempts & Contracting Status				Cook Only Health Plans	
Region / Facility Name	# of Members within the NF (HFS Estimates)*	BCBS	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Springs At Monarch Landing	2	1	NF not contracting	2	1		
Valley Hi Nursing Home	49	2	3	4	1		
Total NF Contracted by Health Plan		**2 of 32**	**6 of 32**	**8 of 32**	**3 of 32**	**3 of 4**	**3 of 4**
Percent Contracted - Statewide Health Plans		**6%**	**19%**	**25%**	**9%**		

Notes

• In preparation for the MLTSS Statewide expansion HSAG conducted a statewide analysis to evaluate the contracting of nursing facilities (NFs) and, therefore, determine the number of nursing facilities not contracted by any health plan. HFS directed HSAG to work with the health plans to track contracting efforts with each of the non-contracted nursing facilities identified in the grid above.

The table above shows the following information:

*HFS identified the number of enrollees assigned to each nursing facility (NF).

• "Contracted" shaded in green indicates that the health plan has contracted with the identified NF. HSAG's review of the health plan data identified that the nursing facility was not included in the data or was listed in the data as "pending load". HSAG will follow-up with the health plans for accurate reporting of NFs in the next provider network data file submission.

• "Pending" shaded in blue indicates that the health plan reported that they are in the process of executing a contract with the identified nursing facility.

• "NF not contracting" shaded in pink/red indicates that the nursing facility is not contracting with the identified health plan.

• Numeric values in C through H represent the number of outreach attempts to contract with the identified NF.

• The shaded yellow/orange cells in Columns C through H indicate the projected contract execution date of 7/1/19.

Appendix E4. Provider Network Time/ Distance Analysis

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

SFY 2020 Provider Network Time/Distance Analysis

February 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) is responsible for the ongoing monitoring and oversight of its contracted HealthChoice Illinois managed care health plans (health plans) that deliver services to HealthChoice Illinois enrollees. As part of its provider network adequacy monitoring activities, HFS requested its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), conduct a time/distance analysis between enrollees and providers in the HealthChoice Illinois health plan networks. Specifically, the purpose of the State Fiscal Year (SFY) 2020 Time/Distance Analysis was to evaluate the degree to which health plans comply with network standards outlined in the Illinois Department of Healthcare and Family Services—Medicaid Model Contract—2018-24-001, Sections 5.8.1.1.1–5.8.1.1.7.

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

- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare[1-1]
- IlliniCare Health Plan (IlliniCare)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- NextLevel Health (NextLevel)[1-1]

Overall Statewide Time/Distance Study Findings

The findings from Table 1 are summarized below.

Health Plan Compliance—Enrollees Residing within Time/Distance Requirements

HSAG validated the time/distance requirements for 22 provider categories within each service region.

- BCBSIL was compliant with contract standards for 19 provider categories across all service regions.

[1-1] Available only in Cook County.

- IlliniCare, Meridian and Molina were compliant with contract standards for 20 provider categories across all service regions.
- CountyCare was compliant with contract standards for 21 provider categories in the Cook County service region.
- NextLevel was compliant with contract standards for all provider categories in the Cook County service region.

Health Plan Non-Compliance—Provider Categories

Health plans were non-compliant with contract standards for the provider categories in the regions summarized below:

Pharmacies

- BCBSIL: Regions 1, 2, 5
- IlliniCare: Region 2
- Meridian: Region 2
- Molina: Regions 1, 2

Neurosurgery

- BCBSIL: Regions 1, 3

Oral Surgery

- BCBSIL: Regions 1, 2, 3
- IlliniCare: Regions 1, 2, 3
- Meridian: Regions 1, 2, 3
- Molina: Region 3

Urology[1-2]

- CountyCare: Region 4

[1-2] No urology providers were present in the data HSAG received from CountyCare which may indicate a data issue rather than a network gap.

Table 1—Regional Summary for Enrollees Residing Within Time/Distance-Based Access Standards and Non-Complaint Provider Categories by Health Plan*

	Statewide Health Plans				Cook County Only Health Plans	
Health Plans	**BCBSIL**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Provider Categories						
Adult PCPs	✓	✓	✓	✓	✓	✓
Pediatric PCPs	✓	✓	✓	✓	✓	✓
Adult Behavioral Health Service Providers	✓	✓	✓	✓	✓	✓
Pediatric Behavioral Health Service Providers	✓	✓	✓	✓	✓	✓
OB/GYN Providers	✓	✓	✓	✓	✓	✓
Dentistry, Adult	✓	✓	✓	✓	✓	✓
Pediatric Dentist	✓	✓	✓	✓	✓	✓
Hospitals	✓	✓	✓	✓	✓	✓
Pharmacies	1, 2, 5	2	2	1, 2	✓	✓
Specialists						
Allergy and Immunology	✓	✓	✓	✓	✓	✓
Cardiology	✓	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓	✓
ENT/Otolaryngology	✓	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓	✓
General Surgery	✓	✓	✓	✓	✓	✓
Infectious Disease	✓	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓	✓
Neurosurgery	1,3	✓	✓	✓	✓	✓
Oncology	✓	✓	✓	✓	✓	✓
Oral Surgery	1, 2, 3	1, 2, 3	1, 2, 3	3	✓	✓
Psychiatry	✓	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	4**	✓

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Check marks (✓) indicate that the health plan met the time/distance requirements in all regions for the identified provider category. Numeric values in red font indicate the region number the health plan was non-compliant.

** No urology providers were present in the data HSAG received from CountyCare which may indicate a data issue rather than a network gap.

Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for HFS and the health plans to strengthen the HealthChoice Illinois Medicaid managed care provider networks and ensure enrollees' timely access to healthcare services:

- While most health plans are meeting the contract standards for most provider categories, HFS should collaborate with the health plans to continue to monitor the status of time/distance standards for all provider categories. Additionally, HFS and the health plans should continue to improve provider data collection to indicate populations served by the providers, especially regarding pediatric providers. Future time/distance analyses should be stratified for pediatric providers to ensure that these providers are accurately represented in the health plans' networks so that the unique needs of the pediatric population can be met.
- HFS should continue to collaborate with those health plans that do not meet the time/distance standards in specific regions, to contract with additional providers if available. Provider categories of concern include Pharmacies, Neurosurgery, and Oral Surgery.
- HFS should conduct an in-depth review of provider categories for which no health plans met the time/distance standards, with the goal of determining whether failure to meet the time/distance network access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area. Future analyses should evaluate the extent to which health plans have requested exemptions from HFS for provider categories for which providers may not be available or willing to contract with the health plans.
- As the time/distance analyses represent the potential geographic distribution of contracted providers and may not directly reflect the availability of providers at any point in time, HFS should continue using appointment availability surveys to evaluate providers' availability. HSAG also recommends incorporating encounter data to assess enrollees' utilization of services, as well as potential gaps in access to care resulting from inadequate provider availability.
- HFS should continue to develop requirements for Long-Term Services and Supports (LTSS) providers that require the enrollee to travel to the provider. LTSS network requirements are included in the new requirements governing network adequacy in the 2016 Medicaid Managed Care Rule.

Appendix A. Compliance With Time/Distance Standards Findings

Network Accessibility

Geographic network distribution analyses assess whether enrollees in each county are required to travel a reasonable amount of time or distance to reach the nearest provider. HFS has established access standards by provider category for the maximum allowable distance or time an enrollee should be required to travel to receive care (presented in Table D-1). This section presents the percentage of enrollees living within the access standards for each region and for each health plan as well as the percentage of counties per region meeting the contract requirements as defined by the health plan contracts. For Cook County (i.e., Region 4), only results for enrollees living in urban areas are presented since Cook County is classified as urban.

Region 1—Northwestern

Table A-1 and Table A-2 display the percentage of enrollees residing within the access standards (i.e., time/distance standards) in Region 1.

Table A-1—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity: Region 1

Statewide Health Plans—Region 1												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 2019	6,317	4,141	10,458	38,990	25,562	64,552	93,460	52,985	146,445	23,168	14,857	38,025

Table A-2—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Provider Type: Region 1*

Statewide Health Plans—Region 1												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Statewide Health Plans—Region 1												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
OB/GYN Providers	100.0	99.2	99.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	99.9	100.0	**99.9**	100.0	100.0	100.0	100.0	100.0	100.0	> 99.9	100.0	**> 99.9**
Specialists												
Allergy and Immunology	84.6	99.8	90.7	100.0	100.0	100.0	100.0	100.0	100.0	99.9	100.0	99.9
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	89.8	100.0	93.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	70.2	93.4	**79.5**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	> 99.9	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	75.4	100.0	**85.3**	81.4	99.3	**88.4**	62.9	> 99.9	**76.5**	100.0	100.0	100.0
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Cells shaded gray indicate percentages of enrollees in urban or rural counties that did not meet the access standard. Cells shaded red with red font indicate total results (i.e., urban and rural) that did not meet the access standard.

Table A-3 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 1. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category which requires that 100 percent of enrollees have coverage within the access standard.

Table A-3—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 1*

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	99.7	95.8	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	**99.9**	**91.7**	100.0	100.0	100.0	100.0	**> 99.9**	**95.8**
Specialists								
Allergy and Immunology	90.7	**87.5**	100.0	100.0	100.0	100.0	99.9	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	93.9	95.8	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	**79.5**	**75.0**	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	**85.3**	91.7	**88.4**	**87.5**	**76.5**	91.7	100.0	100.0
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard and 100 percent of enrollees for pharmacy providers. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Appendix B contains a complete list by health plan of counties not meeting the contract requirements for each provider category.

Region 2—Central

Table A-4 and Table A-5 display the percentage of enrollees residing within the access standards in Region 2.

Table A-4—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity: Region 2

Statewide Health Plans—Region 2												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 2019	9,209	11,215	20,424	24,237	22,528	46,765	54,196	52,316	106,512	35,381	15,849	51,230

Table A-5—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Provider Type: Region 2*

Statewide Health Plans—Region 2												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	> 99.9	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	94.8	100.0	97.7	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	99.7	100.0	**99.9**	99.6	100.0	**99.8**	99.6	100.0	**99.8**	98.7	100.0	**99.1**
Specialists												
Allergy and Immunology	91.9	> 99.9	96.4	100.0	99.4	99.7	100.0	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Statewide Health Plans—Region 2												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	99.5	95.3	97.2	100.0	93.9	97.1	100.0	86.8	93.3	100.0	100.0	100.0
Nephrology	93.5	100.0	97.1	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	45.6	100.0	**75.7**	59.1	73.1	**65.7**	61.3	99.9	**80.9**	99.6	94.3	97.9
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Cells shaded gray indicate percentages of enrollees in urban or rural counties that met the access standard. Cells shaded red with red font indicate total results (i.e., urban and rural) that did not meet the access standard.

Table A-6 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 2. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category which requires that 100 percent of enrollees have coverage within the access standard.

Table A-6—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 2*

	BCBSIL		**IlliniCare**		**Meridian**		**Molina**	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	> 99.9	100.0	100.0	100.0	100.0	100.0
Hospitals	97.7	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	**99.9**	**88.6**	**99.8**	**88.6**	**99.8**	**88.6**	**99.1**	**91.4**
Specialists								
Allergy and Immunology	96.4	94.3	99.7	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	97.2	94.3	97.1	97.1	93.3	94.3	100.0	100.0
Nephrology	97.1	97.1	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	**75.7**	97.1	**65.7**	**54.3**	**80.9**	97.1	97.9	94.3
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard and 100 percent of enrollees for pharmacy providers. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Appendix B contains a complete list by health plan of counties not meeting the contract requirements for each provider category.

Region 3—Southern

Table A-7 and Table A-8 display the percentage of enrollees residing within the access standards in Region 3.

Table A-7—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity: Region 3

Statewide Health Plans—Region 3												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Urbanicity	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**	**Urban**	**Rural**	**Total**
Enrollment Count as of September 2019	2,354	8,032	10,386	7,597	36,277	43,874	54,537	55,490	110,027	26,301	15,081	41,382

Table A-8—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Provider Type: Region 3*

Statewide Health Plans—Region 3												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	> 99.9	100.0	> 99.9	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists												
Allergy and Immunology	100.0	95.3	96.5	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	99.7	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Statewide Health Plans—Region 3												
Health Plans	BCBSIL			IlliniCare			Meridian			Molina		
Provider Categories	Urban %	Rural %	Total %	Urban %	Rural %	Total %	Urban %	Rural %	Total %	Urban %	Rural %	Total %
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	96.7	98.3	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	0.5	100.0	**74.0**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	50.4	**63.4**	0.0	33.0	**26.3**	100.0	46.5	**72.8**	100.0	64.8	**86.5**
Psychiatry	100.0	> 99.9	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Cells shaded gray indicate percentages of enrollees in urban or rural counties that did not meet the access standard. Cells shaded red with red font indicate total results (i.e., urban and rural) that did not meet the access standard.

Table A-9 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 3. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category which requires that 100 percent of enrollees have coverage within the access standard.

Table A-9—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 3*

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	> 99.9	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists								
Allergy and Immunology	96.5	**85.3**	100.0	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	98.3	91.2	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	**74.0**	94.1	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	**63.4**	**58.8**	**26.3**	**35.3**	**72.8**	**41.2**	**86.5**	**58.8**
Psychiatry	> 99.9	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard and 100 percent of enrollees for pharmacy providers. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Region 4—Cook County

Table A-10 and Table A-11 display the percentage of enrollees residing within the access standards in Region 4.

Table A-10—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity: Region 4

Statewide Health Plans—Region 4					Cook County Only Health Plans—Region 4	
Health Plans	**BCBSIL**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Urbanicity	**Urban**	**Urban**	**Urban**	**Urban**	**Urban**	**Urban**
Enrollment Count as of September 2019	236,261	106,969	223,250	64,822	316,716	51,743

Table A-11—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Provider Type: Region 4*

Statewide Health Plans—Region 4					Cook County Only Health Plans—Region 4	
Health Plans	**BCBSIL**	**IlliniCare**	**Meridian**	**Molina**	**CountyCare**	**NextLevel**
Provider Categories	**Urban %**	**Urban %**	**Urban %**	**Urban %**	**Urban %**	**Urban %**
Adult PCPs	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Pediatric PCPs	100.0	100.0	100.0	100.0	> 99.9	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	> 99.9	> 99.9
OB/GYN Providers	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Dentistry, Adult	100.0	100.0	100.0	100.0	> 99.9	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	> 99.9	100.0
Hospitals	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Pharmacies	100.0	100.0	100.0	100.0	100.0	100.0
Specialists						
Allergy and Immunology	100.0	100.0	100.0	100.0	> 99.9	100.0
Cardiology	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Endocrinology	100.0	100.0	100.0	100.0	> 99.9	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Gastroenterology	100.0	100.0	100.0	100.0	> 99.9	100.0

Statewide Health Plans—Region 4					Cook County Only Health Plans—Region 4	
Health Plans	BCBSIL	IlliniCare	Meridian	Molina	CountyCare	NextLevel
Provider Categories	Urban %	Urban %	Urban %	Urban %	Urban %	Urban %
General Surgery	100.0	100.0	100.0	100.0	> 99.9	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	> 99.9	100.0
Neurosurgery	100.0	100.0	100.0	100.0	> 99.9	100.0
Oncology	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Oral Surgery	100.0	100.0	100.0	100.0	> 99.9	100.0
Psychiatry	100.0	100.0	100.0	100.0	> 99.9	> 99.9
Urology	100.0	100.0	100.0	100.0	**0.0**	> 99.9

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Cells shaded red with red font indicate results that did not meet the access standard.

It should be noted that no urology specialists were present in the data that HSAG received from CountyCare, which may indicate that the lack of urology specialists identified in the data may be due to a data issue, not a true lack of providers able to provide services to the enrollees.

Region 5—Collar Counties

Table A-12 and Table A-13 display the percentage of enrollees residing within the access standards in Region 5.

Table A-12—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Urbanicity: Region 5

Statewide Health Plans—Region 5												
Health Plans	BCBSIL			IlliniCare			Meridian			Molina		
Urbanicity	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural	Total
Enrollment Count as of September 2019	124,410	3,773	128,183	70,647	2,853	73,500	162,207	8,939	171,146	13,596	568	14,164

Table A-13—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards by Provider Category: Region 5*

Statewide Health Plans—Region 5												
Health Plans	**BCBSIL**			**IlliniCare**			**Meridian**			**Molina**		
Provider Categories	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**	**Urban %**	**Rural %**	**Total %**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	100.0	99.9	100.0	99.9	100.0	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	99.8	100.0	**99.8**	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Specialists												
Allergy and Immunology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for pharmacy providers which requires that 100 percent of enrollees have access to providers within the access standard. Cells shaded gray indicate the percentage of enrollees in urban or rural counties that did not meet the access standard. Cells shaded red with red font indicate total results (i.e., urban and rural) that did not meet the access standard.

Table A-14 displays the percentage of enrollees residing within the access standards and the percentage of participating counties meeting the contract requirements for Region 5. While the access standards vary by provider category, the contract requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standard, except for the Pharmacy provider category which requires that 100 percent of enrollees have coverage within the access standard.

Table A-14—Percentage of Enrollees Residing Within Time/Distance-Based Access Standards and Percentage of Counties Meeting Contract Requirements—Region 5*

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**	**Enrollees Within Standard (%)**	**Counties Meeting Standard (%)**
Adult PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric PCPs	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Adult Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Behavioral Health Service Providers	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
OB/GYN Providers	100.0	100.0	99.9	100.0	100.0	100.0	100.0	100.0
Dentistry, Adult	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pediatric Dentist	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospitals	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Pharmacies	**99.8**	**87.5**	100.0	100.0	100.0	100.0	100.0	100.0
Specialists								
Allergy and Immunology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Cardiology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Endocrinology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
ENT/Otolaryngology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Gastroenterology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
General Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Infectious Disease	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Nephrology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Neurosurgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oncology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Oral Surgery	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

	BCBSIL		IlliniCare		Meridian		Molina	
Provider Categories	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)	Enrollees Within Standard (%)	Counties Meeting Standard (%)
Psychiatry	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Urology	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

* The contract standard requires that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the time/distance standard and 100 percent of enrollees for pharmacy providers. Cells shaded red with red font indicate statewide results that did not meet the time/distance standard.

Appendix B contains a complete list by health plan of counties not meeting the contract requirements for each provider category.

Appendix B. Summary of Counties Not Meeting Contract Requirements

For each health plan, Appendix B lists counties that did not meet the contract requirements for each provider category.

Blue Cross Blue Shield of Illinois (BCBSIL)

OB/GYN Providers

- Jo Daviess

Hospitals

- Vermilion

Pharmacies

- Champaign, DeKalb, Kankakee, McLean, Rock Island, Sangamon, Vermilion

Allergy and Immunology

- Champaign, Crawford, Edwards, Lawrence, Mercer, Peoria, Richland, Rock Island, Vermilion, Wabash

Endocrinology

- Rock Island

Infectious Disease

- Adams, Hancock

Nephrology

- Vermilion

Neurosurgery

- Henry, Knox, Madison, Mercer, Peoria, Rock Island, St. Clair, Tazewell

Oral Surgery

- Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Peoria, Pope, Pulaski, Saline, Sangamon, Tazewell, Union, White, Williamson

IlliniCare Health Plan (IlliniCare)

Pharmacies

- Champaign, McLean, Sangamon, Vermilion

Infectious Disease

- Adams

Oral Surgery

- Adams, Alexander, Brown, Calhoun, Cass, Clinton, Franklin, Gallatin, Greene, Hamilton, Hancock, Hardin, Jackson, Jefferson, Jersey, Johnson, Macoupin, Madison, Mason, Massac, McLean, Menard, Monroe, Morgan, Peoria, Perry, Pike, Pope, Pulaski, Randolph, Saline, Sangamon, Schuyler, Scott, St. Clair, Tazewell, Union, Washington, White, Williamson, Woodford

MeridianHealth (Meridian)

Pharmacies

- Champaign, McLean, Sangamon, Vermilion

Infectious Disease

- Adams, Hancock, Lawrence, Richland, Wabash

Oral Surgery

- Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Lawrence, Massac, Peoria, Pope, Pulaski, Richland, Saline, Sangamon, Tazewell, Union, Wabash, Wayne, White, Williamson

Molina Healthcare of Illinois (Molina)

Pharmacies

- Champaign, McLean, Rock Island, Vermilion

Oral Surgery

- Adams, Alexander, Franklin, Gallatin, Hamilton, Hancock, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, White, Williamson

CountyCare

Urology

- Cook

NextLevel Health (NextLevel)

None.

Appendix C. Average Travel Time and Distance Findings

For each health plan, Appendix C presents the average travel time and travel distance to the nearest three providers for rural and urban areas. For CountyCare, no urology specialists were included in the data received from the health plan.

Table C-1—BCBSIL Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

	First-Nearest		Second-Nearest		Third-Nearest	
Provider Categories	**Distance (Miles)**	**Time (Minutes)**	**Distance (Miles)**	**Time (Minutes)**	**Distance (Miles)**	**Time (Minutes)**
Adult PCPs	3.6	3.9	4.2	4.5	4.7	5.1
Pediatric PCPs	4.0	4.3	5.2	5.7	6.3	6.9
Adult Behavioral Health Service Providers	5.6	6.1	6.0	6.6	8.0	8.8
Pediatric Behavioral Health Service Providers	11.6	13.0	12.2	13.7	12.5	14.0
OB/GYN Providers	9.1	10.0	11.5	12.8	14.0	15.6
Dentistry, Adult	9.0	9.8	11.5	12.6	13.8	15.2
Pediatric Dentist	8.9	9.8	12.3	13.5	13.7	15.1
Hospitals	10.0	11.2	22.1	24.7	28.4	31.8
Pharmacies	3.7	4.0	5.7	6.2	9.0	9.8
Specialists						
Allergy and Immunology	35.0	39.0	45.7	51.4	62.9	73.1
Cardiology	11.6	12.8	14.4	16.0	17.2	19.1
Endocrinology	22.7	25.7	32.9	37.1	38.7	44.2
ENT/Otolaryngology	15.2	16.9	19.9	22.1	25.8	29.1
Gastroenterology	19.8	22.2	23.6	26.4	28.0	31.6
General Surgery	10.0	11.0	14.2	15.7	17.6	19.5
Infectious Disease	29.2	33.7	33.7	38.8	38.4	44.2
Nephrology	22.0	24.8	27.5	30.9	32.1	36.4
Neurosurgery	33.2	38.2	39.8	46.2	40.7	47.4
Oncology	12.8	14.3	17.1	19.1	20.9	23.3
Oral Surgery	53.4	60.0	76.0	88.6	94.5	118.6
Psychiatry	29.3	32.6	35.6	39.9	39.9	44.9
Urology	15.3	16.9	22.7	25.2	28.2	31.6

Table C-2—BCBSIL Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

	First-Nearest		Second-Nearest		Third-Nearest	
Provider Categories	**Distance (Miles)**	**Time (Minutes)**	**Distance (Miles)**	**Time (Minutes)**	**Distance (Miles)**	**Time (Minutes)**
Adult PCPs	1.0	1.6	1.2	1.9	1.4	2.2
Pediatric PCPs	1.1	1.7	1.3	2.1	1.5	2.4
Adult Behavioral Health Service Providers	1.3	2.1	1.4	2.3	1.6	2.6
Pediatric Behavioral Health Service Providers	2.3	3.8	2.3	3.9	2.4	4.0
OB/GYN Providers	1.6	2.6	1.9	3.0	2.1	3.4
Dentistry, Adult	1.1	1.7	1.3	2.0	1.4	2.2
Pediatric Dentist	1.0	1.6	1.2	1.9	1.4	2.2
Hospitals	3.4	5.6	5.8	9.5	8.1	12.9
Pharmacies	0.9	1.5	1.3	2.2	1.7	2.7
Specialists						
Allergy and Immunology	5.8	9.2	8.0	12.2	9.2	14.5
Cardiology	2.5	4.1	3.0	5.0	3.3	5.4
Endocrinology	4.1	6.6	5.4	8.5	6.2	9.6
ENT/Otolaryngology	3.9	6.3	5.0	8.0	5.9	9.3
Gastroenterology	2.9	4.7	3.6	5.8	3.9	6.4
General Surgery	2.8	4.5	3.5	5.7	3.9	6.4
Infectious Disease	4.1	6.6	5.2	8.5	6.0	9.8
Nephrology	3.6	5.8	4.6	7.2	5.2	8.3
Neurosurgery	6.4	10.0	7.1	11.2	7.8	12.4
Oncology	3.1	5.0	3.7	6.0	4.1	6.7
Oral Surgery	8.3	12.6	10.5	16.5	13.7	21.4
Psychiatry	4.2	7.0	5.9	9.5	6.7	10.9
Urology	3.7	6.1	4.9	8.0	5.7	9.2

Table C-3—CountyCare Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	0.6	1.2	0.8	1.5	0.9	1.6
Pediatric PCPs	0.9	1.8	1.2	2.3	1.4	2.7
Adult Behavioral Health Service Providers	0.8	1.4	0.9	1.7	1.0	1.9
Pediatric Behavioral Health Service Providers	1.4	2.6	1.8	3.4	2.2	4.2
OB/GYN Providers	0.8	1.6	1.0	1.9	1.1	2.0
Dentistry, Adult	0.7	1.3	0.8	1.5	0.9	1.7
Pediatric Dentist	3.0	5.7	3.7	7.2	3.9	7.5
Hospitals	2.2	4.3	3.5	6.7	4.4	8.5
Pharmacies	0.6	1.1	0.9	1.6	1.1	2.1
Specialists						
Allergy and Immunology	3.2	6.2	3.9	7.5	4.5	8.5
Cardiology	1.1	2.1	1.4	2.7	1.6	3.0
Endocrinology	2.0	3.7	2.6	4.8	3.0	5.6
ENT/Otolaryngology	2.3	4.3	3.3	6.1	3.6	6.6
Gastroenterology	1.7	3.2	2.1	4.0	2.4	4.7
General Surgery	1.5	2.9	1.7	3.3	1.9	3.6
Infectious Disease	1.5	2.9	1.8	3.4	1.9	3.7
Nephrology	1.1	2.0	1.2	2.3	1.4	2.6
Neurosurgery	3.4	6.5	4.4	8.3	4.7	9.0
Oncology	1.7	3.3	2.0	3.8	2.2	4.2
Oral Surgery	3.6	6.9	4.6	8.9	4.8	9.3
Psychiatry	1.5	2.9	1.9	3.6	2.2	4.2
Urology*	—	—	—	—	—	—

* It should be noted that no urology specialists were present in the data that HSAG received from CountyCare, which may indicate that the lack of urology specialists identified in the data may be due to a data issue, not a true lack of providers able to provide services to the enrollees.

Table C-4—IlliniCare Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.3	3.5	3.8	4.1	4.2	4.6
Pediatric PCPs	3.5	3.8	4.2	4.5	4.8	5.3
Adult Behavioral Health Service Providers	7.1	7.7	8.1	8.9	9.5	10.4
Pediatric Behavioral Health Service Providers	7.7	8.4	9.3	10.2	10.8	11.8
OB/GYN Providers	8.7	9.5	10.6	11.6	11.7	12.8
Dentistry, Adult	10.8	11.8	12.9	14.2	15.7	17.3
Pediatric Dentist	10.9	12.0	13.0	14.4	15.8	17.5
Hospitals	8.3	9.1	19.3	21.6	25.1	28.1
Pharmacies	3.5	3.7	5.4	5.8	7.4	8.1
Specialists						
Allergy and Immunology	34.4	38.8	41.0	46.8	50.9	58.7
Cardiology	8.2	8.9	9.6	10.6	10.6	11.6
Endocrinology	25.4	28.0	35.9	40.3	39.9	44.9
ENT/Otolaryngology	14.4	15.9	18.0	20.0	21.3	23.7
Gastroenterology	17.6	19.6	21.3	23.8	27.3	30.6
General Surgery	8.5	9.3	11.5	12.6	13.6	15.0
Infectious Disease	23.1	26.2	28.4	32.0	33.9	38.9
Nephrology	23.6	26.3	29.3	32.9	33.7	37.9
Neurosurgery	27.1	30.5	34.3	38.9	36.9	42.8
Oncology	10.7	11.8	15.2	16.9	17.6	19.5
Oral Surgery	75.9	86.7	92.3	112.0	161.4	200.4
Psychiatry	24.8	28.2	31.9	36.8	38.1	44.7
Urology	14.7	16.4	20.9	23.2	24.3	27.1

Table C-5—IlliniCare Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.1	1.6	1.3	1.9	1.5	2.1
Pediatric PCPs	1.3	1.9	1.6	2.2	1.7	2.5
Adult Behavioral Health Service Providers	1.6	2.2	1.9	2.7	2.0	3.0
Pediatric Behavioral Health Service Providers	2.0	2.9	2.3	3.4	2.6	3.9
OB/GYN Providers	2.3	3.3	2.7	3.8	2.9	4.2
Dentistry, Adult	1.6	2.3	1.9	2.7	2.1	3.0
Pediatric Dentist	1.6	2.2	1.8	2.6	2.0	2.8
Hospitals	4.1	6.3	7.5	11.6	11.6	17.1
Pharmacies	1.0	1.4	1.5	2.1	1.9	2.7
Specialists						
Allergy and Immunology	5.8	8.6	10.0	14.0	11.4	16.5
Cardiology	2.5	3.6	2.9	4.3	3.3	4.9
Endocrinology	4.2	6.4	5.5	8.3	8.7	12.5
ENT/Otolaryngology	3.5	5.3	4.4	6.6	5.0	7.3
Gastroenterology	3.4	5.2	4.5	6.7	5.0	7.6
General Surgery	2.6	3.8	3.0	4.4	3.3	5.0
Infectious Disease	3.6	5.5	4.9	7.5	5.7	8.6
Nephrology	4.0	5.8	4.6	6.8	5.5	8.0
Neurosurgery	5.9	9.0	7.3	11.5	8.4	13.1
Oncology	3.0	4.4	3.5	5.1	3.6	5.4
Oral Surgery	18.6	24.9	23.9	33.4	32.3	44.9
Psychiatry	4.7	7.0	6.0	9.1	8.1	11.9
Urology	5.0	7.8	8.8	12.7	10.3	14.8

Table C-6—Meridian Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.0	3.3	3.3	3.6	4.0	4.4
Pediatric PCPs	3.6	3.9	4.4	4.8	5.7	6.2
Adult Behavioral Health Service Providers	6.3	6.9	7.7	8.4	9.6	10.5
Pediatric Behavioral Health Service Providers	9.1	10.0	12.9	14.1	15.2	16.8
OB/GYN Providers	7.8	8.5	9.7	10.7	10.9	12.1
Dentistry, Adult	9.2	10.0	11.6	12.7	14.0	15.4
Pediatric Dentist	9.2	10.1	11.9	13.0	13.7	15.1
Hospitals	7.9	8.7	20.4	22.8	26.1	29.3
Pharmacies	3.3	3.6	5.1	5.6	6.9	7.5
Specialists						
Allergy and Immunology	25.7	28.4	45.9	53.4	52.8	61.5
Cardiology	9.9	10.9	11.5	12.7	13.2	14.6
Endocrinology	24.3	27.3	35.0	39.7	44.6	50.4
ENT/Otolaryngology	14.4	16.0	19.8	22.1	24.3	27.5
Gastroenterology	17.1	19.1	20.9	23.7	25.2	29.0
General Surgery	8.0	8.8	11.0	12.2	14.2	15.8
Infectious Disease	34.9	39.9	38.9	45.1	41.6	49.0
Nephrology	15.0	16.5	18.3	20.2	24.0	26.9
Neurosurgery	25.6	29.4	30.8	36.0	37.7	44.1
Oncology	10.9	11.9	13.3	14.7	15.4	16.9
Oral Surgery	61.1	73.8	102.4	130.0	111.0	149.9
Psychiatry	23.1	26.2	30.8	35.7	36.8	42.7
Urology	12.5	13.8	20.4	22.7	23.7	26.4

Table C-7—Meridian Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.2	1.7	1.4	1.9	1.6	2.2
Pediatric PCPs	1.4	2.1	1.7	2.5	2.0	2.9
Adult Behavioral Health Service Providers	1.8	2.5	2.0	2.8	2.2	3.1
Pediatric Behavioral Health Service Providers	2.2	3.2	2.6	3.7	2.8	4.1
OB/GYN Providers	2.2	3.0	2.6	3.7	2.9	4.1
Dentistry, Adult	1.7	2.3	2.0	2.8	2.3	3.1
Pediatric Dentist	1.6	2.2	1.9	2.6	2.1	2.9
Hospitals	3.8	5.8	7.3	10.7	10.3	14.8
Pharmacies	1.1	1.5	1.5	2.2	1.9	2.7
Specialists						
Allergy and Immunology	5.3	7.4	8.4	11.3	10.2	13.8
Cardiology	3.0	4.2	3.4	4.9	3.7	5.4
Endocrinology	4.1	5.9	7.1	9.5	8.8	11.9
ENT/Otolaryngology	4.1	6.0	5.0	7.4	5.6	8.3
Gastroenterology	4.1	5.8	4.5	6.5	5.1	7.4
General Surgery	2.8	4.0	3.3	4.7	3.6	5.2
Infectious Disease	4.7	6.7	6.2	8.7	8.2	11.4
Nephrology	3.7	5.3	4.3	6.2	5.2	7.4
Neurosurgery	5.8	8.5	7.4	11.0	9.1	13.1
Oncology	2.9	4.2	3.3	4.7	3.4	5.0
Oral Surgery	24.6	34.4	40.0	55.7	44.8	69.2
Psychiatry	4.2	6.1	5.2	7.4	6.1	8.8
Urology	3.9	5.6	4.2	6.1	5.0	7.3

Table C-8—Molina Average Travel Distances and Travel Times to the Nearest Three Providers—Rural

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	3.3	3.6	3.8	4.1	4.2	4.5
Pediatric PCPs	3.3	3.6	3.8	4.2	4.2	4.5
Adult Behavioral Health Service Providers	5.6	6.0	6.9	7.5	7.9	8.6
Pediatric Behavioral Health Service Providers	6.4	7.0	8.9	9.8	10.4	11.3
OB/GYN Providers	8.5	9.3	9.8	10.7	10.3	11.4
Dentistry, Adult	10.1	11.0	11.9	13.0	16.0	17.5
Pediatric Dentist	9.4	10.3	11.8	12.9	15.2	16.6
Hospitals	9.0	9.9	19.4	21.7	25.5	28.7
Pharmacies	3.4	3.7	5.6	6.1	7.9	8.6
Specialists						
Allergy and Immunology	29.1	32.4	37.3	42.1	44.3	49.9
Cardiology	8.5	9.3	11.0	12.1	11.7	12.9
Endocrinology	27.0	30.7	34.5	39.3	37.6	43.2
ENT/Otolaryngology	9.9	10.9	14.1	15.6	16.3	18.1
Gastroenterology	18.9	21.0	24.3	27.4	26.0	29.6
General Surgery	7.5	8.2	9.9	10.8	11.7	12.8
Infectious Disease	20.8	23.0	27.6	30.9	31.1	35.0
Nephrology	18.7	20.6	22.3	24.9	28.2	31.4
Neurosurgery	26.7	30.5	32.8	38.0	35.4	41.2
Oncology	10.9	11.9	13.9	15.2	15.1	16.6
Oral Surgery	50.5	58.8	61.8	74.0	65.0	78.0
Psychiatry	18.2	20.3	26.6	29.6	31.1	34.8
Urology	15.1	16.6	19.9	22.0	23.8	26.5

Table C-9—Molina Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	1.4	1.9	1.6	2.2	1.7	2.4
Pediatric PCPs	1.2	1.7	1.4	2.0	1.6	2.3
Adult Behavioral Health Service Providers	2.0	2.7	2.2	3.0	2.4	3.3
Pediatric Behavioral Health Service Providers	2.1	2.9	2.3	3.2	2.6	3.6
OB/GYN Providers	2.3	3.2	2.8	3.9	3.2	4.4
Dentistry, Adult	2.3	3.0	2.5	3.4	2.7	3.7
Pediatric Dentist	2.0	2.6	2.2	3.0	2.3	3.2
Hospitals	4.4	6.7	8.9	13.0	13.0	18.6
Pharmacies	1.2	1.6	1.7	2.3	2.2	2.9
Specialists						
Allergy and Immunology	6.5	9.4	10.3	14.4	12.7	17.5
Cardiology	3.4	4.7	4.2	6.0	4.6	6.7
Endocrinology	7.1	9.8	9.0	12.7	10.4	14.6
ENT/Otolaryngology	3.8	5.5	5.0	7.4	6.9	10.1
Gastroenterology	4.0	5.7	4.7	6.8	6.8	9.8
General Surgery	3.8	5.3	4.3	6.1	4.8	6.9
Infectious Disease	4.2	5.9	5.2	7.4	7.2	10.5
Nephrology	4.4	6.0	5.0	6.9	7.1	9.8
Neurosurgery	7.7	11.6	9.5	14.1	10.2	15.4
Oncology	3.3	4.7	3.9	5.5	4.2	6.0
Oral Surgery	15.2	20.1	20.6	28.6	24.2	31.7
Psychiatry	4.6	6.4	6.4	8.8	8.6	11.8
Urology	5.4	7.7	6.6	9.5	8.7	12.4

Table C-10—NextLevel Average Travel Distances and Travel Times to the Nearest Three Providers—Urban

Provider Categories	First-Nearest		Second-Nearest		Third-Nearest	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
Adult PCPs	0.8	1.5	0.9	1.8	1.0	1.9
Pediatric PCPs	1.4	2.7	1.8	3.3	2.0	3.7
Adult Behavioral Health Service Providers	1.0	1.9	1.2	2.2	1.3	2.5
Pediatric Behavioral Health Service Providers	3.9	7.0	5.2	9.5	5.7	10.5
OB/GYN Providers	1.3	2.4	1.5	2.8	1.7	3.1
Dentistry, Adult	0.8	1.5	1.0	1.8	1.1	2.0
Pediatric Dentist	3.5	6.7	5.7	10.6	6.7	12.5
Hospitals	3.4	6.4	4.9	9.4	6.1	11.7
Pharmacies	0.6	1.1	0.9	1.7	1.1	2.1
Specialists						
Allergy and Immunology	4.0	7.6	5.9	11.2	7.0	13.3
Cardiology	2.8	5.4	3.8	7.4	4.1	8.0
Endocrinology	4.3	7.7	5.2	10.0	5.9	11.3
ENT/Otolaryngology	4.1	7.6	4.5	8.4	5.5	10.1
Gastroenterology	4.5	8.2	5.6	10.4	5.9	11.4
General Surgery	3.1	5.8	3.6	6.8	3.9	7.4
Infectious Disease	3.3	6.1	4.3	8.3	4.8	9.2
Nephrology	3.8	7.1	4.4	8.3	5.2	9.8
Neurosurgery	6.3	12.1	6.7	12.8	7.0	13.4
Oncology	4.0	7.8	4.8	9.4	5.5	10.7
Oral Surgery	4.0	7.7	4.4	8.6	5.1	9.9
Psychiatry	3.9	7.4	5.1	9.7	5.9	11.4
Urology	4.1	7.7	5.3	10.0	5.8	11.1

Appendix D. Methodology

Data Sources

HFS and the health plans provided Medicaid enrollee demographic information and provider network files to HSAG for use in the time/distance analyses. The health plans submitted the provider data as part of their regular, ongoing submissions to HSAG. HSAG submitted a detailed data requirements document to HFS requesting its Medicaid enrollee data, including data which met the following criteria:

- Enrollee demographic data as of September 1, 2019.
- Enrollee eligibility and enrollment data including start and end dates for enrollment with the health plan.

Data Processing

HSAG cleaned, processed, and used the submitted data to define unique lists of providers, provider locations, and enrollees for inclusion in the analyses. HSAG standardized and geocoded all Medicaid enrollee and provider addresses using Quest Analytics Suite software. The following member inclusion criteria were applied, as applicable:

- Analyses of pediatric dentists were limited to enrollees younger than 18 years of age.
- Analyses of adult dentists were limited to enrollees 18 years of age and older.
- Analyses of obstetrics and gynecology (OB/GYN) providers were limited to female enrollees ages 15 years and older.
- Analyses for all specialist providers were limited to enrollees 18 years of age and older.

Provider offices in the State of Illinois or in contiguous counties were included in the time/distance analyses. All provider office locations associated with a provider were included in the analyses. For example, if a single provider practiced at three locations, each location was considered a unique location for the time/distance analyses.

Table D-1 shows the provider categories included in the time/distance analyses, the enrollee criteria for the time/distance analyses, and the network access standards (i.e., time/distance standards). For each of the access standards presented in Table D-1, the contract requirements state that the health plans must ensure that 90.0 percent of enrollees in each county of the contracting area have access within the stated time or distance standard, except for pharmacy services where 100 percent of the enrollees must have access within the stated time or distance standard. Analyses were conducted by region to illustrate differences between regions of the State.

The access standards are defined separately for enrollees living in urban and rural areas. HSAG used the definitions for “urban” and “rural” counties as defined in the Medicaid Model Contract—Attachment II.

Using those definitions, Illinois had 19 urban counties and 83 rural counties. Enrollee urbanicity was assigned using the county name associated with the enrollee's residential address included in the provided data. For records without a valid county name, standard county names produced during the geocoding process were used to assign urbanicity. A small portion of the enrollee data could not be geocoded (i.e., < 0.01 percent). These enrollees were excluded from the analyses.

Table D-1—Provider Categories, Enrollee Criteria, and Access Standards

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Adult Primary Care Providers (PCPs)[2]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Pediatric PCPs[2]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 PCPs within 30 miles or 30 minutes	Access to 1 PCP within 60 miles or 60 minutes
Adult Behavioral Health Service Providers[3]	All adults (on or after 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
Pediatric Behavioral Health Service Providers[3]	All children (up to 18th birthday) enrolled in a health plan	Access to 2 behavioral health service providers within 30 miles or 30 minutes	Access to 1 behavioral health service provider within 60 miles or 60 minutes
OB/GYN Providers[4]	Female adults (on or after 15th birthday) enrolled in a health plan	Access to 2 OB/GYN providers within 30 miles or 30 minutes	Access to 1 OB/GYN provider within 60 miles or 60 minutes
Dentistry, Adult	All adults (on or after 18th birthday) enrolled in a health plan	Access to 1 specialty services provider within 60 miles or 60 minutes	Access to 1 specialty services provider within 90 miles or 90 minutes
Pediatric Dentist	All children (up to 18th birthday) enrolled in a health plan	Access to 1 pediatric dentist within 30 miles or 30 minutes	Access to 1 pediatric dentist within 60 miles or 60 minutes
Hospitals	All enrollees enrolled in a health plan	Access to 1 general or critical access hospital within 30 miles or 30 minutes	Access to 1 general or critical access hospital within 60 miles or 60 minutes
Pharmacies	All enrollees enrolled in a health plan	Access to 1 pharmacy within 15 miles or 15 minutes	Access to 1 pharmacy within 60 miles or 60 minutes

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Specialist[5]			
Allergy and Immunology	All adults (on or after 18th birthday) enrolled in a health plan	Access to 1 specialty services provider within 60 miles or 60 minutes	Access to 1 specialty services provider within 90 miles or 90 minutes
Cardiology	All adults (on or after 18th birthday) enrolled in a health plan		
Endocrinology	All adults (on or after 18th birthday) enrolled in a health plan		
ENT/Otolaryngology	All adults (on or after 18th birthday) enrolled in a health plan		
Gastroenterology	All adults (on or after 18th birthday) enrolled in a health plan		
General Surgery	All adults (on or after 18th birthday) enrolled in a health plan		
Infectious Disease	All adults (on or after 18th birthday) enrolled in a health plan		
Nephrology	All adults (on or after 18th birthday) enrolled in a health plan		
Neurosurgery	All adults (on or after 18th birthday) enrolled in a health plan		
Oral Surgery	All adults (on or after 18th birthday) enrolled in a health plan		
Oncology	All adults (on or after 18th birthday) enrolled in a health plan		
Psychiatry	All adults (on or after 18th birthday) enrolled in a health plan		

Provider Categories	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Urology	All adults (on or after 18th birthday) enrolled in a health plan	Access to 1 specialty services provider within 60 miles or 60 minutes	Access to 1 specialty services provider within 90 miles or 90 minutes

[1] For these analyses, "urban" and "rural" are defined by the Medicaid Model Contract 2018-24-001.
[2] Adult PCPs include providers with a specialty of general practice, internal medicine, family medicine, family practice, nurse practitioner, physician assistant, and a PCP flag indicator. Pediatric PCPs include providers with a specialty of pediatric medicine, pediatric physician assistant, pediatric nurse practitioner, and a PCP flag indicator.
[3] Adult behavioral health service providers include providers with a specialty of psychiatry, psychology, alcohol and substance abuse rehabilitation services, licensed professional/licensed clinical social worker, and other behavioral health services. Pediatric behavioral health service providers were limited to providers with a specialty of pediatric psychiatry, pediatric psychology, mental health counselor, qualified mental health professional, and licensed practitioner of the healing arts.
[4] OB/GYN providers include providers with a specialty of obstetrics, gynecology, obstetrics/gynecology, or nurse midwife.
[5] Only adult providers were included for analyzing adult access to specialty providers (i.e., providers with a pediatric specialty such as pediatric cardiologists and pediatric neurologists were excluded).

Time/Distance Analyses

HSAG used Quest Analytics Suite software to review enrollee and provider addresses to ensure they could be geocoded to the exact geographic locations (i.e., latitude and longitude). Geocoded enrollee and provider addresses were assembled into datasets used to conduct the following three spatial analyses for each health plan for the provider categories listed in Table D-1:

- Percentage of enrollees within predefined access standards
  - A higher percentage of enrollees meeting access standards indicates a better geographic distribution of the health plan's providers relative to the Medicaid enrollees.
- Percentage of counties providing access to a provider within the predefined access standards to at least 90.0 percent of enrollees [D-1]
  - A higher percentage of counties meeting the access standards indicates a better geographic distribution of the health plan's providers relative to the Medicaid enrollees.
- Average travel distances (driving distances in miles) and travel times[D-2] (driving times in minutes) to the nearest three providers
  - A shorter driving distance or travel time indicates greater accessibility to providers since enrollees must travel fewer miles or minutes to access care.

[D-1] For pharmacy providers, the contract requirement states that 100 percent of enrollees must have access within the stated time or distance standard.
[D-2] Average drive time may not mirror driver experience, based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to the distribution of enrollees.

  - Results from the average travel distances and travel times to each provider category are presented by health plan in Appendix C.

Study Limitations

- Time/distance metrics represent a high-level measurement of the similarity of the geographic distribution of providers relative to enrollees. These raw, comparative statistics do not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) at a specific location or how active the provider is in the Medicaid program. It is likely that some providers are contracted to provide services for multiple health plans. As such, time/distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations.
- When evaluating the results of these analyses, it is important to note that the reported, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- The assessment of the time/distance metrics for the provider specialty categories is limited to adult members and does not include a specific assessment of pediatric specialists. The results may not be generalizable to the pediatric population.
- The availability of providers in some counties, specifically rural counties, may be unknown. These study results may assist HFS in determining if provider contracting deficits in certain counties are due to a lack of providers in the county or an inability of the health plans to contract with existing providers.
- When evaluating the results presented in this report, note that provider data supplied by the health plans do not include providers contracted with the health plans under limited use contracts or single case agreements. A larger number of enrollees may have access to providers if health plans contract with selected providers under these limited use agreements versus standard contract agreements.
- County names included in the enrollment data were used to determine enrollees' urbanicity and region. About 5.4 percent of enrollees did not have a valid county name in the data provided by HFS. As such, county names produced by Quest during geocoding were used to assign urbanicity and region to these enrollees.

Appendix E5. Access & Availability Survey Report

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

SFY 2020 Provider Network Access and Availability Survey:

Primary Care Providers (PCPs) and Obstetrician/Gynecologist (OB/GYN) Providers

February 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Executive Summary

Introduction

The Illinois Department of Healthcare and Family Services (HFS) is responsible for the ongoing monitoring and oversight of its contracted HealthChoice Illinois managed care plans that deliver services to Medicaid managed care enrollees. As part of its provider network adequacy monitoring activities, HFS requested its External Quality Review Organization (EQRO), Health Services Advisory Group, Inc. (HSAG), conduct access and availability surveys of provider offices to evaluate the average time to an appointment for Illinois Medicaid enrollees.

During Fiscal Year (FY) 2020, HSAG will conduct two secret shopper telephone surveys. The results of the first survey of primary care providers (PCPs) and obstetrics/gynecology (OB/GYN) providers are summarized in this report. A subsequent report will summarize the results of a survey of dental and specialty providers. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from health care providers without potential biases introduced by knowing the identity of the surveyor.

The goal of the FY 2020 Access and Availability PCP and OB/GYN Secret Shopper Survey was to evaluate appointment availability among the health plans' networks of PCP and OB/GYN providers. The health plans assessed in this analysis were:

- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare[1-1]
- IlliniCare Health Plan (IlliniCare)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- NextLevel Health (NextLevel)[1-1]

[1-1] Available only in Cook County.

Summary of Secret Shopper Survey Findings

Results of the fall 2019 secret shopper survey of primary care and OB/GYN providers on access and availability of provider offices indicate an overall response rate of 50.3 percent, which exceeds a typical provider response rate of approximately 15 percent to 20 percent for similar studies. By health plan, providers' response rates ranged from 39.8 percent (IlliniCare) to 69.2 percent (BCBSIL).

HSAG found that 10.5 percent of the providers did not accept the health plan and only 0.8 percent did not accept Medicaid. Moreover, 3.9 percent of the providers indicated that they were specialists, and 5.8 percent of all health plans did not accept new patients, ranging from 1.9 percent (NextLevel) to 12.5 percent (Meridian) (as shown in Table 1).

Table 1 displays the survey call outcomes, including the reasons that calls were excluded from the study, such as providers could not be reached, did not accept the health plan or Medicaid, were specialists, did not accept new patients, and had other limitations. Overall, 10.7 percent of the calls placed to providers indicated having an available appointment, with appointment availability rates ranging from 7.4 percent (CountyCare) to 14.0 percent (Molina).

Table 1—Outcome of Survey Calls to PCP and OB/GYN Providers by Health Plan

Outcome	BCBSIL[1]	CountyCare[1]	IlliniCare[1]	Meridian[1]	Molina[1]	NextLevel[1]	All Health Plans[2]
Provider Could Not be Reached	165 (30.8%)	306 (57.7%)	322 (60.2%)	211 (39.4%)	276 (51.7%)	301 (58.4%)	1,581 (49.7%)
Provider Not Accepting Plan	18 (3.4%)	64 (12.1%)	76 (14.2%)	35 (6.5%)	71 (13.3%)	70 (13.6%)	334 (10.5%)
Provider Not Accepting Medicaid	21 (3.9%)	2 (0.4%)	0 (0.0%)	1 (0.2%)	2 (0.4%)	0 (0.0%)	26 (0.8%)
Provider Is a Specialist/Not Included Provider	18 (3.4%)	11 (2.1%)	19 (3.6%)	19 (3.6%)	34 (6.4%)	23 (4.5%)	124 (3.9%)
Provider Not Accepting New Patients	54 (10.1%)	26 (4.9%)	18 (3.4%)	67 (12.5%)	11 (2.1%)	10 (1.9%)	186 (5.8%)
Other Limitation to Scheduling Appointment	217 (40.6%)	82 (15.5%)	40 (7.5%)	134 (25.0%)	65 (12.2%)	54 (10.5%)	592 (18.6%)
Appointment Available	42 (7.9%)	39 (7.4%)	60 (11.2%)	68 (12.7%)	75 (14.0%)	57 (11.1%)	341 (10.7%)

[1] The denominator is the total number of contracted provider locations for the health plan.
[2] The denominator is the total number of contracted provider locations for all health plans.

Ninety percent of the providers accepting the health plan and Medicaid confirmed being a PCP or OB/GYN provider as listed in the provider data. Of these, 83.4 percent reported accepting new patients, but limitations to scheduling appointments were observed across health plans. Appointment availability without a noted limitation was reported in 36.5 percent of all survey calls where the provider accepted the health plan, Medicaid, and new patients, with a range of 16.2 percent for BCBSIL to 60.0 percent for IlliniCare. Table 2 displays the top five limitations to scheduling appointments among survey calls to appropriate providers who could be reached and accepted the health plan and Medicaid. The primary limitation was the requirement to pre-register before scheduling an appointment for calls with an appointment (31.1 percent) and calls without an appointment (63.9 percent).

Table 2—Limitations to Scheduling Appointments With OB/GYN and PCP Providers

Limitation	Calls With Appointment		Calls Without Appointment	
	Number	Percentage[1]	Number	Percentage[2]
Requires pre-registration or personal information to schedule	106	31.1	378	63.9
Must designate provider as PCP through insurance first	89	26.1	147	24.8
Requires eligibility (Medicaid ID) verification	55	16.1	149	25.2
Requires medical record review	13	3.8	65	11.0
Requires panel review (may be assigned to another provider)	4	1.2	43	7.3

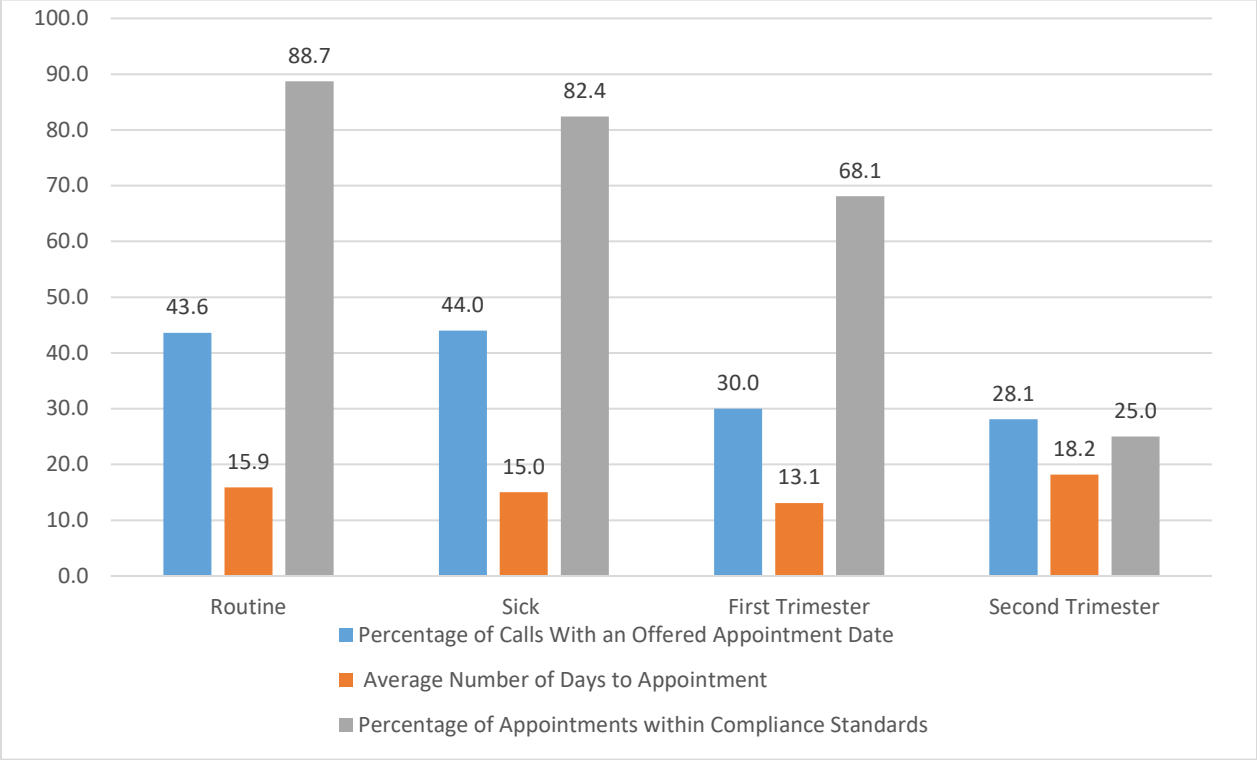
[1] The denominator is the number of calls with an appointment to contracted provider locations that were able to be reached and the sampled provider was still with the plan and accepting Medicaid.

[2] The denominator is the number of calls without an appointment to contracted provider locations that were able to be reached and the sampled provider was still with the plan and accepting Medicaid.

Despite the limited number of cases with appointment availability, PCP offices that could be reached and that offered appointments for new Medicaid patients requesting sick visits were in compliance with the contract standards for 82.4 percent of the offered appointments. For new Medicaid patients requesting routine well-checks, these offices were in compliance with the contract standards for 88.7 percent of the offered appointments. The average time to appointment was similar for both routine and sick PCP visit types. The all health plan median time to appointment for well-checks was 12 days, slightly longer than for sick visits (i.e., 10 days).

Figure 1 displays the characteristics of calls for new patient appointment to both PCP and OB/GYN providers.

Figure 1—Characteristics of New Patient Appointment for a Visit With an OB/GYN or PCP Provider



The OB/GYN appointments complied with contract standards in 68.1 percent of cases for first trimester visits. For second trimester visits, 25.0 percent of these appointments complied with contract standards, ranging from 0.0 percent (NextLevel) to 46.2 percent (IlliniCare and Meridian). As expected, the mean time to appointment for the first trimester (13.1 days) was shorter than for the second trimester (18.2). The same was true for the median days to appointment (12 versus 14 days). Table 3 displays the waiting time to schedule an appointment by provider and visit. HSAG. calls to PCP providers for sick visits were offered appointments earlier than for routine visits; calls to OB/GYN providers for first trimester visits were offered appointments earlier than for second trimester visits.

Table 3—New Patient Appointment Wait Time for a Visit With an OB/GYN or PCP Provider

Visit Type	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standards[1]	
		Number	Percentage[2]	Min	Max	Median	Average	Number	Percentage[3]
Routine	243	106	43.6	0	70	12	15.9	94	88.7
Sick	232	102	44.0	0	106	10	15.0	84	82.4
First Trimester	230	69	30.0	0	71	12	13.1	47	68.1

Visit Type	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standards[1]	
		Number	Percentage[2]	Min	Max	Median	Average	Number	Percentage[3]
Second Trimester	228	64	28.1	0	84	14	18.2	16	25.0

[1] HSAG classified appointments in compliance with standards in accordance with the Illinois Department of Healthcare and Family Services Medicaid Model Contract—2018-24-001, Section 5.8.3. Appointments were considered in compliance if the provider was a PCP and appointments were scheduled within five weeks for routine well-check visits and within three weeks for sick visits. Appointments with OB/GYN providers were considered in compliance if scheduled within two weeks for first trimester pregnancies and one week for enrollees in the second trimester.

[2] The denominator is the number of calls *for* an appointment with contracted provider locations that were able to be reached, where the sampled provider accepted the health plan, accepted Medicaid, confirmed being a PCP provider (routine and sick visit) or an OB/GYN provider(first and second trimester), and accepted new patients.

[3] The denominator is the number of calls *with* an appointment with contracted provider locations that were able to be reached, where the sampled provider accepted the health plan, accepted Medicaid, confirmed being a PCP provider (routine and sick visit) or an OB/GYN provider (first and second trimester), and accepted new patients.

Recommendations

Based on the survey results presented in this report, HSAG identified several opportunities for improvement related to accurate provider information, enrollees' ability to successfully schedule an appointment, and the timeliness of available appointments relative to enrollees' needs. HSAG offers the following recommendations to address potential opportunities to improve access among enrollees covered by HealthChoice Illinois managed care plans:

- HSAG was unable to reach more than 30 percent of sampled cases for each health plan, and a key nonresponse reason involved call attempts in which the provider was no longer at the location listed in the provider data.
  - As the health plans are required to conduct annual provider directory audits and confirm provider information for providers who have not submitted a claim within six months, HFS should continue conducting oversight of the health plans provider directory reviews and require the review the findings of the reviews. Additionally, HFS should follow-up with the health plans regarding deficiencies noted in the during the reviews and collaborate with the health plans to ensure deficiencies are resolved for the subsequent year's review.
  - HFS should consider collaborating with its EQRO to conduct an independent provider directory review to validate the information provided to enrollees in the online provider directory and to validate the findings from the health plans annual provider directory audits.
- HSAG was only able to obtain an appointment date with 43.6 percent of the sampled providers that were accepting the health plan, Medicaid, and new patients. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling, Medicaid eligibility verification, designation with the PCP through insurance prior to appointment scheduling, and medical record review. While some barriers pose unique limitations to

a secret shopper survey where caller information cannot be provided to the office, (i.e., pre-registration or requiring personal information to schedule), other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments. HFS and the health plans should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollees' ability to schedule an appointment.

- In coordination with ongoing outreach and network management activities, the health plans should review physician office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials. In particular, HFS and the health plans should work with OB/GYN providers to ensure (1) that providers are aware of the different appointment availability standards based on a woman's trimester and (2) that barriers to scheduling appointments are identified and corrected.
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with specific geographic areas. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with standards.
- HFS should continue to monitor the health plans compliance with existing state standards for appointment availability and audits to assess the accuracy of their online provider directories to ensure enrollees' access to services. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.

Appendix A. Detailed Findings

Table A-1 reports the survey response rates regarding whether the provider locations were able to be contacted. Overall, a 50.3 percent response rate was achieved for this survey. This response rate exceeds the typical Medicaid provider response rate of 15 percent to 20 percent that HSAG has observed historically across its book of business.

Table A-1—Telephone Survey Response Rate

Health Plan	Total Number of Sampled PCP and OB/GYN Providers	Respondents (N)	Non-Respondents (N)	Response Rate[1] (%)
BCBSIL	535	370	165	69.2
CountyCare	530	224	306	42.3
IlliniCare	535	213	322	39.8
Meridian	535	324	211	60.6
Molina	534	258	276	48.3
NextLevel	515	214	301	41.6
All Health Plans	3,184	1,603	1,581	50.3

[1] The denominator is the total number of sampled contracted provider locations.

Table A-2 reports whether survey respondents were still participating with the health plan as indicated in the provider data file submitted by the health plan. Overall, 79.2 percent of providers reached were still contracted with the health plan.

Table A-2—Health Plan Participation Distribution for Respondents

Health Plan	Respondents (N)	Participating With Health Plan (N)	Not Participating With Health Plan (N)	Participation Rate [1] (%)
BCBSIL	370	352	18	95.1
CountyCare	224	160	64	71.4
IlliniCare	213	137	76	64.3
Meridian	324	289	35	89.2
Molina	258	187	71	72.5
NextLevel	214	144	70	67.3
All Health Plans	1,603	1,269	334	79.2

[1] The denominator is the number of contracted provider locations that were able to be reached.

All Medicaid provider offices that confirmed during the survey that the sampled provider was a PCP or an OB/GYN provider at the sampled location were included in the eligible study population and were asked if the sampled provider accepted new Medicaid patients at the sampled locations. Table A-3 reports the survey responses regarding contacted provider locations that were accepting new patients for the sampled provider at the time of the survey.

Table A-3—Number and Percentage of PCP and OB/GYN Providers Who Could Be Reached by Telephone and Were Accepting New Patients by Health Plan

Health Plan	Providers Participating With Health Plan and Medicaid	Is a PCP or OB/GYN provider		Providers Accepting New Patients	
		Number	Percentage[1]	Number	Percentage[2]
BCBSIL	331	313	94.6	259	82.7
CountyCare	158	147	93.0	121	82.3
IlliniCare	137	118	86.1	100	84.7
Meridian	288	269	93.4	202	75.1
Molina	185	151	81.6	140	92.7
NextLevel	144	121	84.0	111	91.7
All Health Plans	1,243	1,119	90.0	933	83.4

[1] The denominator is the number of contracted provider locations that were able to be reached and the sampled provider was still with the plan and accepting Medicaid.

[2] The denominator is the number of contracted provider locations that were able to be reached and the sampled provider was still with the plan; accepting Medicaid; and confirmed being a PCP or an OB/GYN provider.

Table A-4 displays the overall number and percentage of calls with an appointment and the appointments were in compliance with contract standards among provider locations accepting new patients. Of the 341 calls with appointments, 70.7 percent were in compliance with the standards.

Table A-4—Appointment Availability for All Appointment Types by Health Plan

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Appointments in Compliance With Standards	
		Number	Percentage[1]	Number	Percentage[2]
BCBSIL	259	42	16.2	25	59.5
CountyCare	121	39	32.2	27	69.2
IlliniCare	100	60	60.0	44	73.3
Meridian	202	68	33.7	52	76.5
Molina	140	75	53.6	52	69.3

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Appointments in Compliance With Standards	
		Number	Percentage[1]	Number	Percentage[2]
NextLevel	111	57	51.4	41	71.9
All Health Plans	933	341	36.5	241	70.7

[1] The denominator is the number of contracted provider locations that were able to be reached and the sampled provider was still with the plan; accepting Medicaid; accepting new patients; and confirmed being a PCP or an OB/GYN provider.

[2] The denominator is the number of calls with appointments to contracted provider locations that were able to be reached and the sampled provider was still with the plan; accepting Medicaid; accepting new patients; and confirmed being a PCP or an OB/GYN provider.

HSAG classified appointments in compliance with standards in accordance with the Illinois Department of Healthcare and Family Services Medicaid Model Contract—2018-24-001, Section 5.8.3. Appointments were considered in compliance if the provider was a PCP and appointments were scheduled within five weeks for routine well-check visits, or within three weeks for sick visits. Conversely, appointments with OB/GYN providers were considered in compliance if scheduled within two weeks for first trimester pregnancies and one week for enrollees in their second trimester.

Table A-5 displays the appointment information for routine visits with PCPs, including the number and percentage of calls resulting in a valid appointment date, the number of days to an appointment, and whether the appointment date was in compliance with the contract standard. The average wait time to an appointment for routine visits was 15.9 days.

Table A-5—New Patient Appointment Wait Time for a Routine Visit With a PCP

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standards	
		Number	Percentage[1]	Min	Max	Median	Average	Number	Percentage[2]
BCBSIL	71	10	14.1	0	59	9.0	16.1	8	80.0
CountyCare	30	15	50.0	2	70	9.0	18.9	11	73.3
IlliniCare	25	16	64.0	2	28	13.0	14.8	16	100.0
Meridian	51	23	45.1	0	64	9.0	15.7	20	87.0
Molina	36	21	58.3	0	60	14.0	15.0	20	95.2
NextLevel	30	21	70.0	5	53	12.0	15.6	19	90.5
All Health Plans	243	106	43.6	0	70	12.0	15.9	94	88.7

[1] The denominator is the number of calls for a routine visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being a PCP.

[2] The denominator is the number of calls with an appointment for a routine visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being a PCP.

Table A-6 displays the appointment information for sick visits with PCPs, including the number and percentage of calls resulting in a valid appointment date, the number of days to an appointment, and whether the appointment date was in compliance with the contract standard. The average wait time to appointments for sick visits was 15 days.

Table A-6—New Patient Appointment Wait Time for a Sick Visit With a PCP

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standards	
		Number	Percentage [1]	Min	Max	Median	Average	Number	Percentage [2]
BCBSIL	67	18	26.9	0	64	12.0	20.4	10	55.6
CountyCare	28	12	42.9	0	86	8.0	14.0	10	83.3
IlliniCare	26	15	57.7	2	83	13.0	15.7	14	93.3
Meridian	48	18	37.5	0	106	7.0	16.3	14	77.8
Molina	37	21	56.8	3	47	11.0	13.1	18	85.7
NextLevel	26	18	69.2	0	21	10.5	10.3	18	100.0
All Health Plans	232	102	44.0	0	106	10.0	15.0	84	82.4

[1] The denominator is the number of calls for a sick visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being a PCP.

[2] The denominator is the number of calls with an appointment for a sick visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being a PCP.

Table A-7 displays the appointment information for first trimester visits with an OB/GYN provider, including the number and percentage of calls resulting in a valid appointment date, the number of days to an appointment, and whether the appointment date was in compliance with the contract standard. The average wait time to an appointment for a first trimester visit was 13.1 days.

Table A-7—New Patient Appointment Wait Time for a First Trimester Visit With an OB/GYN Provider

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standard	
		Number	Percentage [1]	Min	Max	Median	Average	Number	Percentage [2]
BCBSIL	56	7	12.5	0	71	7.0	16.0	6	85.7
CountyCare	33	5	15.2	1	20	4.0	6.4	4	80.0
IlliniCare	25	16	64.0	5	55	14.0	15.3	8	50.0
Meridian	51	14	27.5	2	21	9.0	9.7	12	85.7
Molina	37	20	54.1	2	47	12.5	13.8	13	65.0

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standard	
		Number	Percentage [1]	Min	Max	Median	Average	Number	Percentage [2]
NextLevel	28	7	25.0	2	42	12.0	15.1	4	57.1
All Health Plans	230	69	30.0	0	71	12.0	13.1	47	68.1

[1] The denominator is the number of calls for a first trimester visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being an OB/GYN provider.

[2] The denominator is the number of calls with an appointment for a first trimester visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being an OB/GYN provider.

Table A-8 displays the appointment information for second trimester visits with an OB/GYN provider, including the number and percentage of calls resulting in a valid appointment date, the number of days to an appointment, and whether the appointment date was in compliance with the contract standard. The average wait time to an appointment for second trimester visits was 18.2 days.

Table A-8—New Patient Appointment Wait Time for a Second Trimester Visit With an OB/GYN Provider

Health Plan	Providers Contacted and Accepting New Patients	Calls With an Appointment		Days to Appointment				Appointments in Compliance With Standards	
		Number	Percentage [1]	Min	Max	Median	Average	Number	Percentage [2]
BCBSIL	65	7	10.8	5	76	24.0	30.1	1	14.3
CountyCare	30	7	23.3	5	76	21.0	27.4	2	28.6
IlliniCare	24	13	54.2	0	84	10.0	15.3	6	46.2
Meridian	52	13	25.0	1	70	10.0	15.5	6	46.2
Molina	30	13	43.3	1	20	14.0	13.0	1	7.7
NextLevel	27	11	40.7	8	42	15.0	17.5	0	0.0
All Health Plans	228	64	28.1	0	84	14.0	18.2	16	25.0

[1] The denominator is the number of calls for a second trimester visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being an OB/GYN provider.

[2] The denominator is the number of calls with an appointment for a second trimester visit to contracted provider locations that were able to be reached and the sampled provider was still with the plan, accepting Medicaid, accepting new patients, and confirmed being an OB/GYN provider.

Appendix B. Methodology

Methodology

Data Collection

HSAG will conduct two access and availability surveys for HFS during FY 2020 (July 1, 2019, through June 30, 2020) with the primary purpose of collecting appointment availability information for well-check ("routine"), nonurgent problem-focused ("sick"), or initial prenatal visits for new Medicaid enrollees.

- HSAG conducted the first secret shopper survey in fall 2019 and included PCP and OB/GYN providers enrolled with one of the six health plans as of the most recent monthly data submission file at the time the survey cases were sampled.
- HSAG will conduct the second provider survey in spring 2020 and it will include specialists and dental providers.

For the fall survey, HSAG assembled the sample frame based on providers identified in the most recent provider data extracts submitted to HSAG/HFS by the health plans and used it to determine a statistically valid number of unique providers to include in the sample. Table B-1 shows the provider specialties included in each provider category and the appointment standards for each provider category.

Table B-1—Provider Categories Included in the Fall Secret Shopper Survey

Provider Category	Provider Specialties	Appointment Standard[1]
PCP Providers	• Family Practice • General Practice • Internal Medicine • Physician's Assistant • Nurse Practitioner • Pediatric Medicine	• Five weeks for routine, preventive care • Three weeks for problems or complaints that are not deemed serious
OB/GYN Providers	• Obstetrics • Gynecology • Nurse Midwife	• Two weeks for an enrollee in her first trimester • One week for an enrollee in her second trimester

[1] Network adequacy standards are outlined in the Illinois Department of Healthcare and Family Services Medicaid Model Contract—2018-24-001, Section 5.8.3.

Appointment Availability Analysis

Information on appointment availability was collected for the first available appointment at the specified location (i.e., appointment requests were limited to selected providers). HSAG conducted a single statewide survey with proportional distribution of sampled cases across the geographic regions. HSAG used a two-stage random sampling approach to generate a representative sample of providers, proportionally distributed across the region. First, HSAG determined a statistically valid number of unique providers for each health plan based on a 95 percent confidence level and ±5 percent margin of error, and an additional 40 percent oversample to increase the probability of capturing appointment availability information and equally distributed the sample between provider category (i.e., PCP and OB/GYN). HSAG then randomly selected an appropriate number of unique providers for each health plan, then equally distributed across provider category (e.g., PCP, OB/GYN) and appointment type (e.g., routine versus sick). The sample size was based on health plan-level total population sizes and ensures statistically significant health plan-level results.

Telephone Survey of Provider Offices

During the survey, callers used an HFS-approved script (Appendix C) while attempting a maximum of two telephone calls to each sampled provider's office. All telephone calls were made during standard operating hours (i.e., 9 a.m. to 5 p.m. CT).

If, on the first call attempt, the secret shopper reached an answering service or voicemail, a second call attempt was made on a different day, at a different time of day. If, during the second call attempt, the caller was still unable to reach the appointment scheduling staff, the provider location was considered unreachable. In cases where the caller was put on hold, the callers were instructed to wait five minutes for a response before ending the call. If the extended hold occurred on a first call attempt, a second call attempt was made. However, if the extended hold occurred on a second call attempt, the provider was considered unreachable. Callers did not leave voicemails or request return calls from the providers' offices.

Callers underwent project-specific training with a dedicated analytics manager to ensure standardized survey administration and data collection during the phone calls. The analytics manager reviewed 100 percent of the calls. Daily briefings were held with callers to share any issues identified in the survey tool or to reinforce training concepts.

HSAG callers entered survey call responses into an electronic data collection tool. Prior to analyzing the data, HSAG reviewed the responses for completeness and accuracy. Survey responses were used to assess appointment availability and to validate selected information in the provider file. HSAG callers gathered the following information during survey calls:

- Telephone number (Note: If the telephone number was incorrect for the location and the correct number could not be obtained at the time of the survey, the survey stopped.)
- Provider information:

  - The sampled provider accepts the health plan at the sampled location. (Note: If the provider did not accept the health plan at the sampled location, the survey stopped.)
  - The sampled provider accepts Medicaid at the sampled location. (Note: If the provider did not accept Medicaid, the survey stopped.)
  - The sampled provider accepts new patients at the sampled location. (Note: If the provider did not accept new patients, the survey stopped.)
- Appointment availability:
  - Number of calendar days to the first available appointment for a new Medicaid patient

Due to the nature of the survey script, data may be unavailable for some provider locations. For example, if the telephone number was incorrect for the provider location and a corrected telephone number could not be obtained from the person responding to the survey, the survey stopped, and the remaining survey elements would be missing.

Study Limitations

Due to the secret shopper nature of the survey, the following limitations should be considered when generalizing survey results across PCP and OB/GYN providers contracted with the HealthChoice Illinois Managed care plans:

- Survey findings were compiled from self-reported responses supplied to HSAG's callers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication. The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Health plans are responsible for ensuring that enrollees have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the health plans' processes for aiding enrollees who require timely appointments.
- Certain survey responses ended the caller's conversations without collecting data for all survey elements. Calls identified as being made on behalf of HFS are likely to collect data for all survey elements but would not accurately portray enrollees' experiences.
- To maintain the secret nature of the survey, callers posed as Medicaid enrollees who were not existing patients at the sampled provider locations. As such, survey results may not represent appointment timeliness among existing Medicaid patients.

Appendix C. Provider Survey Script

NOTE: This sample script served as a guide in gathering information relevant to obtaining appointment information. Callers were permitted to improvise during actual calls as needed. Callers were instructed to conduct the survey as though they were moving to the area and seeking a primary care provider (PCP) for a routine well-check or a nonurgent sick visit or an obstetrician-gynecologist (OB-GYN) or certified nurse midwife (CNM) for prenatal care with the designated health plan. The electronic data collection tool controlled skip logic between survey elements and collected the date(s) of the initial and subsequent calls. Callers were instructed not to leave voicemail messages or schedule appointments.

1. Call the office and note the name of the person to whom you are speaking.

   If the telephone number is disconnected or does not connect to a medical facility, the survey will end, and the case is considered a nonrespondent (i.e., an invalid telephone number).

2. Hello, I'm calling to find out if I can make an appointment with <<**provider's first and last name**>>; my insurance is with <<**plan**>>." Does <<**provider's first and last name**>> still see patients from <<**plan**>>?

   If yes, continue to Element #3.

   If the office indicates that it does not accept the plan, the survey will end.

3. Does <<**provider's first and last name**>> take *Medicaid*?

   If the office indicates that the provider accepts Medicaid, continue to Element #4.

   If the office indicates that the provider does not accept Medicaid, the survey will end.

4. Is << **provider's first and last name**>> a <<**PCP/OB-GYN/CNM**>> with <<**plan**>>?

   If yes, continue to Element #5.

   If the office indicates that the provider is not a PCP, OB-GYN, or CNM, record any specialty information offered and the survey will end.

5. Is <<**provider's first and last name**>> accepting new patients for <<**plan**>>?

   If yes, continue to Element #6.

   If the office indicates that the provider is not accepting new patients, the survey will end.

6. **If PCP Well-Check:** How soon would I be able to get an appointment for a well-check with <<**provider's first and last name**>> for (myself/my son / my daughter)?

   Record the date for the soonest available appointment with any provider at the location and continue to Element #7. Note whether the appointment is with the sampled provider or a different provider at the location.

If the office offers limitations to patient access or appointment availability, record any limitations offered (e.g., the patient must have their medical records reviewed by the provider prior to scheduling an initial appointment, or must designate the provider as the PCP through their insurance first). Callers will not inquire about additional limitations.

If an appointment date is not offered due to limitations, record "12/31/2099" (i.e., no appointment available) and the survey will end.

If PCP Sick Visit: For the past week, I've been having (my son/ my daughter has had) a cough for a week, but no fever. How soon would I be able to get an appointment with <<**provider's first and last name**>> for (myself/my son/my daughter)?"

Record the date for the soonest available appointment with any provider at the location and continue to Element #7. Note whether the appointment is with the sampled provider or a different provider at the location.

If the office offers limitations to patient access or appointment availability, record any limitations offered (e.g., patients must have their medical records reviewed by the provider prior to scheduling an initial appointment, or the office will only schedule sick visits for established patients). Callers will not inquire about additional limitations.

If an appointment date is not offered due to limitations, record "12/31/2099" (i.e., no appointment available) and the survey will end.

If Prenatal 1st Trimester Visit: I'm 9 weeks pregnant and would like to schedule a prenatal visit. How soon would I be able to get an appointment scheduled with < **provider's first and last name**>?

Record the date for the soonest available appointment with any provider at the location and continue to Element #7. Note whether the appointment is with the sampled provider or a different provider at the location.

If the office offers limitations to patient access or appointment availability, record any limitations offered (e.g., patients must have their medical records reviewed by the provider prior to scheduling an initial appointment or require an in-office pregnancy test prior to scheduling and appointment). Callers will not inquire about additional limitations.

If an appointment date is not offered due to limitations, record "12/31/2099" (i.e., no appointment available) and the survey will end.

If Prenatal 2nd Trimester Visit: I'm 20 weeks pregnant and would like to schedule a prenatal visit. How soon would I be able to get an appointment scheduled with < **provider's first and last name**>?

Record the date for the soonest available appointment with any provider at the location and continue to Element #7. Note whether the appointment is with the sampled provider or a different provider at the location.

If the office offers limitations to patient access or appointment availability, record any limitations offered (e.g., patients must have their medical records reviewed by the provider prior to scheduling

an initial appointment or require an in-office pregnancy test prior to scheduling and appointment). Callers will not inquire about additional limitations.

If an appointment date is not offered due to limitations, record "12/31/2099" (i.e., no appointment available) and the survey will end.

7. Thank you. I will call back later.

Appendix F1. Beneficiary Experience With Care Methodology

Member Experience Surveys

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. BCBSIL, CountyCare , IlliniCare, Meridian, Molina, and NextLevel were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys on their behalf.[F1-1] Results for all six plans were forwarded to HSAG for analysis. For the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/CHIP) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

The CAHPS results are presented by program type by population. Both the adult and child Medicaid populations were surveyed under HealthChoice Illinois for BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel. Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and Illinois Medicaid programs were surveyed.[F1-2]

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

Overview

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

Technical Methods of Data Collection and Analysis

FHP/ACA and ICP Health Plans

The technical method of data collection was through the administration of the CAHPS 5.0H Adult Medicaid Survey to the adult populations and the CAHPS 5.0H Child Medicaid Survey to the child populations. BCBSIL, CountyCare, Meridian, Molina, and NextLevel used a mixed-mode methodology,

[F1-1] In 2019, SPH Analytics administered the CAHPS surveys on behalf of CountyCare, Meridian, and Molina. Morpace administered the CAHPS surveys on behalf of BCBSIL, IlliniCare, and NextLevel. In 2020, SPH Analytics administered the CAHPS surveys on behalf of all health plans.

[F1-2] The Illinois statewide program aggregate results presented in this report represent the results of the All Kids and Illinois Medicaid programs combined.

which included both mail and telephone surveys for data collection.[F1-3] IlliniCare used a mixed-mode methodology for the child population and a mail-only methodology for the adult population for data collection. BCBSIL, CountyCare, IlliniCare, and NextLevel included the option to complete the surveys in English and Spanish for both the adult and child populations. Molina included the option to complete the surveys in English and Spanish for the child population only.

All Kids and Illinois Medicaid Statewide Survey

The technical method of data collection was through the administration of the CAHPS 5.0 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For All Kids and Illinois Medicaid, a sample representing the general child population and a CCC supplemental sample (i.e., a sample of child members who were identified as more likely to have a chronic condition) were selected from each program. All Kids and Illinois Medicaid used a standard mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

Survey Measures for CAHPS

The survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite measures. The global ratings reflected members' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). For All Kids and Illinois Medicaid, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five additional measures of experience. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

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

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box score). For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices

[F1-3] In 2019 and 2020, BCBSIL, IlliniCare, and NextLevel used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.0H Adult Medicaid Survey and CAHPS 5.0H Child Medicaid Survey. This protocol allowed sampled members the option to complete the survey via the Internet.

were "Never," "Sometimes," "Usually," and "Always." For the composite measures (*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*), a positive, or top-box response, was defined as a response of "Usually" or "Always." Composite measure scores were calculated by averaging the percentage of positive responses for each item. The percentage of top-box responses was referred to as a global proportion (or top-box score) for the composite measures.

For each of the CCC composites and items for the CCC population, the percentage of respondents who chose a positive response was calculated. CAHPS CCC composite measure/item question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "No" and "Yes." For three of the CCC composite measures/items (*Access to Specialized Services*, *Access to Prescription Medicines*, and *Family-Centered Car* (*FCC): Getting Needed Information*), a positive, or top-box, response was defined as a response of "Usually" or "Always." For two CCC composite measures/items (*FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions*), a positive, or top-box, response was defined as a response of "Yes." CCC composite and item top-box scores were calculated by averaging the percentage of positive responses for each item.

For each CAHPS measure, the resulting 2019 top-box scores were compared to NCQA's 2018 Quality Compass Benchmark and Compare Quality Data, and the resulting 2020 top-box scores were compared to NCQA's 2019 Quality Compass Benchmark and Compare Quality Data.[F1-4,F1-5] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, with one being the lowest possible rating and five being the highest possible rating, using the percentile distributions shown in Table F1-1.

Table F1-1—Star Ratings

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

[F1-4] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2018.* Washington, DC: NCQA. September 2018.

[F1-5] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019.* Washington, DC: NCQA. September 2019.

Appendix F2. Beneficiary Experience With Care Detailed Results

Adult CAHPS Medicaid Survey

Response Rates

The 2020 adult Medicaid CAHPS response rates are presented in the tables below for each adult health plan and the statewide aggregate (i.e., all health plans combined).

Table F2-1—2020 Adult Response Rates

BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Aggregate
19.90%	20.23%	10.53%	20.97%	18.46%	9.27%	14.38%

Adult Plan-Specific Findings and Comparisons

The 2019 and 2020 adult Medicaid CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for each adult health plan and the statewide aggregate.

Composite Measures

Table F2-2—2019 and 2020 Adult Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
BCBSIL	2019	83.6% ★★★	81.5% ★★	93.8% ★★★★	90.3% ★★★★
	2020	79.6% ★	82.2% ★★	94.6% ★★★★	90.7% ★★★
CountyCare	2019	81.2% ★★	82.3% ★★	93.6% ★★★★	94.3% ★★★★★
	2020	81.4% ★★	81.8% ★★	92.0% ★★	87.1% ★
IlliniCare	2019	82.7% ★★	83.0% ★★★	93.0% ★★★	89.1% ★★★
	2020	82.0% ★★	79.6% ★	93.3% ★★★	89.6% ★★★
Meridian	2019	83.4% ★★★	82.9% ★★★	92.2% ★★★	89.5% ★★★
	2020	81.2% ★★	80.9% ★★	93.1% ★★★	92.3% ★★★★

Experience of Care

Statewide Adult Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2019	78.5% ★	79.6% ★★	91.2% ★★	84.6% ★
	2020	80.7% ★★	83.8% ★★★	92.8% ★★★	85.4% ★
NextLevel	2019	71.1%+ ★+	74.0%+ ★+	92.5%+ ★★★+	88.0%+ ★★+
	2020	71.6% ★	75.3% ★	91.3% ★★	84.8% ★
Statewide Aggregate	2019	82.1% ★★	82.0% ★★	92.9% ★★★	89.8% ★★★
	2020	81.0% ★★	81.0% ★★	93.2% ★★★	89.8% ★★★

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

Notable

- Compared to national benchmarks, 2020 experience survey results indicated that adult BCBSIL members reported top-box scores above the 75th percentile for *How Well Doctors Communicate* and adult Meridian members reported top-box scores above the 75th percentile for *Customer Service*.
- Star ratings for Meridian improved from 2019 to 2020 for *Customer Service*. Also, star ratings for Molina improved from 2019 to 2020 for *Getting Needed Care*, *Getting Care Quickly*, and *How Well Doctors Communicate*.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that adult members in two of the six MCOs reported top-box scores below the 50th percentiles for all four composite measures. Of these, all six MCOs reported top-box scores below the 50th percentile for *Getting Needed Care*.

Global Ratings

Table F2-3—2019 and 2020 Adult Plan-Specific Results

Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
BCBSIL	2019	54.1% ★★	67.2% ★★	71.4% ★★★★	60.9% ★★★
	2020	59.6% ★★★★	72.6% ★★★★	67.4% ★★	60.8% ★★
CountyCare	2019	52.6% ★★	66.2% ★★	64.3% ★★	61.8% ★★★
	2020	61.3% ★★★★★	72.3% ★★★★	73.2% ★★★★★	68.3% ★★★★★
IlliniCare	2019	55.3% ★★★	71.9% ★★★★	70.6% ★★★★	57.2% ★★
	2020	54.3% ★★	68.4% ★★★	65.2% ★★	57.4% ★★
Meridian	2019	56.9% ★★★	69.2% ★★★	67.2% ★★	61.4% ★★★
	2020	55.4% ★★★	67.4% ★★	65.5% ★★	59.4% ★★
Molina	2019	53.2% ★★	68.9% ★★★	68.0% ★★★	57.1% ★★
	2020	59.9% ★★★★	70.7% ★★★★	69.4% ★★★	57.8% ★★
NextLevel	2019	47.0%+ ★+	65.0%+ ★★+	51.5%+ ★+	47.2% ★
	2020	48.0% ★	66.8% ★★	59.9% ★	49.0% ★
Statewide Aggregate	2019	54.6% ★★	69.0% ★★★	68.1% ★★★	59.3% ★★
	2020	56.7% ★★★	69.4% ★★★	67.0% ★★	59.9% ★★

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

Notable

- Compared to national benchmarks, 2020 experience survey results indicated that adult CountyCare members reported top-box scores at or above the 75th percentiles for all four global ratings. In addition, adult BCBSIL and Molina members reported top-box scores between the 75th and 89th percentiles for two measures.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that adult members in five of the six MCOs reported top-box scores below the 50th percentile for *Rating of Health Plan*. In addition, adult NextLevel members reported top-box scores below the 50th percentiles for all four global ratings.

Child CAHPS Medicaid Survey

Response Rates

The 2020 child Medicaid CAHPS response rates are presented in the tables below for each child health plan and the statewide aggregate (i.e., all health plans combined).

Table F2-4—2020 Child Response Rates

BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Statewide Aggregate
13.46%	14.59%	10.61%	20.98%	14.54%	7.23%	12.27%

Child Plan-Specific Findings and Comparisons

The 2019 and 2020 child Medicaid CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for each child health plan and the statewide aggregate.

Composite Measures

Table F2-5—2019 and 2020 Child Plan-Specific Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
BCBSIL	2019	77.0% ★	82.3% ★	94.6% ★★★	87.0% ★
	2020	77.0% ★	82.4% ★	94.3% ★★★	88.5% ★★
CountyCare	2019	83.8% ★★	81.8% ★	92.9% ★★	85.6% ★
	2020	74.9% ★	87.3% ★★	91.6% ★	87.0% ★★
IlliniCare	2019	77.1% ★	90.0% ★★★	92.5% ★★	89.3% ★★★
	2020	81.5%+ ★★+	90.1%+ ★★★+	93.6% ★★	83.8%+ ★+

Experience of Care

Statewide Child Results

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Meridian	2019	79.6% ★	87.4% ★★	94.2% ★★★	87.9% ★★
	2020	84.3% ★★	90.2% ★★★	95.0% ★★★	84.6% ★
Molina	2019	83.8% ★★	87.5% ★★	93.0% ★★	84.4% ★
	2020	85.0% ★★★	91.3% ★★★	96.0% ★★★★	90.1% ★★★★
NextLevel	2019	75.4% ★	80.9% ★	90.2% ★	86.0% ★
	2020	70.8% ★	75.9% ★	90.6% ★	79.3% ★
Statewide Aggregate	2019	79.7% ★	85.6% ★	93.6% ★★	87.1% ★
	2020	81.0% ★	88.2% ★★	94.2% ★★★	86.2% ★

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

Notable

- Compared to national Medicaid percentiles, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores between the 75th and 89th percentiles for *How Well Doctors Communicate* and *Customer Service* for Molina.
- Star ratings improved from 2019 to 2020 for all four composite measures for Molina, with two of the measures increasing by at least two stars.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 50th percentiles for *Getting Needed Care* and *Customer Service* for all MCOs, with the exception of Molina.
- Star ratings declined below the 25th percentiles from 2019 to 2020 for *Getting Needed Care* and *How Well Doctors Communicate* for CountyCare, and *Customer Service* for IlliniCare and Meridian.

Global Ratings

Table F2-6—2019 and 2020 Child Plan-Specific Results

Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
BCBSIL	2019	74.6% ★★★★	77.7% ★★★	75.7% ★★★	75.3% ★★★
	2020	78.4% ★★★★★	78.4% ★★★	79.8%+ ★★★★★+	75.9% ★★★★
CountyCare	2019	70.0% ★★	78.6% ★★★	76.8%+ ★★★+	74.2% ★★★
	2020	70.3% ★★	78.7% ★★★	73.3%+ ★★+	71.1% ★★
IlliniCare	2019	63.8% ★	74.4% ★	63.0%+ ★+	62.8% ★
	2020	70.6% ★★	72.0% ★	71.4%+ ★★+	60.2% ★
Meridian	2019	71.8% ★★★	77.4% ★★★	74.7%+ ★★★+	69.1% ★★
	2020	73.7% ★★★	80.4% ★★★★	73.1%+ ★★+	67.7% ★
Molina	2019	69.1% ★★	77.0% ★★★	69.4%+ ★+	62.6% ★
	2020	74.0% ★★★	76.1% ★★	75.0%+ ★★★+	63.5% ★
NextLevel	2019	65.0% ★	73.6% ★	61.2%+ ★+	64.0% ★
	2020	58.0% ★	73.1% ★	68.4%+ ★+	53.4% ★
Statewide Aggregate	2019	70.6% ★★★	77.1% ★★★	72.9% ★★	69.7% ★★
	2020	73.6% ★★★	78.1% ★★★	74.4% ★★★	68.3% ★

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

Experience of Care

Statewide Child Results

Notable

- Compared to national Medicaid percentiles, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores at or above the 75th percentile for three of the four global ratings (*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*) for BCBSIL and one of the four global ratings (*Rating of Personal* Doctor) for Meridian.
- The star ratings for those health plans with global ratings at or above the 75th percentile improved from 2019 to 2020, along with all three composite measures for Molina.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 50th percentiles for all four global ratings for IlliniCare and NextLevel.
- Star ratings declined from 2019 to 2020 for *Rating of Specialist Seen Most Often* and *Rating of Health Plan* for CountyCare and Meridian, and *Rating of Personal Doctor* for Molina.

Statewide CAHPS Medicaid Survey

Response Rates

The table below presents the 2020 response rates for the general child population and CCC supplemental samples for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate (i.e., All Kids and Illinois Medicaid combined).

Table F2-7—2020 Statewide Survey Response Rates

Program Name	2020 Response Rate
All Kids	36.73%
Illinois Medicaid	23.57%
Illinois Statewide Aggregate	30.16%

General Child Population Findings and Comparisons

The 2019 and 2020 general child populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[F2-1,F2-2]

Table F2-8—2019 and 2020 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2019	85.2% ★★★	85.5% ★★★	84.9% ★★★
	2020	84.2% ★★	81.9% ★★	88.4% ★★★★

[F2-1] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

[F2-2] Due to significant differences between the total eligible populations of the All Kids and Illinois Medicaid programs, the 2020 Illinois statewide program aggregate was not weighted. For consistency, HSAG recalculated the 2019 Illinois statewide program aggregate results, so the results were not weighted. Therefore, these results are different from the 2019 weighted aggregate in the 2019 External Quality Review Annual Report.

Experience of Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Getting Care Quickly	2019	87.0% ★★	86.2% ★	88.4% ★★
	2020	88.3% ★★	88.1% ★★	88.3% ★★
How Well Doctors Communicate	2019	94.0% ★★	94.3% ★★★	93.5% ★★
	2020	94.2% ★★★	95.2% ★★★	92.7% ★★
Customer Service	2019	87.3% ★★	87.6% ★★	87.0% ★
	2020	79.1% ★	78.4%+ ★+	80.1%+ ★+
Global Ratings				
Rating of All Health Care	2019	71.5% ★★★	73.0% ★★★★	69.6% ★★
	2020	70.2% ★★	70.2% ★★	70.1% ★★
Rating of Personal Doctor	2019	77.8% ★★★	78.5% ★★★	76.8% ★★★
	2020	76.3% ★★	76.7% ★★	75.7% ★★
Rating of Specialist Seen Most Often	2019	81.2% ★★★★★	82.1% ★★★★★	80.0%+ ★★★★★+
	2020	75.9% ★★★	80.8%+ ★★★★★+	66.7%+ ★+
Rating of Health Plan	2019	63.9% ★	64.7% ★	62.9% ★
	2020	61.3% ★	59.9% ★	63.7% ★

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

Experience of Care

Statewide Child Results

Notable

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores between the 75th and 89th percentiles for *Getting Needed Care* for Illinois Medicaid and above the 90th percentile for *Rating of Specialist Seen Most Often* for All Kids.

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the general child population reported top-box scores below the 50th percentiles for *Getting Care Quickly*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan* for All Kids and Illinois Medicaid.
- The star rating declined from 2019 to 2020 for *Rating of Personal Doctor* for All Kids and Illinois Medicaid.

CCC Child Population Findings and Comparisons

The 2019 and 2020 CCC populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[F2-3]

Table F2-9—2019 and 2020 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2019	83.1% ★	83.3% ★	82.8% ★
	2020	85.5% ★★	84.8% ★★	86.4%+ ★★★+
Getting Care Quickly	2019	88.7% ★	87.3% ★	90.2% ★
	2020	90.7% ★	91.5% ★★	89.7%+ ★+
How Well Doctors Communicate	2019	93.7% ★★	94.6% ★★	92.7% ★
	2020	95.0% ★★★	96.5% ★★★★	93.1% ★
Customer Service	2019	83.8% ★	84.3% ★	83.1% ★
	2020	84.7% ★	83.3%+ ★+	86.2%+ ★+
Global Ratings				
Rating of All Health Care	2019	62.2% ★	62.4% ★	62.0% ★
	2020	67.6% ★★	71.3% ★★★	62.6% ★
Rating of Personal Doctor	2019	75.0% ★★	75.9% ★★	73.8% ★
	2020	75.5% ★★	80.3% ★★★★	69.5% ★

[F2-3] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Rating of Specialist Seen Most Often	2019	74.8% ★★★	75.7% ★★★	73.6% ★★
	2020	76.3% ★★★	83.5%+ ★★★★★+	66.1%+ ★+
Rating of Health Plan	2019	56.0% ★	55.1% ★	57.0% ★
	2020	57.9% ★	57.7% ★	58.1% ★
CCC Composites and Items				
Access to Specialized Services	2019	68.9% ★	69.5%+ ★+	68.0%+ ★+
	2020	70.5%+ ★+	67.4%+ ★+	75.2%+ ★★+
FCC: Personal Doctor Who Knows Child	2019	91.1% ★★	92.5% ★★★	89.5% ★
	2020	89.9% ★	92.2% ★★★	86.9% ★
Coordination of Care for Children with Chronic Conditions	2019	77.7% ★★★	79.2% ★★★	76.9% ★★
	2020	81.9%+ ★★★★★+	79.4%+ ★★★★+	85.4%+ ★★★★★+
Access to Prescription Medicines	2019	88.2% ★	87.2% ★	89.5% ★
	2020	90.3% ★★	90.7% ★★	89.8% ★
FCC: Getting Needed Information	2019	90.1% ★	90.7% ★	89.3% ★
	2020	92.4% ★★★	92.3% ★★★	92.7% ★★★

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

Notable

- Star ratings improved from 2019 to 2020 for All Kids and Illinois Medicaid for the following measures: *Getting Needed Care, Coordination of Care for Children with Chronic Conditions,* and *FCC: Getting Needed Information.*

Needs Work

- Compared to national benchmarks, 2020 experience survey results indicated that parents/caretakers of child members from the CCC population reported top-box scores below the 50th percentile for *Getting Care Quickly, Customer Service, Rating of Health Plan, Access to Specialized Services,* and *Access to Prescription Medicines* for All Kids and Illinois Medicaid.

Recommendations

According to the NCQA, a minimum of 100 responses on each item is required to obtain a reportable CAHPS survey result. Higher response rates minimize the potential effects of nonresponse bias and provide more reliable results. To achieve this targeted number of completed surveys, HSAG recommends the following:

- HFS and the MCOs may want to evaluate the quality of member data in their system by ensuring they have the most accurate and up-to-date information when pulling sample frame files. The MCOs should keep in mind that maintaining accurate member contact information in their systems should help eliminate a high number of undeliverables or members that cannot be contacted during survey administration.
- The MCOs should continue using a mixed-mode survey administration protocol (i.e., allow at least two methods by which the surveys can be completed). In addition, the MCOs should consider including the standardized Internet data collection protocol enhancement to the mixed-mode survey administration. Research has shown that a mixed-mode methodology has the greatest potential to increase response rates, since members can be reached via mail or telephone, and/or members have an alternative option to complete the survey online.
- The MCOs should evaluate those measures that had a decline in scores from 2019 to 2020 and continue to monitor scores to ensure that there are no statistically significant declines in future years.

Appendix G1. Biannual CY 2020 Staffing and Training Review

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Case Management

Biannual CY 2020

Staffing and Training Review

Of

HealthChoice Illinois

and

Medicare Medicaid Capitated Financial Alignment Initiative

for

Aggregate – All Health Plans

May 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of State Medicaid managed care health plans (health plans) that provide services for the HealthChoice Illinois (HealthChoice) and Medicare-Medicaid Alignment Initiative (MMAI) populations. Health Services Advisory Group (HSAG), the external quality review organization (EQRO) for Illinois, is contracted by HFS to conduct a biannual review of the health plans' compliance with case management staffing and training requirements.

Overview

This biannual calendar year (CY) 2020 Case Management Staffing and Training report provides an evaluation of the health plans' compliance with the HealthChoice and MMAI contracts[1], based on an analysis of staffing and training data for staff members with hire dates on or before March 1, 2020. Health plans were also required to provide remediation responses related to findings from the CY 2019 biannual staffing and training reviews. Detailed descriptions of findings are provided in Section 3 and Section 4 of this report.

Staffing and training data were evaluated for non-waiver and home- and community-based waiver services (HCBS) case management requirements, which are included in *Appendix A – HealthChoice Staffing and Training Contract Requirements* and *Appendix B – MMAI Staffing and Training Contract Requirements* of this report. Data were also evaluated for the Managed Long Term Services and Supports (MLTSS) and Special Needs Children (SNC) 1915(b) waivers, which are included in *Appendix C – MLTSS Data* and *Appendix D – SNC Data*. For health plans who manage both HealthChoice and MMAI populations and have case management staff with combined line of business (LOB) caseloads, data was evaluated for combined caseload compliance and is included in *Appendix E – Combined LOB Data*.

This review included assessment of internal health plan staff as well as any delegated entities performing case management services. For those delegated entities serving more than one health plan, an additional analysis was completed to determine compliance to case management requirements when the delegated case manager's caseload was assessed across all health plans served. This analysis is included in *Appendix F – Delegate Data.*

Methodology

[1] Contract citations are provided in Appendix A and Appendix B of this report.

HSAG conducts biannual staffing and training assessments to determine health plan compliance to the HealthChoice and MMAI contract requirements. A detailed description of the methodology and analysis processes is provided in Section 2 of this report.

Summary of Findings

HSAG analyzed 17 contractually-required elements of case management staffing and training. HSAG noted that training is completed on a calendar year basis; results of training analyses are included but should be reviewed with caution as health plans may not have scheduled or completed training as of March 1, 2020. HSAG will reassess training completion during the second biannual review of CY 2020. HSAG reviewed the health plan's submissions for internal and delegated case management. If a health plan delegated case management, the delegate's findings were incorporated into the assessment of compliance for the health plan overall (e.g., if the health plan was found to be compliant but its delegate was not, the finding will display as not met; percentages are a sum of internal and delegated data).

HealthChoice

Table 1.1 displays the results of the staffing and training analyses for the HealthChoice health plans.

Table 1.1 – HealthChoice Staffing and Training Review Findings

Element	BCBSIL[1]	CountyCare[1]	IlliniCare[1]	Meridian	Molina	NextLevel[1]
Weighted Caseload </= 600	Met	Met	Met	Not Met	Met	Met
High Risk Caseload </= 75	Met	Met	Met	Not Met	Met	Met
Moderate Risk Caseload </= 150	Met	Met	Met	Not Met	Met	Met
Low Risk Caseload </= 600	Met	Met	Met	Met	Met	Met
Cultural Competency Training Completed*	0.2% (1/479)	6% (18/305)	0% (0/373)	13% (45/343)	33% (47/143)	57% (35/61)
BI Waiver: Case Manager Qualification/Education	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
BI Waiver: Caseload Limit 1:30	Met	Met	Met	Not Met	Not Met	Met
BI Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Met
ELD Waiver: Case Manager Qualification/Education	Met	Met	Met	Met	Met	Met
ELD Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Met
HIV Waiver: Case Manager Qualification/Education	Not Met	Met	Met	Not Met	Not Met	Met

Element	BCBSIL[1]	CountyCare[1]	IlliniCare[1]	Meridian	Molina	NextLevel[1]
HIV Waiver: Related Experience	Met	Met	Not Met	Not Met	Not Met	Met
HIV Waiver: Caseload Limit 1:30	Met	Met	Met	Not Met	Not Met	Met
HIV Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Met
PD Waiver: Case Manager Qualification/Education	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
SLP Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Waiver Training: 20 Hours Annually*	0% (0/338)	6% (8/135)	1% (1/185)	6% (9/154)	0% (0/70)	0% (0/17)

Shaded cells represent data that was not applicable
**Health plans have the calendar year to complete trainings*
[1]*The health plan provides case management via internal and delegated staff*

As noted in Table 1.1, the following findings were identified:

- Five of the six health plans met requirements for weighted, high risk, and moderate risk caseloads. One health plan, Meridian, did not meet requirements.
- All six health plans met requirements for low risk caseloads.
- Completion of cultural competency training ranged from 0 percent to 57 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- None of the six health plans met BI waiver case manager qualification/education requirements.
- Four of the six health plans met BI waiver caseload requirements. Two health plans, Meridian and Molina, did not meet requirements.
- One of the six health plans, NextLevel, had evidence of completed BI waiver-specific training for all its BI waiver case managers. The remaining five health plans did not have training completed for all BI waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- All six health plans met ELD waiver qualification/education requirements.
- One of the six health plans, NextLevel, had evidence of completed ELD waiver-specific training for all its ELD waiver case managers. The remaining five health plans did not have training completed for all ELD waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Three of the six health plans met HIV waiver qualification/education requirements.
- Three of the six health plans met HIV waiver related experience requirements.

- Four of the six health plans met HIV waiver caseload requirements. Two health plans, Meridian and Molina, did not meet requirements.
- One of the six health plans, NextLevel, had evidence of completed HIV waiver-specific training for all its HIV waiver case managers. The remaining five health plans did not have training completed for all HIV waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- None of the six health plans met PD waiver case manager qualification/education requirements.
- None of the six health plans had evidence of completed SLP waiver-specific training for all SLP case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review
- Completion of 20 hours of annual waiver training ranged from 0 percent to 6 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.

MLTSS

The MLTSS population is a subset of the HealthChoice population. The HealthChoice findings include MLTSS case management. HSAG assessed staffing and training requirements for those case managers with MLTSS caseloads to provide data unique to the MLTSS population only; these findings are represented in *Appendix C – MLTSS Data*.

SNC

The SNC population is a subset of the HealthChoice population. The HealthChoice findings include SNC case management. HSAG assessed staffing and training requirements for those case managers with SNC caseloads to provide data unique to the SNC population only; these findings are represented in *Appendix D – SNC Data*.

MMAI

Table 1.2 displays the results of the staffing and training analyses for the MMAI health plans.

Table 1.2 – MMAI Staffing and Training Review Findings

Element	Aetna	BCBSIL	Humana[1]	IlliniCare	Meridian	Molina
Weighted Caseload </= 600	Met	Met	Met	Met	Met	Met
High Risk Caseload </= 75	Met	Met	Met	Met	Met	Met
Moderate Risk Caseload </= 150	Met	Met	Met	Met	Met	Met
Low Risk Caseload </= 600	Met	Met	Met	Met	Met	Met
Cultural Competency Training Completed*	96% (52/54)	0% (0/231)	24% (14/59)	23% (14/60)	0% (0/84)	13% (8/63)

Element	Aetna	BCBSIL	Humana[1]	IlliniCare	Meridian	Molina
BI Waiver: Case Manager Qualification/Education	Met	Met	Not Met	Met	Met	Not Met
BI Waiver: Caseload Limit 1:30	Met	Met	Met	Met	Met	Not Met
BI Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
ELD Waiver: Case Manager Qualification/Education	Met	Met	Met	Met	Met	Met
ELD Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
HIV Waiver: Case Manager Qualification/Education	Met	Met	Met	Met	Met	Not Met
HIV Waiver: Related Experience	Met	Met	Met	Not Met	Not Met	Not Met
HIV Waiver: Caseload Limit 1:30	Met	Met	Met	Met	Met	Not Met
HIV Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
PD Waiver: Case Manager Qualification/Education	Met	Not Met	Not Met	Met	Not Met	Not Met
SLP Waiver: Waiver-Specific Training*	Not Met	Not Met	Not Met	Not Met	Not Met	Not Met
Waiver Training: 20 Hours Annually*	0% (0/33)	0% (0/187)	33% (9/27)	0% (0/17)	3% (1/36)	0% (0/37)

Shaded cells represent data that was not applicable
**Health plans have the calendar year to complete trainings*
[1]*The health plan provides case management via internal and delegated staff*

As noted in Table 1.2, the following findings were identified:

- All six health plans met requirements for weighted, high risk, moderate risk, and low risk caseloads.
- Completion of cultural competency training ranged from 0 percent to 96 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Four of the six health plans met BI waiver case manager qualification/education requirements. Two health plans, Humana and Molina, did not meet requirements.
- Five of the six health plans met BI waiver caseload requirements. One health plan, Molina, did not meet requirements.

- None of the six health plans had evidence of completed BI waiver-specific training for all its BI waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- All six health plans met ELD waiver qualification/education requirements.
- None of the six health plans had evidence of completed ELD waiver-specific training for all its ELD waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Five of the six health plans met HIV waiver qualification/education requirements. One health plan, Molina, did not meet requirements.
- Three of the six health plans met HIV waiver related experience requirements.
- Five of the six health plans met HIV waiver caseload requirements. One health plan, Molina, did not meet requirements.
- None of the six health plans had evidence of completed HIV waiver-specific training for all its HIV waiver case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.
- Two of the six health plans met PD waiver case manager qualification/education requirements. The remaining four health plans did not meet requirements.
- None of the six health plans had evidence of completed SLP waiver-specific training for all SLP case managers. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review
- Completion of 20 hours of annual waiver training ranged from 0 percent to 33 percent. Training is completed on a calendar year basis; HSAG will reassess training during the second biannual staffing and training review.

Combined LOB Health Plans

Three health plans serve both HealthChoice and MMAI. HSAG assessed staffing and training requirements for those case managers with combined LOB caseloads to identify the scope of a case manager's caseload when reviewed across all enrollees being managed, regardless of the LOB. Since contractual requirements are the same for both the HealthChoice and MMAI populations, the data analysis assumed that a case manager's caseload should meet those requirements when analyzed in totality; these findings are represented in *Appendix E – Combined LOB Data*.

Delegates Serving More Than One Health Plan

Two delegates serve more than one health plan. HSAG assessed staffing and training requirements for those case managers with combined health plan caseloads to identify the scope of a case manager's caseload when reviewed across all enrollees being managed; these include case managers with combined LOB caseloads. Since contractual requirements are the same for both the HealthChoice and

MMAI populations, the data analysis assumed that a case manager's caseload should meet those requirements when analyzed in totality; these findings are represented in *Appendix F – Delegate Data*.

Recommendations

Health plan-specific findings are included in each health plan's individual report. HSAG noted that some findings may be a result of the completeness of the health plans' submissions; although training and detailed workbook completion instructions are provided to the health plans, HSAG will continue to remind the health plans that findings may be reduced if appropriate and thorough information is provided in submissions.

Based on the findings of the biannual staffing and training analysis, HSAG identified the following recommendations for HFS.

- HFS should require that Meridian provide a plan to comply with weighted caseload and caseload volume requirements and redistribute cases to ensure the requirement is met.
- HFS should review the qualification/education requirements for the BI, HIV, and PD waivers to determine if further clarity and guidance related to interpretation of the contract language can be provided to the health plans. HFS may also consider identification of qualification/education requirements not specifically dictated in contract language that HSAG may consider compliant in future assessments.
- HFS should provide guidance related to interpretation of the contract language related to HIV and BI waiver caseload maximums to Meridian and Molina.
- HFS should consider providing guidance to health plans related to expectations for caseloads for those case managers with combined LOB caseloads.
- HFS should consider providing guidance to health plans and their delegates related to expectations for caseloads for those case managers serving more than one health plan.

2. Overview and Methodology for Aggregate – All Health Plans

Introduction

The Centers for Medicare & Medicaid Services (CMS) requires the Illinois Department of Healthcare and Family Services (HFS) to provide quality oversight of state Medicaid managed care health plans (health plans) that provide services for the HealthChoice Illinois (HealthChoice) population, including Home and Community Based Services (HCBS) 1915(c), Managed Long Term Services and Supports (MLTSS) 1915(b), and Special Needs Children (SNC) 1915(b) waiver services, and Medicare-Medicaid Alignment Initiative (MMAI) population, including HCBS 1915(c) waiver services. Health Services Advisory Group (HSAG), the external quality review organization (EQRO) for Illinois, is contracted by HFS to conduct a biannual review of the health plans' compliance with case management staffing and training contract requirements related to:

- Qualifications and related experience
- Caseload assignments
- General training content and completion
- Waiver-specific training content and completion

These requirements are included in *Appendix A – HealthChoice Staffing and Training Contract Requirements* and *Appendix B – MMAI Staffing and Training Contract Requirements* of this report.

This report provides a summary of the health plans' compliance with the staffing and training requirements for case management staff. This report also identifies non-contractually-required data and information relative to management positions and case manager staff member positions. Data were also evaluated for the Managed Long Term Services and Supports (MLTSS) and Special Needs Children (SNC) 1915(b) waivers, which are included in *Appendix C – MLTSS Data* and *Appendix D – SNC Data*. For health plans who manage both HealthChoice and MMAI populations and have case management staff with combined line of business (LOB) caseloads, data was evaluated for combined caseload compliance and is included in *Appendix E – Combined LOB Data.*

This review included assessment of internal health plan staff as well as any delegated entities performing case management services. For those delegated entities serving more than one health plan, an additional analysis was completed to determine compliance to case management requirements when the delegated case manager's caseload was assessed across all health plans served. This analysis is included in *Appendix F – Delegate Data.*

The first biannual review of calendar year (CY) 2020 included health plan data for staff members with hire dates on or before March 1, 2020. Health plans were also required to provide remediation responses related to findings from the CY 2019 biannual staffing and training reviews.

Methodology for Data Collection and Analysis

HSAG reviewed the staffing and training specifications described in the HealthChoice and MMAI contracts to define the scope of the first staffing and training analysis for CY 2020. The following HCBS waivers were included:

- Persons with Physical Disabilities (PD)
- Persons with HIV/AIDS (HIV)
- Persons with Brain Injury (BI)
- Persons who are Elderly (ELD)
- Persons in a Supportive Living Program (SLP)

HSAG developed an Excel workbook tool that each health plan was required to complete for analysis. HSAG used the tool to assess contract compliance in each of the following domains:

- Total caseload
- Caseloads by risk stratification
- Caseloads for case managers with BI and HIV waiver caseloads
- Weighted caseloads
- Staff qualifications
- Staff related experience for case managers with HIV waiver caseloads
- General training completion
- Waiver-specific training completion

HSAG also used the tool to assess non-contractually-required data related to management and case manager positions.

The tool HSAG provided included several spreadsheets requiring health plans to identify their case management program staffing and training as described below.

Case Manager Management Staff Member Positions

Health plans were required to identify their internal and delegated management staff with direct oversight of case manager staff members. The Management worksheet provided the names, positions, full time equivalency (FTE), and qualifications of each managerial position. HSAG analyzed management staff member data for the following, which are not contractually required but provide information regarding oversight of the case management program:

- Total number of management staff
- Total FTE of management staff
- Qualifications of management staff
- Ratio of management to case manager staff member

Case Manager Staff Members

Health plans were required to identify their internal and delegated case manager staff members with active dedicated caseloads. The Staffing and Delegated Staffing worksheets provided case management the names, positions, type (telephonic or field), dedicated FTE, qualifications and related experience, and completed training hours of the case management staff members. Additionally, health plans were required to list each case manager's member caseload assignments by waiver, non-waiver, and risk stratification level. HSAG analyzed case manager staff member data for the following contractually-required elements:

- Qualifications by program and waiver type
- Related experience for staff managing HIV waiver caseloads
- Caseload assignment for staff managing HIV and/or BI waiver caseloads
- Weighted caseload
- Total caseload
- Caseload by risk stratification
- General training completion
- Waiver-specific training completion
- Total waiver training hours

In addition, HSAG analyzed case manager staff member data for the following, which are not contractually required but provide information regarding the case management program:

- Total number of case manager staff members
- Total FTE of case manager staff members
- Type of care management provided (telephonic or field-based)
- Ratio of case manager staff member to beneficiary

3. HealthChoice Staffing and Training Findings and Conclusions for Aggregate – All Health Plans

Health Plan Information

Six health plans provide services in the HealthChoice Illinois (HealthChoice) program. The health plans provide case management via internal staff and delegated staff. The following health plans delegate case management for specific populations identified below:

- BCBSIL: Lurie Children's Health Partners Care Coordination (Lurie) – non-waiver beneficiaries
- CountyCare: Access Community Health Network (Access): non-waiver Access members
- CountyCare: Cook County Health & Hospitals System Centralized Care Coordination Department (CCC): non-waiver for non-MHN members
- CountyCare: Independent Living Systems (ILS): Home and Community Based Services/Long Term Services and Supports members
- CountyCare: MHN ACO (MHN): non-waiver for MHN ACO members only
- IlliniCare: Precedence CCE (Precedence) – waiver and non-waiver beneficiaries
- IlliniCare: Coordinated Care Alliance (CCA) – waiver beneficiaries
- NextLevel: Access Community Health Network (Access): non-waiver Access members

As required by contract, the health plans manage beneficiaries in the following waiver programs:

- Persons with Physical Disabilities (PD)
- Persons with HIV/AIDS (HIV)
- Persons with Brain Injury (BI)
- Persons who are Elderly (ELD)
- Persons in a Supportive Living Program (SLP)

In the first calendar year (CY) 2020 biannual review, HSAG conducted an analysis of case management staffing and training program requirements for the health plans, with data for staff hired on or before March 1, 2020. This report serves to provide an analysis of staffing and training for the case management program, as well as provide the health plans' responses to the findings of the biannual staffing and training review conducted in CY 2019.

General Information

To provide general information regarding the scope of the health plans' case management programs, HSAG identified the following information: health plan enrollment, the number and FTE of case manager management and case manager staff members, the qualifications of management and staff members, the type of case management provided, and the ratios of case manager management to staff member and staff member to beneficiary.

Table 3.1 provides the health plans' enrollment as of February 1, 2020.

Table 3.1 – Health Plan Enrollment*

Health Plan	ELD	BI	HIV	PD	SLP	Non-Waiver	Total
BCBSIL	9,534	401	185	4,037	1,980	437,355	453,492
CountyCare	5,155	424	222	2,444	269	309,320	317,834
IlliniCare	6,442	339	143	3,184	1,027	344,118	355,253
Meridian	6,944	319	123	3,594	1,097	715,632	727,709
Molina	1,987	65	46	1,298	230	215,780	219,406
NextLevel	852	37	11	319	94	59,258	60,571
TOTAL	**30,914**	**1,585**	**730**	**14,876**	**4,697**	**2,081,463**	**2,134,265**

**Enrollment as of 2/1/2020.*

Case Management Data

Internal Case Management

Table 3.2 displays general data related to internal case manager management staff (Mgmt staff) and case managers (CMs).

Table 3.2 – General Case Management Program Data: Internal

General Case Management Program Data: Internal												
	BCBSIL		CountyCare		IlliniCare		Meridian		Molina		NextLevel	
Element	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs
Total Number of Staff	40	476	12	106	50	324	45	343	21	143	7	36
Total FTE	40.00	399.53	12.00	106.00	50.00	323.99	45.00	326.84	21.00	121.85	7.00	36.00
Registered Nurse*	20	136	5	33	14	76	15	52	3	40	3	6
Social Worker/ Professional Counselor**	19	226	5	73	27	152	7	71	15	83	3	12
Other Qualification	1	114	2	0	9	96	23	220	3	20	1	18
Telephonic		0		0		92		190		0		0
Field-Based		476		106		232		153		143		36
Management Staff per Case Manager	1:12		1:9		1:6		1:8		1:7		1:5	

General Case Management Program Data: Internal												
	BCBSIL		CountyCare		IlliniCare		Meridian		Molina		NextLevel	
Element	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs
Case Manager per Beneficiary		1:60		1:82		1:63		1:156		1:65		1:85

Shaded cells represent data that was not applicable
**Registered nurse category includes registered nurses or any of the following degree types: BSN, MSN, APN, DNP*
***Social worker/professional counselor category includes any of the following degree types: SW, LSW, LSCW, BSW, MSW, LPC, LCPC*

As identified in Table 3.2, the health plans reported a range of seven to 50 management positions for the case management program, and a range of 36 to 476 case manager staff members. Most managers were registered nurses or social workers/professional counselors; most case managers were social workers/professional counselors.

An analysis of management to case manager staff identified a ratio range of 1:5 to 1:12. An analysis of the case manager staff to the overall caseload (beneficiary count) identified a range of 1:60 to 1:156.

Data analysis derived from the caseload data reported by the health plans identified that case management caseloads represented the following percent of total enrollment for the health plans identified in Table 3.1 (data does not include any caseloads managed by delegated entities):

- BCBSIL: six percent of the total enrollment
- CountyCare: three percent of the total enrollment
- IlliniCare: six percent of the total enrollment
- Meridian: seven percent of the total enrollment
- Molina: four percent of the total enrollment
- NextLevel: five percent of the total enrollment

Delegated Case Management

Table 3.3 displays general data related to delegated case manager management staff and case managers. BCBSIL reported one delegate; CountyCare reported four delegates; IlliniCare reported two delegates; and NextLevel reported one delegate. For those health plans with more than one delegate, the data represents an aggregate of their delegates' information.

Table 3.3 – General Case Management Program Data: Delegated

General Case Management Program Data: Delegated								
Element	BCBSIL		CountyCare		IlliniCare		NextLevel	
	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs
Total Number of Staff	3	3	30	199	21	49	3	25
Total FTE	0.70	2.00	26.25	184.44	12.17	27.9	3.00	25.00

General Case Management Program Data: Delegated								
Element	BCBSIL		CountyCare		IlliniCare		NextLevel	
	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs
Registered Nurse*	1	2	11	112	0	3	1	18
Social Worker/Professional Counselor*	2	1	11	59	8	12	2	7
Other Qualification	0	0	8	28	13	34	0	0
Telephonic		0		0		0		0
Field-Based		3		199		49		25
Management Staff per Case Manager	1:1		1:7		1:2		1:8	
Case Manager per Beneficiary		1:21		1:43		1:40		1:12

Shaded cells represent data that was not applicable
**Registered nurse category includes registered nurses or any of the following degree types: BSN, MSN, APN, DNP*
**Social worker/professional counselor category includes any of the following degree types: SW, LSW, LSCW, BSW, MSW, LPC, LCPC*

As identified in Table 3.3, the health plans' delegates reported a range of three to 30 management positions for the case management program, and a range of three to 199 case manager staff members. Most managers were registered nurses or social workers/professional counselors; most case managers were registered nurses.

An analysis of management to case manager staff identified a ratio range of 1:1 to 1:8. An analysis of the case manager staff to the overall caseload (beneficiary count) identified a range of 1:12 to 1:43.

Data analysis derived from the caseload data reported by the health plans' delegates identified that case management caseloads represented the following percent of total enrollment for the health plans identified in Table 3.1:

- BCBSIL's delegate: less than one percent of the total enrollment
- CountyCare's delegates: three percent of the total enrollment
- IlliniCare's delegates: one percent of the total enrollment
- NextLevel's delegate: one percent of the total enrollment

Contract Requirements – General Case Management

The HealthChoice contract specifies requirements for all case managers related to caseloads and training, regardless of the type of caseload managed by the case manager:

- Total caseload cannot exceed a maximum weighted caseload of 600, with low risk weighted as one, moderate risk weighted as four, and high risk weighted as eight.
- High risk enrollees cannot exceed 75

- Moderate risk enrollees cannot exceed 150
- Low risk enrollees cannot exceed 600
- Staff must complete annual cultural competency training

HSAG evaluated the health plans' staffing and training submission for compliance to total caseload, risk stratification-based caseload, weighted caseload, and required annual training. HSAG also reviewed any remediation actions described by the health plans related to findings from the CY 2019 biannual staffing and training reviews.

Internal Case Management

Table 3.4 displays the results of the analyses for the health plans' internal staff.

Table 3.4 – General Case Management Findings: Internal Staff

General Case Management Findings: Internal Staff					
Health Plan	**Weighted Caseload </= 600**	**High Risk Caseload </= 75**	**Moderate Risk Caseload </= 150**	**Low Risk Caseload </= 600**	**Cultural Competency Training Completed**
BCBSIL	Met (476/476)	Met (433/433)	Met (421/421)	Met (235/235)	0.2% (1/476)
CountyCare	Met (106/106)	Met (101/101)	Met (106/106)	Met (84/84)	0% (0/106)
IlliniCare	Met (321/321)	Met (269/269)	Met (280/280)	Met (109/109)	0% (0/324)
Meridian	Not Met (135/343)	Not Met (180/329)	Not Met (296/327)	Met (276/276)	13% (45/343)
Molina	Met (143/143)	Met (137/137)	Met (115/115)	Met (139/139)	33% (47/143)
NextLevel	Met (36/36)	Met (28/28)	Met (35/35)	Met (13/13)	97% (35/36)

As identified in Table 3.4, five of the six health plans met all contract requirements related to caseloads. Meridian did not meet all contract requirements related to caseloads. As a result of CY 2019 biannual staffing and training reviews, Meridian had findings related to weighted, high-risk, and moderate-risk caseloads. Those findings have not been remediated.

Analysis revealed that five of the six health plans had less than 90 percent of case managers reported with completion of required annual cultural competency training as of March 2020. Training completion will be reassessed during HSAG's second biannual staffing and training review, as training is competed annually and may not have been conducted as of March 2020.

Delegated Case Management

Table 3.5 displays the results of the analyses for the health plans' delegated staff.

Table 3.5 – General Case Management Findings: Delegated Staff

General Case Management Findings: Delegated Staff					
Delegate	**Weighted Caseload </= 600**	**High Risk Caseload </= 75**	**Moderate Risk Caseload </= 150**	**Low Risk Caseload </= 600**	**Cultural Competency Training Completed**
BCBSIL: Lurie	Met (3/3)	Met (3/3)	NA (0/0)	NA (0/0)	0% (0/3)
CountyCare: Access	Met (25/25)	Met (25/25)	Met (23/23)	Met (16/16)	4% (1/25)
CountyCare: CCC	Met (51/51)	Met (51/51)	Met (51/51)	Met (47/47)	0% (0/51)
CountyCare: ILS	Met (31/31)	Met (29/29)	Met (30/30)	NA (0/0)	55% (17/31)
CountyCare: MHN	Met (92/92)	Met (91/91)	Met (38/38)	NA (0/0)	0% (0/92)
IlliniCare: CCA	Met (20/20)	Met (20/20)	Met (18/18)	NA (0/0)	0% (0/29)
IlliniCare: Precedence	Met (19/19)	Met (13/13)	Met (19/19)	Met (17/17)	0% (0/20)
NextLevel: Access	Met (25/25)	Met (23/23)	Met (15/15)	Met (13/13)	0% (0/25)

As identified in Table 3.5, all delegates met all contract requirements related to caseloads.

Analysis revealed that all delegates had less than 90 percent of case managers reported with completion of required annual cultural competency training as of March 2020. Training completion will be reassessed during HSAG's second biannual staffing and training review, as training is competed annually and may not have been conducted as of March 2020.

As a result of CY 2019 biannual staffing and training reviews, IlliniCare's delegates had findings related to general training, which were remediated.

Contract Requirements – Waiver Case Management

HSAG evaluated the health plans' submission against contract requirements for waiver-specific caseloads, waiver-specific qualifications, and waiver training completion, as identified in *Attachment A – HealthChoice Staffing and Training Contract Requirements*. HSAG also reviewed any remediation actions described by the health plans related to findings from the CY 2019 biannual staffing and training reviews.

Internal Case Management

Table 3.6 displays the results of the waiver-specific analyses for internal waiver case managers.

Table 3.6 – Waiver Case Manager Staff Member Findings: Internal

Waiver Case Manager Staff Member Findings: Internal						
Waiver/Element	**BCBSIL**	**CountyCare**	**IlliniCare**	**Meridian**	**Molina**	**NextLevel**
BI						
Qualification/Education	Not Met (23/24)	Met (14/14)	Not Met (12/17)	Not Met (15/18)	Not Met (25/32)	Not Met (1/2)
Caseload Limit: 1:30	Met (24/24)	Met (14/14)	Met (17/17)	Not Met (15/18)	Not Met (1/32)	Met (2/2)
Waiver-specific training	Not Met (0/24)	Not Met (0/14)	Not Met (1/17)	Not Met (1/18)	Not Met (0/32)	Met (2/2)
ELD						
Qualification/Education	Met (305/305)	Met (71/71)	Met (141/141)	Met (134/134)	Met (64/64)	Met (14/14)
Waiver-specific training	Not Met (0/305)	Not Met (0/71)	Not Met (3/141)	Not Met (10/134)	Not Met (5/64)	Met (14/14)
HIV						
Qualification/Education	Not Met (19/20)	Met (7/7)	Met (8/8)	Not Met (14/15)	Not Met (20/21)	Met (2/2)
Related Experience	Met (20/20)	Met (7/7)	Not Met (5/8)	Not Met (8/15)	Not Met (1/21)	Met (2/2)
Caseload Limit: 1:30	Met (20/20)	Met (7/7)	Met (8/8)	Not Met (13/15)	Not Met (0/21)	Met (2/2)
Waiver-specific training	Not Met (0/20)	Not Met (0/7)	Not Met (1/8)	Not Met (1/15)	Not Met (0/21)	Met (2/2)
PD						

Waiver Case Manager Staff Member Findings: Internal						
Waiver/Element	**BCBSIL**	**CountyCare**	**IlliniCare**	**Meridian**	**Molina**	**NextLevel**
Qualification/Education	Not Met (235/255)	Met (44/44)	Not Met (116/120)	Not Met (99/117)	Not Met (66/68)	Not Met (11/12)
SLP						
Waiver-specific training	Not Met (0/128)	Not Met (0/14)	Not Met (0/51)	Not Met (2/35)	Not Met (2/41)	Not Met (0/1)

Shaded cells represent data that was not applicable

As displayed in Table 3.6, the health plans' submissions identified compliance and findings related to waiver case management. HSAG noted the following:

- BI waiver: all six health plans had one or more findings related to the BI waiver. Training completion will be reassessed during HSAG's second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to BI waiver-specific qualification/education:

  - IlliniCare: findings have not been remediated in CY 2020.
  - Meridian: findings have not been remediated in CY 2020.
  - Molina: findings have not been remediated in CY 2020.
  - NextLevel had a finding, which was remediated. The CY 2020 finding is related to a different case manager.

  As a result of CY 2019 biannual staffing and training reviews, Molina had findings related to BI waiver caseloads, which have not been remediated. Molina's remediation noted that the health plan's interpretation of the contract language does not preclude a case manager from having a combined caseload of greater than 30, only that the volume of BI (and any HIV cases) does not exceed 30.

- ELD waiver: five of the six health plans had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

- HIV waiver: five of the six health plans had one or more findings related to the HIV waiver. Training completion will be reassessed during HSAG's second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, Meridian had findings related to HIV waiver-specific qualification/education, which have not been remediated.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to HIV waiver related experience:

  - BCBSIL: findings were remediated by the health plan.
  - Meridian: findings have not been remediated in CY 2020.
  - Molina: findings have not been remediated in CY 2020.

As a result of CY 2019 biannual staffing and training reviews, Molina had findings related to HIV waiver caseloads, which have not been remediated. Molina's remediation noted that the health plan's interpretation of the contract language does not preclude a case manager from having a combined caseload of greater than 30, only that the volume of HIV (and any BI cases) does not exceed 30.

- PD waiver: five of the six health plans had findings related to the PD waiver.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to BI waiver-specific qualification/education:

  - Meridian: findings have not been remediated in CY 2020.
  - NextLevel: findings have not been remediated in CY 2020.

- SLP waiver: all six health plans had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, BCBSIL and IlliniCare had findings related to SLP waiver-specific training, which were remediated.

Delegated Case Management

CountyCare and IlliniCare delegated waiver case management. Table 3.7 displays the results of the waiver-specific analyses for the delegated entities.

Table 3.7 – Delegated Waiver Case Manager Staff Member Findings

Waiver Case Manager Staff Member Findings: Delegated			
Waiver/Element	**CountyCare: ILS**	**IlliniCare: CCA**	**IlliniCare: Precedence**
BI			
Qualification/Education	Not Met (1/2)	NA (0/0)	Not Met (1/3)
Caseload Limit: 1:30	Met (2/2)	NA (0/0)	Met (3/3)
Waiver-specific training	Not Met (0/2)	NA (0/0)	Not Met (0/3)
ELD			
Qualification/Education	Met (27/27)	NA (0/0)	Met (15/15)
Waiver-specific training	Not Met (9/27)	NA (0/0)	Not Met (2/15)
HIV			
Qualification/Education	Met	NA	Met

Waiver Case Manager Staff Member Findings: Delegated			
Waiver/Element	**CountyCare: ILS**	**IlliniCare: CCA**	**IlliniCare: Precedence**
	(2/2)	(0/0)	(2/2)
Related Experience	Met (2/2)	NA (0/0)	Met (2/2)
Caseload Limit: 1:30	Met (2/2)	NA (0/0)	Met (2/2)
Waiver-specific training	Not Met (0/2)	NA (0/0)	Not Met (0/2)
PD			
Qualification/Education	Not Met (18/20)	Not Met (19/20)	Not Met (13/16)
SLP			
Waiver-specific training	Not Met (0/3)	NA (0/0)	Not Met (0/9)

Shaded cells represent data that was not applicable

As displayed in Table 3.7, the delegates' submissions identified compliance and findings related to waiver case management. HSAG noted the following:

- BI waiver: the two delegates with BI waiver caseloads had two findings related to the BI waiver. Training completion will be reassessed during HSAG's second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.
- ELD waiver: the two delegates with ELD waiver caseloads had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.
- HIV waiver: the two delegates with HIV waiver caseloads had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.
- PD waiver: all three delegates had findings related to the PD waiver.
- SLP waiver-specific training: all three delegates had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

Waiver Training Completion: 20 Hours Annually

In addition to waiver-specific training, the health plans are contractually required to ensure that all waiver case managers complete 20 hours of annual waiver training (prorated based on date of hire). HSAG noted that health plans complete training on an annual basis; therefore, results from March may

not be inclusive of the full complement of the health plans' training programs. Training completion will be reassessed during HSAG's second biannual staffing and training review. Table 3.8 provides the training completion as of March 2020.

Table 3.8 – Waiver Training: 20 Hours Annually*

Health Plan/Delegate	Number of Waiver Case Managers with 20 Hours of Training	Number of Waiver Case Managers	Percent of Waiver Case Managers with 20 Hours of Training as of March 2020
BCBSIL	0	338	0%
CountyCare	0	106	0%
CountyCare: ILS	8	29	28%
IlliniCare	1	149	1%
IlliniCare: CCA	0	20	0%
IlliniCare: Precedence	0	16	0%
Meridian	9	154	6%
Molina	0	70	0%
NextLevel	0	17	0%

**Completion is assessed on an annual basis*

Five of the six health plans had CY 2019 findings related to 20 hours of waiver training; Meridian did not have findings. HSAG reviewed the health plans' remediation responses related to findings identified in the CY 2019 biannual staffing and training reviews:

- BCBSIL: all waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- CountyCare: all delegated ILS waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019. CountyCare's delegate, CCC, was non-compliant with completion of 20 hours of waiver training in CY 2019. CCC was no longer delegated for waiver case management in CY 2020.
- IlliniCare: all internal waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019. Most delegated Precedence waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- Molina: all but one waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- NextLevel: all waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.

4. Staffing and Training Findings and Conclusions for Aggregate – All Health Plans

Health Plan Information

Six health plans provide services in the Medicare-Medicaid Alignment Initiative (MMAI) program. The health plans provide case management via internal staff and delegated staff. The following health plan delegates case management for specific populations identified below:

- Humana: Beacon Health Options (Beacon) – non-waiver beneficiaries
- Humana: Independent Living Systems (ILS) – waiver beneficiaries

As required by contract, the health plans manage beneficiaries in the following waiver programs:

- Persons with Physical Disabilities (PD)
- Persons with HIV/AIDS (HIV)
- Persons with Brain Injury (BI)
- Persons who are Elderly (ELD)
- Persons in a Supportive Living Program (SLP)

In the first calendar year (CY) 2020 biannual review, HSAG conducted an analysis of case management staffing and training program requirements for the health plans, with data for staff hired on or before March 1, 2020. This report serves to provide an analysis of staffing and training for the case management program, as well as provide the health plans' responses to the findings of the biannual staffing and training review conducted in CY 2019.

General Information

To provide general information regarding the scope of the health plans' case management program, HSAG identified the following information: health plan enrollment, the number and FTE of case manager management and case manager staff members, the qualifications of management and staff members, the type of case management provided, and the ratios of case manager management to staff member and staff member to beneficiary.

Table 4.1 provides the health plans' enrollment as of February 1, 2020.

Table 4.1 – Health Plan Enrollment*

Health Plan	ELD	BI	HIV	PD	SLP	Non-Waiver	Total
Aetna	683	27	31	146	113	5,958	6,958
BCBSIL	3,291	92	57	800	745	13,233	18,218

Health Plan	ELD	BI	HIV	PD	SLP	Non-Waiver	Total
Humana	1,138	20	6	180	127	6,070	7,541
IlliniCare	672	32	22	225	141	6,004	7,096
Meridian	729	29	14	256	150	6,364	7,542
Molina	697	32	13	382	282	6,648	8,054
TOTAL	**7,210**	**232**	**143**	**1,989**	**1,558**	**44,277**	**55,409**

**Enrollment as of 2/1/2020.*

Case Management Data

Internal Case Management

Table 4.2 displays general data related to internal case manager management staff (Mgmt staff) and case managers (CMs).

Table 4.2 – General Case Management Program Data: Internal

General Case Management Program Data												
	Aetna		BCBSIL		Humana		IlliniCare		Meridian		Molina	
Element	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs	Mgmt Staff	CMs
Total Number of Staff	7	54	40	231	2	26	7	60	45	84	21	63
Total FTE	7.00	54.00	40.00	105.43	2.00	26.00	7.00	59.00	45.00	35.15	21.00	27.15
Registered Nurse*	1	4	20	66	2	9	2	19	15	0	3	26
Social Worker/ Professional Counselor**	5	21	19	90	0	3	5	30	7	16	15	28
Other Qualification	1	29	1	75	0	14	0	11	23	68	3	9
Telephonic		21		0		26		43		44		0
Field-Based		33		231		0		17		40		63
Management Staff per Case Manager	1:8		1:6		1:13		1:9		1:2		1:3	
Case Manager per Beneficiary		1:125		1:40		1:208		1:119		1:89		1:37

Shaded cells represent data that was not applicable
**Registered nurse category includes registered nurses or any of the following degree types: BSN, MSN, APN, DNP*

***Social worker/professional counselor category includes any of the following degree types: SW, LSW, LSCW, BSW, MSW, LPC, LCPC*

As identified in Table 4.2, the health plans reported a range of two to 45 management positions for the case management program, and a range of 26 to 231 case manager staff members. Most managers were registered nurses or social workers/professional counselors; most case managers were social workers/professional counselors or had some other qualification (not registered nurses or social workers/professional counselors).

An analysis of management to case manager staff identified a ratio range of 1:2 to 1:13. An analysis of the case manager staff to the overall caseload (beneficiary count) identified a range of 1:37 to 1:208.

Data analysis derived from the caseload data reported by the health plans identified that case management caseloads represented the following percent of total enrollment for the health plans identified in Table 4.1 (data does not include any caseloads managed by delegated entities):

- Aetna: 97 percent of the total enrollment
- BCBSIL: 51 percent of the total enrollment
- Humana: 72 percent of the total enrollment
- IlliniCare: 100 percent of the total enrollment
- Meridian: 99 percent of the total enrollment
- Molina: 29 percent of the total enrollment

Delegated Case Management

Humana delegated case management; the remaining five health plans did not delegate case management. Table 4.3 displays general data related to Humana's delegated case manager management staff and case managers.

Table 4.3 – General Case Management Program Data: Delegated

General Case Management Program Data: Delegated				
Element	**Beacon**		**ILS**	
	Case Manager Management Staff	**Case Managers**	**Case Manager Management Staff**	**Case Managers**
Total Number of Staff	3	5	5	28
Total FTE	3.00	5.00	3.50	21.50
Registered Nurse	0	0	0	2
Social Worker/Professional Counselor	3	4	2	8
Other Qualification	0	1	3	18
Telephonic		3		0
Field-Based		2		28

General Case Management Program Data: Delegated				
Element	Beacon		ILS	
	Case Manager Management Staff	Case Managers	Case Manager Management Staff	Case Managers
Management Staff per Case Manager	1:2		1:6	
Case Manager per Beneficiary		1:42		1:75

Shaded cells represent data that was not applicable
Registered nurse category includes registered nurses or any of the following degree types: BSN, MSN, APN, DNP
Social worker/professional counselor category includes any of the following degree types: SW, LSW, LSCW, BSW, MSW, LPC, LCPC

As identified in Table 4.3, Beacon had three management positions for the case management program and five case manager staff members. All managers were social workers/professional counselors; most case managers were social worker/professional counselor. ILS had five management positions for the case management program and 28 case manager staff members. Most managers had some other qualification (not registered nurses or social workers/professional counselors); most case managers had some other qualification (not registered nurses or social workers/professional counselors).

An analysis of management to case manager staff resulted in a 1:2 ratio for Beacon and a 1:6 ratio for ILS. An analysis of the case manager staff to the overall caseload (beneficiary count) resulted in a 1:42 ratio for Beacon and a 1:75 ratio for ILS. Data was derived from the caseload data reported by the health plan's delegates and represented 30 percent of the total enrollment for the health plan identified in Table 4.1.

Contract Requirements – General Case Management

The MMAI contract specifies requirements for all case managers related to caseloads and training, regardless of the type of caseload managed by the case manager:

- Total caseload cannot exceed a maximum weighted caseload of 600, with low risk weighted as one, moderate risk weighted as four, and high risk weighted as eight.
- High risk enrollees cannot exceed 75
- Moderate risk enrollees cannot exceed 150
- Low risk enrollees cannot exceed 600
- Staff must complete annual cultural competency training

HSAG evaluated the health plans' staffing and training submission for compliance to total caseload, risk stratification-based caseload, weighted caseload, and required annual training. HSAG also reviewed any remediation actions described by the health plans related to findings from the CY 2019 biannual staffing and training reviews.

Internal Case Management

Table 4.4 displays the results of the analyses for the health plans' internal case management staff.

Table 4.4 – General Case Management Findings: Internal

General Case Management Findings: Internal					
Health Plan	**Weighted Caseload </= 600**	**High Risk Caseload </= 75**	**Moderate Risk Caseload </= 150**	**Low Risk Caseload </= 600**	**Cultural Competency Training Completed**
Aetna	Met (54/54)	Met (18/18)	Met (38/38)	Met (21/21)	96% (52/54)
BCBSIL	Met (231/231)	Met (150/150)	Met (191/191)	Met (111/111)	0% (0/231)
Humana	Met (26/26)	Met (8/8)	Met (25/25)	Met (17/17)	0% (0/26)
IlliniCare	Met (60/60)	Met (26/26)	Met (48/48)	Met (18/18)	23% (14/60)
Meridian	Met (84/84)	Met (37/37)	Met (49/49)	Met (80/80)	0% (0/84)
Molina	Met (63/63)	Met (37/37)	Met (56/56)	Met (53/53)	13% (8/63)

As identified in Table 4.4, all six health plans met all contract requirements related to caseloads.

Analysis revealed that five of the six health plans had less than 90 percent of case managers reported with completion of required annual cultural competency training as of March 2020. Training completion will be reassessed during HSAG's second biannual staffing and training review, as training is competed annually and may not have been conducted as of March 2020.

As a result of CY 2019 biannual staffing and training reviews, BCBSIL, IlliniCare, Meridian, and Molina had findings related to general training. The findings for BCBSIL and Meridian were fully remediated. All but two IlliniCare case managers identified as lacking MMAI general training had completed the required training by December 31, 2019; the remaining two completed training in CY 2020. Most of Molina's CY 2019 training was remediated by December 31, 2019 with the remainder of training completed in February and March of 2020.

Delegated Case Management

Table 4.5 displays the results of the analyses for Humana's delegated staff.

Table 4.5 – General Case Management Findings: Delegated Staff

General Case Management Findings: Delegated Staff					
Delegate	**Weighted Caseload </= 600**	**High Risk Caseload </= 75**	**Moderate Risk Caseload </= 150**	**Low Risk Caseload </= 600**	**Cultural Competency Training Completed**
Beacon	Met (5/5)	Met (5/5)	Met (5/5)	Not Applicable (0/0)	0% (0/5)
ILS	Met (28/28)	Met (26/26)	Met (28/28)	Met (10/10)	50% (14/28)

As identified in Table 4.5, Beacon and ILS met all contract requirements related to caseloads. Beacon's submission revealed that no case managers had completed required annual cultural competency training as of March 2020. ILS' submission revealed that 50 percent of case managers had completed required annual cultural competency training as of March 2020. Training completion will be reassessed during HSAG's second biannual staffing and training review.

Contract Requirements – Waiver Case Management

HSAG evaluated the health plans' submission against contract requirements for waiver-specific caseloads, waiver-specific qualifications, and waiver training completion, as identified in *Attachment B – MMAI Staffing and Training Contract Requirements*. HSAG also reviewed any remediation actions described by the health plans related to findings from the CY 2019 biannual staffing and training reviews.

Internal Case Management

Humana's internal case manager staff did not manage waiver caseloads. Table 4.6 displays the results of the waiver-specific analyses for internal staff.

Table 4.6 – Waiver Case Manager Staff Member Findings: Internal

Waiver Case Manager Staff Member Findings: Internal						
Waiver/Element	**Aetna**	**BCBSIL**	**Humana**	**IlliniCare**	**Meridian**	**Molina**
BI						
Qualification/Education	Met (5/5)	Met (9/9)		Met (2/2)	Met (2/2)	Not Met (10/12)
Caseload Limit: 1:30	Met (5/5)	Met (9/9)		Met (2/2)	Met (2/2)	Not Met (2/12)
Waiver-specific training	Not Met (0/5)	Not Met (0/9)		Not Met (0/2)	Not Met (0/2)	Not Met (0/12)
ELD						

Waiver Case Manager Staff Member Findings: Internal						
Waiver/Element	**Aetna**	**BCBSIL**	**Humana**	**IlliniCare**	**Meridian**	**Molina**
Qualification/Education	Met (31/31)	Met (160/160)		Met (15/15)	Met (27/27)	Met (25/25)
Waiver-specific training	Not Met (0/31)	Not Met (0/160)		Not Met (12/15)	Not Met (1/27)	Not Met (2/25)
HIV						
Qualification/Education	Met (5/5)	Met (7/7)		Met (2/2)	Met (2/2)	Not Met (7/8)
Related Experience	Met (5/5)	Met (7/7)		Not Met (1/2)	Not Met (1/2)	Not Met (1/8)
Caseload Limit: 1:30	Met (5/5)	Met (7/7)		Met (2/2)	Met (2/2)	Not Met (2/8)
Waiver-specific training	Not Met (0/5)	Not Met (0/7)		Not Met (0/2)	Not Met (0/2)	Not Met (0/8)
PD						
Qualification/Education	Met (25/25)	Not Met (77/83)		Met (16/16)	Not Met (14/15)	Not Met (27/28)
SLP						
Waiver-specific training	Not Met (0/22)	Not Met (0/55)		Not Met (0/6)	Not Met (1/24)	Not Met (1/19)

Shaded cells represent data that was not applicable

As displayed in Table 4.6, the health plans' submissions identified compliance and findings related to waiver case management. HSAG noted the following:

- BI waiver: all five health plans had one or more findings related to the BI waiver. Training completion will be reassessed during HSAG's second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to BI waiver-specific qualification/education:

  - IlliniCare: The health plan reported that the staff member was no longer employed. HSAG noted that the remediation action resulted in no findings for BI waiver qualification/education for the first biannual staffing and training review of CY 2020.
  - Meridian: findings were remediated by the health plan.

  As a result of CY 2019 biannual staffing and training reviews, Aetna had findings related to BI waiver caseloads exceeding 30. The health plan reported that remediation included revision of its staffing model to reduce the number of cases managed by BI-designated case managers, as well as

recruitment, hiring, and training of additional staff members. HSAG noted that the remediation action resulted in no findings for caseloads limits for the first biannual staffing and training review of CY 2020.

- ELD waiver: all five health plans had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.
- HIV waiver: all five health plans had one or more findings related to the HIV waiver. Training completion will be reassessed during HSAG's second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to HIV waiver related experience:

  - BCBSIL: findings were remediated by the health plan.
  - Meridian: findings have not been remediated in CY 2020.
  - Molina: findings have not been remediated in CY 2020.

  As a result of CY 2019 biannual staffing and training reviews, the following health plans had findings related to HIV waiver caseloads:

  - Aetna had findings related to HIV waiver caseloads exceeding 30. The health plan reported that remediation included revision of its staffing model to reduce the number of cases managed by HIV-designated case managers, as well as recruitment, hiring, and training of additional staff members. HSAG noted that the remediation action resulted in no findings for caseloads limits for the first biannual staffing and training review of CY 2020.
  - Molina had findings related to HIV waiver caseloads, which have not been remediated. Molina's remediation noted that the health plan's interpretation of the contract language does not preclude a case manager from having a combined caseload of greater than 30, only that the volume of HIV (and any BI cases) does not exceed 30.
- PD waiver: three of the five health plans had findings related to the PD waiver.

  As a result of CY 2019 biannual staffing and training reviews, Meridian had findings related to PD waiver-related qualifications/education, which have not been remediated.
- SLP waiver: all five health plans had findings related to training. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.

  As a result of CY 2019 biannual staffing and training reviews, BCBSIL had findings related to SLP waiver-specific training, which were remediated.

Delegated Case Management

Humana delegated waiver case management to ILS. Table 4.7 displays the results of the waiver-specific analyses for Humana's delegated case management staff.

Table 4.7 – Waiver Case Manager Staff Member Findings: Delegated

Waiver Case Manager Staff Member Findings: Delegated					
Element	**BI**	**ELD**	**HIV**	**PD**	**SLP***
Qualification/Education	Not Met (0/1)	Met (21/21)	Met (1/1)	Not Met (13/14)	
Related Experience			Met (1/1)		
Caseload Limit: 1:30	Met (1/1)		Met (1/1)		
Waiver-specific training	Not Met (0/1)	Not Met (5/21)	Not Met (0/1)		Not Met (0/15)

Shaded cells represent data that was not applicable
**The SLP waiver requires five waiver-specific trainings; data is displayed as a finding for all-or-nothing.*

As displayed in Table 4.7, ILS' submission identified compliance and findings related to waiver case management. HSAG noted the following:

- BI waiver-specific qualification/education: there was one case manager with BI waiver caseloads; the case manager did not meet the qualification/education requirements for the BI waiver.
- BI waiver-specific training: one case manager had a BI waiver caseload and had not completed BI waiver-specific training as of March 2020. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted this training as of March 2020.
- ELD waiver-specific training: five of the 21 case managers with ELD waiver caseloads had completed ELD waiver-specific training as of March 2020. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted this training as of March 2020.
- HIV waiver-specific training: one case manager had an HIV waiver caseload and had not completed HIV waiver-specific training as of March 2020. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted this training as of March 2020.
- PD waiver-specific qualification/education: Of the 14 case managers with PD waiver caseloads; one case manager did not meet the qualification/education requirements for the PD waiver.
- SLP waiver-specific training: none of the 15 case managers with SLP waiver caseloads had completed all five of the SLP waiver-specific trainings as of March 2020. HSAG will review training completion in the second biannual staffing and training review, as the health plans complete training annually and may not have conducted all trainings as of March 2020.
- As a result of CY 2019 biannual staffing and training reviews, ILS had findings related to completion of SLP waiver-specific training. HSAG noted that all but one SLP waiver case manager had completed the required training as of December 31, 2019. One SLP waiver case manager completed the training in 2020.

Waiver Training Completion: 20 Hours Annually

In addition to waiver-specific training, the health plans are contractually required to ensure that all waiver case managers complete 20 hours of annual waiver training (prorated based on date of hire). HSAG noted that health plans complete training on an annual basis; therefore, results from March may not be inclusive of the full complement of the health plans' training programs. Training completion will be reassessed during HSAG's second biannual staffing and training review. Table 4.8 provides the training completion as of March 2020.

Table 4.8 – Waiver Training: 20 Hours Annually*

Health Plan/Delegate	Number of Waiver Case Managers with 20 Hours of Training	Number of Waiver Case Managers	Percent of Waiver Case Managers with 20 Hours of Training as of March 2020
Aetna	0	33	0%
BCBSIL	0	187	0%
Humana: ILS	9	27	33%
IlliniCare	0	17	0%
Meridian	1	36	3%
Molina	0	37	0%

**Completion is assessed on an annual basis*

Five of the six health plans had CY 2019 findings related to 20 hours of waiver training; Meridian did not have findings. HSAG reviewed the health plans' remediation responses related to findings identified in the CY 2019 biannual staffing and training reviews:

- Aetna: all waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- BCBSIL: all waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- Humana: all delegated ILS waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- IlliniCare: all but three waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.
- Molina: all but one waiver case managers identified as lacking 20 hours of training had completed the required number of hours by December 31, 2019.

Appendix A. HealthChoice Staffing and Training Contract Requirements

Staffing Qualifications by Waiver Type*			
Elderly	**Disabilities**	**Brain Injury**	**HIV/AIDS**
1. Registered Nurse licensed in Illinois 2. Bachelor's degree in nursing, social sciences, social work, or related field 3. LPN with one year experience in conducting comprehensive assessments and provision of formal service for the elderly 4. One year satisfactory program experience may replace one year college education, at least four years experience replacing baccalaureate degree	1. Registered Nurse licensed in Illinois 2. Licensed Clinical Social Worker 3. Licensed Marriage and Family Therapist 4. Licensed Clinical Professional Counselor 5. Licensed Professional Counselor 6. PhD 7. Doctorate in Psychology 8. Bachelor or Master's Degree prepared in human services-related field 9. Licensed Practical Nurse	1. Registered Nurse licensed in Illinois 2. Certified or Licensed Social Worker 3. Unlicensed Social Worker: minimum of bachelor's degree or at least three years experience working with people with disabilities 4. Vocational Specialist: certified rehabilitation counselor or at least three years experience working with people with disabilities 5. Licensed Clinical Professional Counselor 6. Licensed Professional Counselor 7. Certified Case Manager	1. Registered Nurse licensed in Illinois and bachelor's degree in nursing, social work, social sciences or counseling or four years case management experience 2. Social worker with bachelor's degree in either social work, social sciences or counseling (bachelor's or masters of social work from a school accredited by nationally recognized organization for accreditation of social work schools preferred) 3. Individual with bachelor's degree in human services field; minimum five years case management experience
			Additionally – Care Coordinator for HIV/AIDS Waiver enrollees must have experience working with: • Addictive and dysfunctional family systems • Racial and ethnic minorities • Homosexuals and bisexuals • Persons with AIDS, and • Substance abusers

**Contract reference: HealthChoice: Attachment XVI, 1.1.1-1.1.4.8*

Caseload Requirements*
Care Coordinators responsible for enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. A Care Coordinator's caseload shall have **a maximum weighted caseload of 600 with low risk weighted as one, moderate risk weighted as four, and high risk weighted as eight.** Caseloads of Care Coordinators shall not exceed the following standards on average during the calendar year: • High Risk Enrollees: 75 • Moderate Risk Enrollees: 150 • Low Risk Enrollees: 600 • BI and HIV/AIDS: 30

**Contract references: HealthChoice 5.17.1-5.17.2.1*

Qualifications for High-Needs and Special Needs Children*	
Contract Citation	**Contract Text**
Attachment XVI, 1.1.5-1.1.5.1.2 HealthChoice	Care Coordinators must meet the following requirements: • Bachelor's degree in nursing, social sciences, social work, or related field • One year of supervised clinical experience in a human services-related field
Attachment XVI, 1.1.5.2-1.1.5.2.2 HealthChoice	Care Coordinator supervisors must meet the following requirements: • Master's degree in nursing, social sciences, social work, or related field • No fewer than three (3) years of supervised experience in a human services-related field
Attachment XVI, 1.1.5.3 HealthChoice, Amendment KA2	Contractor must employ at least one (1) certified trainer in IM-CANS.
Attachment XVI, 1.3.2.2 HealthChoice Amendment KA5	All Supervisors overseeing Care Coordinators assigned to Intensive/Intervention tier Enrollees must be certified as Wraparound coaches by a State-identified and approved entity.

Training Requirements

Contract Citation	Contract Text*
2.3.3	Contractor shall provide timely, relevant training that will help staff members competently perform their duties and targeted training to individual staff members as necessary.
2.7.3	Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to hire staff who reflect the diversity of Enrollee demographics. Contractor shall require all staff, including employees and contract personnel, to complete linguistic and Cultural Competence training upon hire and no less frequently than annually thereafter.
2.7.5	Contractor shall require that its Subcontractors comply with Contractor's Cultural Competence plan and complete Contractor's initial and annual Cultural Competence training. Contractor's oversight committee, established pursuant to section 5.40.4, shall ensure compliance by Subcontractors with contractual and statutory requirements, including the Illinois Human Rights Act, the US Civil Rights Act, and Section 504 of the federal Rehabilitation Act.
5.12.3.2	Training requirements. Care Coordinators who serve High-Needs Children, Special Needs Children, Enrollees within the IDoA Persons Who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Attachment XVI. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees.
5.21.4	Communications with Prospective Enrollees, Potential Enrollees, and Enrollees. The requirements outlined in this section 5.21.4 apply to all Key Oral Contacts and Written Materials. Contractor shall proactively attempt, within the conditions imposed by any court order or consent decree, to promote the hiring of local staff to ensure Cultural Competence. All Contractor staff will receive training on all Contractor policies and procedures during new-hire orientation and ongoing job-specific training to ensure effective communication with a diverse Enrollee population, including translation assistance, assistance to the hearing impaired, and assistance to those with limited English proficiency.
5.23.1.4	Contractor shall train all of Contractor's external-facing employees, Network Providers, Affiliates, and Subcontractors to recognize potential concerns related to Abuse, Neglect, and exploitation, and will train them on their responsibility to report suspected or alleged Abuse, Neglect, or exploitation.
5.35.1.9	FWA: Contractor shall ensure that all its personnel, Network Providers, and Subcontractors receive notice of, and are educated on, these procedures, and shall require adherence to them.
Attachment XVI, 1.3-1.3.1	TRAINING REQUIREMENTS OF CERTAIN CARE COORDINATORS Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of twenty (20) hours in-service training initially and annually. For partial years of employment, training shall be prorated to equal one-and–a-half (1.5) hours for each full month of employment. Care Coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving.

Contract Citation	Contract Text*
Attachment XVI, 1.3.1.1-1.3.1.1.1	Training must include the following: Persons who are Elderly Waiver. Aging related subjects
Attachment XVI, 1.3.1.2-1.3.1.2.1	Training must include the following: Persons with Brain Injury Waiver. Training relevant to the provision of services to persons with brain injuries
Attachment XVI, 1.3.1.3-1.3.1.3.1	Training must include the following: Persons with HIV/AIDS Waiver. Training relevant to the provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, and updates on information relating to treatment procedures)
Attachment XVI, 1.3.1.4-1.3.1.4.1	Training must include the following: Supportive Living Program Waiver. Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training
Attachment XVI, 1.3.2-1.3.2.2	Training must include the following: High-Needs and Special Needs Children. All Care Coordinators must attend the Introduction to Wraparound and Engagement trainings offered by an NWIC-certified trainer and any follow-up training modules developed and made available by the State. All Supervisors overseeing Care Coordinators assigned to Intensive/Intervention tier Enrollees must be certified as Wraparound coaches by a State-identified and approved entity.

**HealthChoice Illinois Contract, Effective January 1, 2018 and Amendment KA5, effective January 2020*

Appendix B. MMAI Staffing and Training Contract Requirements

Staffing Qualifications by Waiver Type*			
Elderly	**Disabilities**	**Brain Injury**	**HIV/AIDS**
1. Registered Nurse licensed in Illinois 2. Bachelor's degree in nursing, social sciences, social work, or related field 3. LPN with one year experience in conducting comprehensive assessments and provision of formal service for the elderly 4. One year satisfactory program experience may replace one year college education, at least four years experience replacing baccalaureate degree	1. Registered Nurse licensed in Illinois 2. Licensed Clinical Social Worker 3. Licensed Marriage and Family Therapist 4. Licensed Clinical Professional Counselor 5. Licensed Professional Counselor 6. PhD 7. Doctorate in Psychology 8. Bachelor or Master's Degree prepared in human services-related field 9. Licensed Practical Nurse	1. Registered Nurse licensed in Illinois 2. Certified or Licensed Social Worker 3. Unlicensed Social Worker: minimum of bachelor's degree or at least three years experience working with people with disabilities 4. Vocational Specialist: certified rehabilitation counselor or at least three years experience working with people with disabilities 5. Licensed Clinical Professional Counselor 6. Licensed Professional Counselor 7. Certified Case Manager	1. Registered Nurse licensed in Illinois and bachelor's degree in nursing, social work, social sciences or counseling or four years case management experience 2. Social worker with bachelor's degree in either social work, social sciences or counseling (bachelor's or masters of social work from a school accredited by nationally recognized organization for accreditation of social work schools preferred) 3. Individual with bachelor's degree in human services field; minimum five years case management experience
			Additionally – Care Coordinator for HIV/AIDS Waiver enrollees must have experience working with: • Addictive and dysfunctional family systems • Racial and ethnic minorities • Homosexuals and bisexuals • Persons with AIDS, and • Substance abusers

**Contract reference: MMAI: Appendix K*

Staffing Caseload Requirements*
Care Coordinators responsible for enrollees with varying risk levels shall have their overall caseload weighted and a blended overall caseload limit set. A Care Coordinator's caseload shall have **a maximum weighted caseload of 600 with low risk weighted as one, moderate risk weighted as four, and high risk weighted as eight.** Caseloads of Care Coordinators shall not exceed the following standards on average during the calendar year: • High Risk Enrollees: 75 • Moderate Risk Enrollees: 150 • Low Risk Enrollees: 600 • BI and HIV/AIDS: 30

**Contract references: MMAI 2.5.2.7-2.5.2.7.1.4*

Training Requirements

Contract Citation	Contract Text*
2.1.7.6	Provide False Claims Education for all employees and First Tier, Downstream, and Related Entities as required in 42 U.S.C § 1396(a)(68).
2.5.3.2	Interdisciplinary Care Team Training: Members of the ICT must be trained on the following topics: person-centered planning processes, cultural and disability competencies, the Ombudsman program, compliance with the Americans with Disabilities Act (ADA), and independent living and recovery.
2.5.3.5.1	Care Coordinators who serve Enrollees within the DoA Persons who are Elderly HCBS Waiver, DHS-DRS Persons with a Brain Injury HCBS Waiver, DHS-DRS Persons with HIV/AIDS HCBS Waiver, DHS-DRS Persons with Disabilities HCBS Waiver, or HFS Supportive Living Program HCBS Waiver must meet the applicable training requirements set forth in Appendix K. Care Coordinators for all other Enrollees must have the appropriate training to address the needs of Enrollees.
2.5.3.7	Care Coordinator Caseloads. The Contractor must include a sufficient number of Care Coordinators with the background and training to serve low, moderate, and high-risk Enrollees, based on an analysis of the population to be served in accordance with Section 2.6.2.
2.9.6.3	The Contractor shall train all of the Contractor's employees, Affiliated Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with Enrollees or Enrollee's Care Plan to recognize potential concerns related to Abuse, Neglect and exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect or exploitation.
5.2.2	Personal Data. The Contractor must inform each of its employees having any involvement with personal data or other confidential information, whether with regard to

Contract Citation	Contract Text*
	design, development, operation, or maintenance of the laws and regulations relating to confidentiality.
Appendix K, A	TRAINING REQUIREMENTS OF CERTAIN CARE COORDINATORS Care Coordinators for HCBS Waiver Enrollees shall receive a minimum of twenty (20) hours in-service training initially and annually. For partial years of employment, training shall be prorated to equal one-and–a-half (1.5) hours for each full month of employment. Care Coordinators must be trained on topics specific to the type of HCBS Waiver Enrollee they are serving.
Appendix K, A	Training must include the following: Persons who are Elderly Waiver. Aging related subjects.
Appendix K, A	Training must include the following: Persons with Brain Injury Waiver. Training relevant to the provision of services to persons with brain injuries.
Appendix K, A	Training must include the following: Persons with HIV/AIDS Waiver. Training relevant to the provision of services to persons with AIDS (e.g., infectious disease control procedures, sensitivity training, and updates on information relating to treatment procedures).
Appendix K, A	Training must include the following: Supportive Living Program Waiver. Training on the following subjects: resident rights; prevention and notification of Abuse, Neglect, and exploitation; behavioral intervention, techniques for working with the elderly and persons with disabilities; and, disability sensitivity training.

**MMAI Three-Way Contract, Effective January 1, 2018 with Amendment September 1, 2019*

Appendix C. MLTSS Data

This Appendix provides a subset of data reported previously in this report, for those case management staff who have caseloads for the HealthChoice Managed Long Term Services and Supports (MLTSS) population. This data identifies the scope of a case manager's MLTSS-only caseload.

General Case Management Data – Caseload Volumes and Weighted Caseloads

Figure C.1 displays the compliance rates with contractual requirements for caseload volumes and weighted caseloads.

Figure C.1 – Compliance with Contract Requirements for Caseload Volumes and Weighted Caseloads

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Weighted caseloads at or below maximum of 600	100% (379/379)	100% (105/105)	100% (31/31)	100% (175/175)	100% (20/20)	79% (119/151)	100% (86/86)	100% (23/23)
High risk caseload at or below maximum of 75	100% (331/331)	100% (90/90)	100% (18/18)	100% (139/139)	100% (20/20)	94% (130/139)	100% (61/61)	100% (10/10)
Moderate risk caseload at or below maximum of 150	100% (346/346)	100% (104/104)	100% (23/23)	100% (168/168)	100% (18/18)	93% (131/141)	100% (86/86)	100% (23/23)
Low risk caseload at or below maximum of 600	100% (61/61)	100% (63/63)	NA (0/0)	100% (41/41)	NA (0/0)	100% (33/33)	100% (75/75)	100% (7/7)

HCBS Waiver Case Management Data

BI Waiver

Figure C.2 displays the compliance rates with contractual requirements for case management staff with BI waiver caseloads.

Figure C.2 – Compliance with Contract Requirements for BI Waiver Case Managers

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Case manager credentials	96% (23/24)	100% (12/12)	NA (0/0)	60% (6/10)	NA (0/0)	83% (15/18)	81% (17/21)	50% (1/2)
Total caseload at or below maximum of 30	100% (24/24)	100% (12/12)	NA (0/0)	100% (10/10)	NA (0/0)	100% (18/18)	43% (9/21)	100% (2/2)
Training specific to waiver	0% (0/24)	0% (0/12)	NA (0/0)	10% (1/10)	NA (0/0)	6% (1/18)	0% (0/21)	100% (2/2)

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Completion of 20 hours of waiver training annually	0% (0/24)	0% (0/12)	NA (0/0)	0% (0/10)	NA (0/0)	6% (1/18)	0% (0/21)	0% (0/2)

ELD Waiver

Figure C.3 displays the compliance rates with contractual requirements for case management staff with ELD waiver caseloads.

Figure C.3 – Compliance with Contract Requirements for ELD Waiver Case Managers

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Case manager credentials	100% (281/281)	100% (66/66)	100% (18/18)	100% (110/110)	NA (0/0)	100% (127/127)	100% (64/64)	100% (14/14)
Training specific to waiver	0% (0/281)	0% (0/66)	6% (1/18)	3% (3/110)	NA (0/0)	8% (10/127)	8% (5/64)	100% (14/14)
Completion of 20 hours of waiver training annually	0% (0/281)	0% (0/66)	6% (1/18)	0% (0/110)	NA (0/0)	6% (8/127)	0% (0/64)	0% (0/14)

HIV Waiver

Figure C.4 displays the compliance rates with contractual requirements for case management staff with HIV waiver caseloads.

Figure C.4 – Compliance with Contract Requirements for HIV Waiver Case Managers

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Case manager credentials	94% (17/18)	100% (7/7)	100% (1/1)	100% (3/3)	NA (0/0)	92% (12/13)	90% (9/10)	100% (1/1)
Case managers with required related experience	100% (18/18)	100% (7/7)	100% (1/1)	33% (1/3)	NA (0/0)	46% (6/13)	10% (1/10)	100% (1/1)
Total caseload at or below maximum of 30	100% (18/18)	100% (7/7)	100% (1/1)	100% (3/3)	NA (0/0)	100% (13/13)	40% (4/10)	100% (1/1)
Training specific to waiver	0% (0/18)	0% (0/7)	0% (0/1)	33% (1/3)	NA (0/0)	8% (1/13)	0% 0/10)	100% (1/1)
Completion of 20 hours of waiver training annually	0% (0/18)	0% (0/7)	0% (0/1)	0% (0/3)	NA (0/0)	8% (1/13)	0% (0/10)	0% (0/1)

PD Waiver

Figure C.5 displays the compliance rates with contractual requirements for case management staff with PD waiver caseloads.

Figure C.5 – Compliance with Contract Requirements for PD Waiver Case Managers

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Case manager credentials	92% (200/218)	100% (32/32)	80% (4/5)	97% (70/72)	95% (19/20)	85% (92/108)	97% (57/59)	91% (10/11)
Completion of 20 hours of waiver training annually	0% (0/218)	0% (0/32)	20% (1/5)	0% (0/72)	0% (0/20)	4% (8/218)	0% (0/59)	0% (0/11)

SLP Waiver

Figure C.6 displays the compliance rates with contractual requirements for case management staff with SLP waiver caseloads.

Figure C.6 – Compliance with Contract Requirements for SLP Waiver Case Managers

Element	BCBSIL	CountyCare	CountyCare: ILS	IlliniCare	IlliniCare: CCA	Meridian	Molina	NextLevel
Training specific to waiver – resident rights	0% (0/123)	0% (0/13)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	15% (6/40)	0% (0/1)
Training specific to waiver – prevention and notification of abuse, neglect, and exploitation	0% (0/123)	0% (0/13)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	75% (30/40)	100% (1/1)
Training specific to waiver – behavioral intervention	0% (0/123)	0% (0/13)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	28% (11/40)	100% (1/1)
Training specific to waiver – techniques for working with the elderly and persons with disabilities	0% (0/123)	0% (0/38)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	40% (16/40)	100% (1/1)
Training specific to waiver – disability sensitivity training	0% (0/123)	0% (0/38)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	63% (25/40)	0% (0/1)
Training for all five required topics	0% (0/123)	0% (0/38)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	3% (1/40)	0% (0/1)
Completion of 20 hours of waiver training annually	0% (0/123)	0% (0/38)	0% (0/3)	0% (0/32)	NA (0/0)	6% (2/33)	0% (0/40)	0% (0/1)

Appendix D. SNC Data

This Appendix provides a subset of data reported previously in this report, for those case management staff who have caseloads for the HealthChoice Special Needs Children (SNC) population. This data identifies the scope of a case manager's SNC-only caseload.

In the first CY 2020 biannual staffing and training analysis, HSAG assessed the SNC caseloads being managed by the health plans. Future analyses will include assessment of additional SNC-specific staffing and training elements. HSAG will also assess data for the University of Illinois Division of Specialized Care for Children (DSCC) in a future analysis.

General Case Management Data – Caseload Volumes and Weighted Caseloads

Figure D.1 displays the compliance rates with contractual requirements for caseload volumes and weighted caseloads.

Figure D.1 – Compliance with Contract Requirements for Caseload Volumes and Weighted Caseloads

Element	BCBSIL	CountyCare[1]	IlliniCare	Meridian	Molina	NextLevel
Weighted caseloads at or below maximum of 600	100% (38/38)	100% (63/63)	100% (11/11)	98% (156/159)	100% (64/64)	100% (5/5)
High risk caseload at or below maximum of 75	100% (18/18)	100% (56/56)	100% (11/11)	97% (66/68)	100% (52/52)	100% (5/5)
Moderate risk caseload at or below maximum of 150	100% (13/13)	100% (24/24)	100% (5/5)	100% (120/120)	100% (13/13)	NA
Low risk caseload at or below maximum of 600	100% (12/12)	100% (12/12)	100% (4/4)	100% (35/35)	100% (41/41)	NA

[1]*CountyCare delegates management of SNC enrollees to two delegates; data represents a summation of the delegates' data.*

Combined, the health plans' submissions reported a caseload total of 5,309 SNC enrollees.

Case Management Data: Qualifications & Training

Care Coordinators

Figure D.2 displays the compliance rates with contractual requirements for case management staff with SNC caseloads.

Figure D.2 – Compliance with Contract Requirements for SNC Case Managers

Element	Number Compliant	Number Non-Compliant	Total Number of Case Managers with SNC Caseloads	Percent Compliant
Case manager qualification/education	*	*	*	*
One year of supervised clinical experience in a human-services related field	*	*	*	*
Training: Introduction to Wraparound and Engagement	*	*	*	*

**Data to be assessed in a future analysis.*

HSAG noted the following information related to the health plans' SNC case managers:

- BCBSIL's submission included 38 case managers (14.27 FTE): six registered nurses and 32 social workers/professional counselors.
- CountyCare's delegates' submissions included:
  - CCC: 23 case managers (8.84 FTE): 15 registered nurses and eight social workers/professional counselors.
  - MHN: 40 case managers (8.50 FTE): 22 registered nurses, 13 social workers/professional counselors, and five staff members with another qualification (not registered nurse or social worker/professional counselor).
- IlliniCare's submission included 11 case managers (11.00 FTE): six registered nurses, four social workers/professional counselors, and one with another qualification.
- Meridian's submission included 159 case managers (28.39 FTE): 15 registered nurses, 33 social workers/professional counselors, and 111 with another qualification (not registered nurse or social worker/professional counselor).
- Molina's submission included 64 case managers (21.95 FTE): 13 registered nurses, 39 social workers/professional counselors, and 12 with another qualification (not registered nurse or social worker/professional counselor).
- NextLevel's submission included five case managers (1.75 FTE): one registered nurse and four social workers/professional counselors.

Care Coordinator Supervisors

Figure D.3 displays the compliance rates with contractual requirements for supervisors of case management staff with SNC caseloads.

Figure D.3 – Compliance with Contract Requirements for Supervisors of SNC Case Managers

Element	Number Compliant	Number Non-Compliant	Total Number of Supervisors	Percent Compliant
Case manager supervisor qualification/education	*	*	*	*

Element	Number Compliant	Number Non-Compliant	Total Number of Supervisors	Percent Compliant
Three years of supervised clinical experience in a human-services related field	*	*	*	*
Wraparound coach certification	*	*	*	*

**Data to be assessed in a future analysis.*

IM-CANS Trainer

Figure D.4 displays the compliance rate with SNC IM-CANS trainer contractual requirements.

Figure D.4 – Compliance with Contract Requirements for IM-CANS Trainer

Element	Compliant (Met/Not Met)
Number of IM-CANS trainers employed by the health plan	*

**Data to be assessed in a future analysis.*

Appendix E. Combined Line of Business Data

This Appendix provides summations of data reported previously in this report, for those case management staff who have caseloads for both HealthChoice and MMAI populations. This data identifies the scope of a case manager's caseload when reviewed across all enrollees being managed, regardless of the line of business (LOB). Since contractual requirements are the same for both the HealthChoice and MMAI populations, this data analysis assumes that a case manager's caseload should meet those requirements when analyzed in totality.

General Case Management Data – Caseload Volumes and Weighted Caseloads

Figure E.1 displays the compliance rates with contractual requirements for caseload volumes and weighted caseloads.

Figure E.1 – Compliance with Contract Requirements for Caseload Volumes and Weighted Caseloads

Element	BCBSIL	Meridian	Molina
Weighted caseloads at or below maximum of 600	100% (202/202)	21% (14/67)	100% (57/57)
High risk caseload at or below maximum of 75	100% (194/194)	39% (24/62)	100% (54/54)
Moderate risk caseload at or below maximum of 150	100% (187/187)	97% (65/67)	100% (57/57)
Low risk caseload at or below maximum of 600	100% (150/150)	100% (66/66)	100% (57/57)

HCBS Waiver Case Management Data

BI Waiver

Figure E.2 displays the compliance rates with contractual requirements for case management staff with BI waiver caseloads.

Figure E.2 – Compliance with Contract Requirements for BI Waiver Case Managers

Element	BCBSIL	Meridian	Molina
Case manager credentials	100% (5/5)	100% (1/1)	75% (15/20)
Total caseload at or below maximum of 30	100% (5/5)	100% (1/1)	0% (0/20)

Element	BCBSIL	Meridian	Molina
Training specific to waiver	0% (0/5)	0% (0/1)	0% (0/20)
Completion of 20 hours of waiver training annually	0% (0/5)	0% (0/1)	0% (0/20)

ELD Waiver

Figure E.3 displays the compliance rates with contractual requirements for case management staff with ELD waiver caseloads.

Figure E.3 – Compliance with Contract Requirements for ELD Waiver Case Managers

Element	BCBSIL	Meridian	Molina
Case manager credentials	100% (148/148)	100% (35/35)	100% (38/38)
Training specific to waiver	0% (0/148)	3% (1/35)	13% (5/38)
Completion of 20 hours of waiver training annually	0% (0/148)	3% (1/35)	0% (0/38)

HIV Waiver

Figure E.4 displays the compliance rates with contractual requirements for case management staff with HIV waiver caseloads.

Figure E.4 – Compliance with Contract Requirements for HIV Waiver Case Managers

Element	BCBSIL	Meridian	Molina
Case manager credentials	100% (5/5)	100% (1/1)	94% (16/17)
Case managers with required related experience	100% (5/5)	100% (1/1)	6% (1/17)
Total caseload at or below maximum of 30	100% (5/5)	100% (1/1)	0% (0/17)
Training specific to waiver	0% (0/5)	0% (0/1)	0% (0/17)
Completion of 20 hours of waiver training annually	0% (0/5)	0% (0/1)	0% (0/17)

PD Waiver

Figure E.5 displays the compliance rates with contractual requirements for case management staff with PD waiver caseloads.

Figure E.5 – Compliance with Contract Requirements for PD Waiver Case Managers

Element	BCBSIL	Meridian	Molina
Case manager credentials	94% (120/128)	81% (22/27)	95% (40/42)
Completion of 20 hours of waiver training annually	0% (0/128)	7% (2/27)	0% (0/42)

SLP Waiver

Figure E.6 displays the compliance rates with contractual requirements for case management staff with SLP waiver caseloads.

Figure E.6 – Compliance with Contract Requirements for SLP Waiver Case Managers

Element	BCBSIL	Meridian	Molina
Training specific to waiver – resident rights	0% (0/60)	8% (2/25)	10% (3/29)
Training specific to waiver – prevention and notification of abuse, neglect, and exploitation	0% (0/60)	8% (2/25)	66% (19/29)
Training specific to waiver – behavioral intervention	0% (0/60)	8% (2/25)	17% (5/29)
Training specific to waiver – techniques for working with the elderly and persons with disabilities	0% (0/60)	8% (2/25)	28% (8/29)
Training specific to waiver – disability sensitivity training	0% (0/60)	8% (2/25)	55% (16/29)
Training for all five required topics	0% (0/60)	8% (2/25)	3% (1/29)
Completion of 20 hours of waiver training annually	0% (0/60)	8% (2/25)	0% (0/29/)

Appendix F. Delegate Data

This Appendix provides summations of data reported previously in this report, for those delegates who provide case management staff for more than one health plan. Data may include case managers who have caseloads for both HealthChoice and MMAI populations. This data identifies the scope of a case manager's caseload when reviewed across all enrollees being managed, regardless of the health plan or line of business (LOB). Since contractual requirements are the same for both the HealthChoice and MMAI populations, this data analysis assumes that a case manager's caseload should meet those requirements when analyzed in totality.

Review of the health plans' reported data identified five health plans with delegated case management across eight delegated entities. Of those, only two delegated entities, Access and ILS, provide case management staff for more than one health plan. Access provides case management for HealthChoice for CountyCare and NextLevel; ILS provides case management for both HealthChoice for CountyCare and MMAI for Humana. This Appendix provides data only for those two delegated entities.

General Case Management Data – Caseload Volumes and Weighted Caseloads

Figure F.1 displays the compliance rates with contractual requirements for caseload volumes and weighted caseloads.

Figure F.1 – Compliance with Contract Requirements for Caseload Volumes and Weighted Caseloads

Element	Access	ILS
Weighted caseloads at or below maximum of 600	96% (24/25)	76% (35/46)
High risk caseload at or below maximum of 75	96% (24/25)	100% (45/45)
Moderate risk caseload at or below maximum of 150	100% (23/23)	98% (44/45)
Low risk caseload at or below maximum of 600	100% (18/18)	100% (10/10)

HCBS Waiver Case Management Data

BI Waiver

Figure F.2 displays the compliance rates with contractual requirements for case management staff with BI waiver caseloads.

Figure F.2 – Compliance with Contract Requirements for BI Waiver Case Managers

Element	Access	ILS
Case manager credentials	NA (0/0)	33% (1/3)
Total caseload at or below maximum of 30	NA (0/0)	100% (3/3)
Training specific to waiver	NA (0/0)	0% (0/3)
Completion of 20 hours of waiver training annually	NA (0/0)	0% (0/3)

ELD Waiver

Figure F.3 displays the compliance rates with contractual requirements for case management staff with ELD waiver caseloads.

Figure F.3 – Compliance with Contract Requirements for ELD Waiver Case Managers

Element	Access	ILS
Case manager credentials	NA (0/0)	100% (42/42)
Training specific to waiver	NA (0/0)	31% (13/42)
Completion of 20 hours of waiver training annually	NA (0/0)	29% (12/42)

HIV Waiver

Figure F.4 displays the compliance rates with contractual requirements for case management staff with HIV waiver caseloads.

Figure F.4 – Compliance with Contract Requirements for HIV Waiver Case Managers

Element	Access	ILS
Case manager credentials	NA (0/0)	100% (3/3)
Case managers with required related experience	NA (0/0)	100% (3/3)
Total caseload at or below maximum of 30	NA (0/0)	100% (3/3)
Training specific to waiver	NA (0/0)	0% (0/3)

Element	Access	ILS
Completion of 20 hours of waiver training annually	NA (0/0)	0% (0/3)

PD Waiver

Figure F.5 displays the compliance rates with contractual requirements for case management staff with PD waiver caseloads.

Figure F.5 – Compliance with Contract Requirements for PD Waiver Case Managers

Element	Access	ILS
Case manager credentials	NA (0/0)	85% (29/34)
Completion of 20 hours of waiver training annually	NA (0/0)	26% (9/34)

SLP Waiver

Figure F.6 displays the compliance rates with contractual requirements for case management staff with SLP waiver caseloads.

Figure F.6 – Compliance with Contract Requirements for SLP Waiver Case Managers

Element	Access	ILS
Training specific to waiver – resident rights	NA (0/0)	0% (0/15)
Training specific to waiver – prevention and notification of abuse, neglect, and exploitation	NA (0/0)	0% (0/15)
Training specific to waiver – behavioral intervention	NA (0/0)	0% (0/15)
Training specific to waiver – techniques for working with the elderly and persons with disabilities	NA (0/0)	0% (0/15)
Training specific to waiver – disability sensitivity training	NA (0/0)	0% (0/15)
Training for all five required topics	NA (0/0)	0% (0/15)
Completion of 20 hours of waiver training annually	NA (0/0)	33% (5/15)

Appendix G2. Critical Incident Monitoring Methodology

Introduction

HFS provides quality oversight of health plans that provide services for the HealthChoice Illinois, MLTSS, and MMAI populations. To provide feedback and analysis on the health plans' compliance with critical incident (CI) requirements, HFS requested that HSAG, the EQRO for Illinois, conduct quarterly reviews of CI records. The results of these reviews are used to highlight strengths and identify areas that require immediate and/or additional attention.

The CI review evaluated the health plans' compliance with all CI contract requirements, State and federal statutes and regulations, and 1915(b) and 1915(c) waiver conditions. The applicable contract citations are included in Appendix G3.

HSAG assessed cases reported in each health plan's internal CI reporting system for each quarter of review. The quarterly reports provided a summary of the health plans' compliance with CI requirements. The reports also identified additional data and information relative to CI processing.

Assessment of Systems Effectiveness

HSAG reviewed information provided by the health plans to assess system effectiveness and the health plans' ability to identify, address, and seek to prevent instances of abuse, neglect, and exploitation (ANE) and unexplained death. HSAG assessed the following elements:

- Internal documentation, including CI forms and case note documentation
- Processes, including care plan/service plan updates, unable to reach (UTR), investigating authority reports and responses, and closure/resolution of incident
- Provision of ANE education to enrollees

Record Review Activities and Technical Methods of Data Collection

Data Analysis

The HFS *Critical Incident Guide for HealthChoice Illinois Managed Care Organizations* defines CIs. Table G2-1 and Table G2-2 provide the health plans' FY 2020 CIs categorized by those definitions, as well as additional categories captured by the health plans, if applicable, which are summarized as "Other."

Table G2-1—HealthChoice FY 2020 Critical Incidents

Category	BCBSIL	CountyCare	IlliniCare	Meridian	Molina	NextLevel	Total
Abuse	1,116	82	62	970	41	11	**2,282**
Neglect	415	57	43	187	29	36	**767**
Exploitation	113	6	4	53	17	2	**195**
Behavioral Health	254	12	15	221	10	8	**520**
Death	91	0	3	41	0	123	**258**
Legal/Criminal Activity	59	6	10	46	1	6	**128**
Medication Management	47	1	7	24	0	4	**83**
Restraint, Seclusion, or other Restrictive Intervention	4	0	1	2	0	1	**8**
Other	2,648	59	178	319	12	51	**3,267**
Total	**4,747**	**223**	**323**	**1,863**	**110**	**242**	**7,508**

Table G2-2—MMAI FY 2020 Critical Incidents

Category	Aetna	BCBSIL	Humana	IlliniCare	Meridian	Molina	Total
Abuse	19	69	18	9	16	15	**146**
Neglect	11	70	10	9	9	13	**122**
Exploitation	12	29	2	2	4	13	**62**
Behavioral Health	0	21	0	2	14	0	**37**
Death	1	8	1	2	0	1	**13**
Legal/Criminal Activity	0	15	0	0	6	1	**22**
Medication Management	0	4	0	2	7	1	**14**
Restraint, Seclusion, or other Restrictive Intervention	0	0	0	0	0	0	**0**
Other	40	292	110	25	93	5	**565**
Total	**83**	**508**	**141**	**51**	**149**	**49**	**981**

Sampling Methodology

HSAG developed a sampling methodology based on the requirements approved by HFS. Quarterly, HSAG selected a random sample determined by the total universe, minus HFS-approved exclusions, of all critical incidents received across all health plans and populations (HealthChoice and MMAI) combined, with a 20 percent oversample. The sample was designed to ensure a 95 percent confidence level and 5 percent margin of error for annualized results of the population targeted by the sample. The random sample of cases was distributed across all plans based on their representative portion of the total universe.

The population and resulting sample included both nonwaiver beneficiaries and HCBS waiver beneficiaries. The following HCBS waiver programs were included in the sample:

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

Limitations to the sampling methodology included known variables such as cases reported incorrectly as a CI or not categorized correctly and could not be replaced due to insufficient data universe.

Methodology for Data Collection

HSAG reviewed the specifications described in the HealthChoice and MMAI contracts, the MLTSS waiver, and the HFS policies (*Critical Incident Guide* and *MCO-002–Adult Protective Services Reporting*) to define the scope of the review. HSAG developed a file review tool to assess a sample of CI cases. HSAG used the tool to assess compliance in each of the following domains:

- Reporting of Incident
- Communication With Investigating Authorities
- Compliance With Investigating Authority Decisions
- Case Management Activities
- Case Closure and Resolution

HSAG also used the tool to assess additional data related to the incident.

Scoring Methodology

During the file review, HSAG reviewed documentation for the selected cases for the review period. The review team determined evidence of case compliance with each of the scored elements. A score of *Met*, *Not Met*, or *Not Applicable (N/A)* was assigned to each requirement under review.

HSAG used a two-point scoring methodology. Each requirement was scored as *Met* or *Not Met* according to the criteria identified below. HSAG also used a designation of *N/A* if the requirement was not applicable to a record; *N/A* findings were not included in the two-point scoring methodology.

Met indicates full compliance defined as all of the following:

- All documentation listed under contract requirements was present in the case file.
- Cases reviewed met the scoring criteria assigned to each requirement.
- Cases reviewed had documentation that met "Due Diligence" criteria.

Not Met indicates noncompliance defined as either of the following:

- Not all documentation was present.
- Cases reviewed did not have documentation that met "Due Diligence" criteria.

N/A indicates a requirement that will not be scored for compliance based on the criteria listed for the specific element in the Evaluation Criteria document.

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

Remediation Actions

Health plans are required to complete remediation of any findings. HSAG will complete review of remediation actions within 30 days after the findings are identified to the health plans.

Appendix G3. Critical Incident Monitoring Contract Citations

HealthChoice Contract Citations

Table A.1 provides the HealthChoice contract (*2018-24-001*) language assessed through the CI Monitoring Review.

Table A.1—HealthChoice Contract Citations

Contract Citation	Contract Language
5.23	*Health, Safety, and Welfare Monitoring*
5.23.1	*Contractor shall comply with all health, safety, and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including the following: critical-incident reporting regarding Abuse, Neglect, and exploitation; critical-incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation; and Performance Measures relating to the areas of health, safety, and welfare and required for operating and maintaining an HCBS Waiver.*
5.23.1.1	*Contractor shall comply with the Department of Human Services Act (20 ILCS 1305/1-1 et seq.), the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.), the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.), and any other similar or related applicable federal and State laws*
5.23.1.2	*Contractor shall comply with Critical Incident reporting requirements of the DHS-DRS, IDoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect, or exploitation. Such reportable incidents include those identified in Attachments XVII, XVIII, and XIX for the appropriate HCBS Waivers.*
5.23.1.3	*Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with federal waiver assurances for health, safety, and welfare as set forth in the approved HCBS Waivers. Contractor, on an ongoing basis, shall identify, address, and seek to prevent the occurrence of Abuse, Neglect, and exploitation. Performance Measures regarding health, safety, welfare, and critical-incident reporting are included in Table 2 to Attachment XI.*
5.23.1.4	*Contractor shall train all of Contractor's external-facing employees, Network Providers, Affiliates, and Subcontractors to recognize potential concerns related to Abuse, Neglect, and exploitation, and will train them on their responsibility to report suspected or alleged Abuse, Neglect, or exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect, or exploitation to the appropriate authorities shall not be subjected to any Adverse Benefit Determination from Contractor, its Network Providers, Affiliates, or Subcontractors.*
5.23.1.5	*Contractor shall train Providers, Enrollees, and Enrollees' family members about the signs of Abuse, Neglect, and exploitation; what to do if they suspect Abuse, Neglect, or exploitation; and the scope of Contractor's responsibilities regarding these issues. Training sessions will be customized to the target audience. Training will include general indicators of Abuse, Neglect, and exploitation and the timeframe requirements for reporting suspected Abuse, Neglect, and exploitation.*

Contract Citation	Contract Language
5.23.1.6	*Reports regarding Enrollees who are age eighteen (18) and older and living in the community are to be made to the Illinois Department on Aging by utilizing the Adult Protective Services hotline.*
5.23.1.7	*Reports regarding Enrollees in NFs must be made to the Department of Public Health's nursing home complaint hotline.*
5.23.1.8	*Reports regarding Enrollees aged eighteen (18) to fifty-nine (59) receiving mental health or Developmental Disability services in programs that are operated, licensed, certified, or funded by DHS are to be made to Illinois Department of Human Services Office of the Inspector General hotline.*
5.23.1.9	*Reports regarding Enrollees in Supportive Living Facilities (SLFs) must be made to the Department of Healthcare and Family Services' Supportive Living Program (SLP) complaint hotline.*
5.23.1.10	*Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect, and exploitation and other Critical Incidents that are reportable, including those in Attachment XVII, Attachment XVIII, and Attachment XIX. Contractor must inform DCFS of any and all such incidents that are reported.*
5.23.1.11	*Contractor shall provide the Department, upon request, with its protocols for assuring the health and safety of the Enrollee after an allegation of Abuse, Neglect, exploitation, or a Critical Incident is reported.*
5.23.2	*Critical-incident reporting*
5.23.2.1	*Contractor shall have processes and procedures in place to receive reports of Critical Incidents. Critical events and incidents must be reported, and issues that are identified must be routed to the appropriate department within Contractor's organization and, when required or otherwise appropriate, to the investigating authority.*
5.23.2.2	*Contractor shall maintain an internal reporting system for tracking the reporting and responding to Critical Incidents, and for analyzing the event to determine whether individual or systemic changes are needed.*
5.23.2.3	*Contractor shall have systems in place to report, monitor, track, and resolve Critical Incidents concerning restraints and restrictive interventions.*
5.23.2.3.1	*Contractor shall make reasonable efforts to detect unauthorized use of restraint or seclusion. Contractor shall require that events involving the use of restraint or seclusion are reported to Contractor as a reportable incident and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or exploitation.*
5.23.2.3.2	*Contractor shall make reasonable efforts to detect unauthorized use of restrictive interventions. Contractor shall require that events involving the use of restrictive interventions are reported to Contractor as a reportable incident and reported to the investigating authority if it rises to the level of Abuse, Neglect, or exploitation.*
5.23.2.3.3	*Contractor will comply with decision made by investigating authority within the timeframe given.*
5.16	*Contractor shall conduct a face-to-face health-risk reassessment for Enrollees receiving HCBS Waiver services or residing in NFs each time there is a significant change in the Enrollee's condition or an Enrollee requests reassessment*
Attachment XVII	*ILLINOIS DEPARTMENT OF HUMAN SERVICES, DIVISION OF REHABILITATION SERVICES, CRITICAL INCIDENT DEFINITIONS*

Contract Citation	Contract Language
Attachment XVIII	*ILLINOIS DEPARTMENT ON AGING ELDER ABUSE AND NEGLECT PROGRAM*
Attachment XIX	*ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES INCIDENT REPORTING FOR SUPPORTIVE LIVING FACILITIES*

MMAI Contract Citations

Table A.1 provides the MMAI contract (*Three-Way Contract, Effective January 1, 2018*) language assessed through the CI Monitoring Review.

Table A.1—MMAI Contract Citations

Contract Citation	Contract Language
2.9.6	*Critical Incidents and Other HCBS Required Reporting*
2.9.6.1	*The Contractor shall comply with critical incident reporting requirements of the DHS-DRS, DoA, and HFS HCBS Waivers for incidents and events that do not rise to the level of Abuse, Neglect or exploitation. Such reportable incidents include, but are not limited to, the incidents identified in Appendix L, M, and N for the appropriate HCBS Waivers.*
2.9.6.2	*The Contractor shall comply with HCBS Waiver reporting requirements to assure compliance with Federal Waiver Assurances for Health Safety, and Welfare, and other Federal requirements as set forth in the approved HCBS Waivers. The Contractor, on an ongoing basis, shall identify, address, and seek to prevent the occurrence of Abuse, Neglect and exploitation. Performance measures regarding health, safety, welfare and critical incident reporting are included for all HCBS programs.*
2.9.6.3	*The Contractor shall train all of the Contractor's employees, Affiliated Providers, Affiliates, and First Tier, Downstream and Related Entities that have interaction with Enrollees or Enrollee's Care Plan to recognize potential concerns related to Abuse, Neglect and exploitation, and on their responsibility to report suspected or alleged Abuse, Neglect or exploitation. Contractor's employees who, in good faith, report suspicious or alleged Abuse, Neglect or exploitation to the appropriate authorities shall not be subjected to any Adverse Benefit Determination from the Contractor, its Affiliated Providers, Affiliates or First Tier, Downstream, or Related Entities.*
2.9.6.4	*The Contractor shall train Providers, Enrollees and Enrollees' family members about the signs of Abuse, Neglect and exploitation, what to do if they suspect Abuse, Neglect or exploitation, and the Contractor's responsibilities. Training sessions will be customized to the target audience. Training will include general indicators of Abuse, Neglect and exploitation and the timeframe requirements for reporting suspected Abuse, Neglect and exploitation.*
2.9.6.5	*Reports regarding Enrollees who are disabled adults age eighteen (18) through fifty-nine (59), who are residing in the community, are to be made to the Illinois Adult Protective Services Unit of DoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).*
2.9.6.6	*Reports regarding Enrollees who are age sixty (60) or older, who reside in the community, are to be made to the Illinois Adult Protective Services Unit of DoA at 1-866-800-1409 (voice) and 1-888-206-1327 (TTY).*
2.9.6.7	*Reports regarding Enrollees in NFs must be made to the DPH's Nursing Home Complaint Hotline at 1-800-252-4343.*
2.9.6.8	*Reports regarding Enrollees in SLFs must be made to the Department's SLF Complaint Hotline at 1-800-226-0768.*

Contract Citation	Contract Language
2.9.6.9	*The Contractor shall provide the Department, upon request, with its protocols for reporting suspected Abuse, Neglect and exploitation and other critical incidents that are reportable.*
2.9.6.10	*The Contractor shall provide the Department, upon request, with its protocols for assuring the health and safety of the Enrollee after an allegation of Abuse, Neglect or exploitation, or a critical incident, is reported.*
2.9.6.11	*Critical Incident Reporting*
2.9.6.11.1	*The Contractor shall have processes and procedures in place to receive reports of critical incidents. Critical events and incidents must be reported and issues that are identified must be routed to the appropriate department within the Contractor and, when required or otherwise appropriate, to the investigating authority.*
2.9.6.11.2	*The Contractor shall maintain an internal reporting system for tracking the reporting and responding to critical incidents, and for analyzing the event to determine whether individual or systemic changes are needed.*
2.9.6.11.3	*The Contractor shall have systems in place to report, monitor, track, and resolve critical incidents concerning restraints and restrictive interventions.*
2.9.6.11.3.1	*The Contractor shall make reasonable efforts to detect unauthorized use of restraint or seclusion. The Contractor shall require that events involving the use of restraint or seclusion are reported to the Contractor as a reportable incident, and reported to the investigating authority as indicated if it rises to the level of suspected Abuse, Neglect, or exploitation.*
2.9.6.11.3.2	*The Contractor shall make reasonable efforts to detect unauthorized use of restrictive interventions. The Contractor shall require that events involving the use of restrictive interventions are reported to the Contractor as a reportable incident, and reported to the investigating authority if it rises to the level of Abuse, Neglect or exploitation.*
2.9.7	*Health, Safety and Welfare Monitoring*
2.9.7.1	*Contractor shall comply with all health, safety and welfare monitoring and reporting required by State or federal statute or regulation, or that is otherwise a condition for a HCBS Waiver, including, but not limited to, the following: critical incident reporting regarding Abuse, Neglect, and exploitation; critical incident reporting regarding any incident that has the potential to place an Enrollee, or an Enrollee's services, at risk, but which does not rise to the level of Abuse, Neglect, or exploitation; and performance measures relating to the areas of health, safety and welfare and required for operating and maintaining a HCBS Waiver.*
2.9.7.2	*Contractor shall comply with the Department of Human Services Act (20 ILCS 1305/1-1 et seq.), the Abuse of Adults with Disabilities Intervention Act (20 ILCS 2435/1 et seq.), the Elder Abuse and Neglect Act (320 ILCS 20/1 et seq.), the Abused and Neglected Child Reporting Act (325 ILCS 5/1 et seq.) and any other similar or related applicable federal and State laws.*
Appendix L	*Illinois Department of Human Services, Division of Rehabilitation Services Critical Incident Definitions*
Appendix M	*Illinois Department on Aging Elder Abuse and Neglect Program*
Appendix N	*Illinois Department of Healthcare and Family Services Incident Reporting for Supportive Living Facilities*

Appendix G4. Quality Assurance Assessment Report

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Quality Assurance Assessment Report

Assessment of Illinois Medicaid Managed Care Health Plans' FY 2020 QA/UR/PR Annual Reports

January 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Introduction

As part of its continuous effort to evaluate quality improvement activities of the Illinois Medicaid managed care plans (health plans), the Illinois Department of Healthcare and Family Services (HFS) contracted Health Services Advisory Group, Inc. (HSAG) to assess each health plan's fiscal year (FY) 2020 Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) annual report. The sections and appendices that follow in this report describe HSAG's process for assessing the QA/UR/PR reports, subsequent findings, and recommendations.

Assessment Methodology

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

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

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

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

Findings

General Requirements

HSAG assessed each health plan's FY 2020 QA/UR/PR report for the following general requirements, which were prescribed by HFS in its annual outline document provided to the health plans:

- Does the report address all populations served by the health plan?
- Did the health plan submit all applicable appendices?
- Is the Executive Summary no more than five pages?
- Is the entire report (excluding appendices) no more than 75 pages?
- Does the report cover the correct time period (FY 2020, HEDIS calendar year 2019)?

Review of the health plans' annual reports identified full compliance with the general requirements.

Contract Requirements

HSAG's assessment of annual QA/UR/PR report contract requirements included 23 elements across HealthChoice and MMAI; some elements were applicable to only one contract. Results of each health plan's review are included in Appendix A. Table 1.1 summarizes the findings for all health plans.

Table 1.1 –Summary Scoring Table

Scoring Summary – Contract Elements				
Health Plan	**Number Met**	**Number Not Met**	**Number N/A**	**Performance Score**
Aetna	17	2	4	89% (16/19)
BCBSIL	23	0	0	100% (23/23)
CountyCare	20	0	3	100% (20/20)
Humana	18	1	4	95% (18/19)
IlliniCare	20	0	3	100% (20/20)
Meridian	23	0	0	100% (23/23)
Molina	18	5	0	78% (18/23)
NextLevel	21	0	2	100% (21/21)

Recommendations

General Requirements

Review of the health plans' annual reports identified full compliance with the general requirements.

Contract Requirements

Three health plans, Aetna, Humana, and Molina, had findings related to contract requirements:

- Aetna's report did not include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year. The health plan should ensure that its FY 2021 report includes an analysis of the QI program, as well as information related to FY2021 identified QI program restructuring or changes.
- Aetna included detailed information about their internal process for identification and investigation of Fraud, Waste, and Abuse; however, the health plan has an opportunity to ensure its FY 2021 report includes additional detail to describe the volume and types of cases reviewed, investigation outcomes, successes of the program, and any opportunities for improvement.
- Humana's report did not include a detailed analysis of chronic conditions, the effectiveness of the health plan's program, or the impact to the population served. The section related to chronic conditions reported mainly on efforts related to unable to contact members and did not provide information regarding the health plan's management of members with chronic conditions. The health plan did not reference any appendices to direct the reader to additional information that would provide more detailed analysis. In its FY 2021 report, the health plan should consider including additional information to further inform the reader of its management of chronic conditions, including but not limited to case management, the effectiveness of the program, and the impact to the population served. *This is a continued finding from FY 2019.*
- Molina detailed its FY2020 successes; however, did not provide analysis of barriers or resulting FY 2021 quality improvement (QI) goals. The health plan should ensure that its FY 2021 report includes a narrative description of barriers to accomplishing QI goals, as well as information related to FY2021 goals and initiatives.
- Molina's report provided some information related to the Quality Improvement program but did not provide adequate detail of the program resources, the structure of the Quality Improvement Committee, or level of practitioner participation and leadership involvement. Although some information was included in the Work Plan, the work plan did not include status on the elements and did not provide specificity of the structure. The health plan should ensure that its FY 2021 report reflects the organizational structure to support and accomplish its Quality Improvement program, including any QI program restructuring or changes.
- Molina's report did not include an analysis of cultural competency. The health plan should include a detailed analysis of how the health plan includes cultural competency in services provided to enrollees and/or provide its CLAS analysis in future reports.
- Molina's report included a Quality Improvement Work Plan; however, the work plan did not include analysis or the status of the elements included. The health plan should include an analysis of the progress of its work plan, which would assist the health plan in identifying successes or opportunities for improvement.
- Molina provided detail of the structure of ADA compliance monitoring; however, the narrative did not include efforts to assess ADA compliance, for example, the number of site visits completed to

assess ADA compliance and the results of those visits. The health plan should ensure that its annual report includes information regarding outcomes of the ADA site assessments. The health plan has an opportunity to not only report data but to report their analysis of data to inform themselves and HFS of any trends, patterns, and opportunities for improvement.

Report Observations

HFS instructed HSAG to include observations about the health plans' reports, including use of appendices, ability to expand on the outline provided, and success of "telling the story" of its population.

Health plan-specific observations are included in each health plan's individual report; however, HSAG noted the following similarities among health plans:

- Most health plans have an opportunity to more successfully utilize the data and information in their attached appendices by referencing the information in their narrative report. For instance, appendices related to population assessment would be appropriate to reference in the health plan's sections related to cultural competency and care management.
- Most health plans followed the HFS outline to establish heading and subheadings in their reports, some using the outline verbatim to report the year's activities. However, the health plans have an opportunity to use the outline more as a guide for information that must be included, rather than following the outline for report setup. For instance, behavioral health utilization and PIPs are both required on the outline in different areas but could be reported together to better draw conclusions about the success of PIP efforts on utilization, or to identify additional opportunities for improvement related to behavioral health utilization. Health plans should determine if the annual report would benefit from restructuring to "tell the story," which would allow the health plans to include all outline elements but in a different order set.
- HSAG noted that the health plans' reports indicate different maturity and sophistication levels of providing narrative information, drawing conclusions, or assessing data to determine success of their QI program. Some health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting.

Appendix A. Health Plan-Specific QA/UR/PR Report Assessment Tools

Health Plan Name: Aetna

Date of Review: 1/5/2021

Standard	Status
1. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
2. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
3. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
4. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☐ Not Met ☒
Findings: The health plan report did not include analysis of QI program structure.	
5. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
6. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☐ Not Met ☐ N/A ☒
7. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☒ Not Met ☐ N/A ☐
8. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
9. Does the report include a detailed population profile?	Met ☒ Not Met ☐

Standard	Status
HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7 *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	
10. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8* *MMAI Three-Way 1/1/18, 2.13.5.1.2.8*	Met ☒ Not Met ☐
11. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☐ Not Met ☐ N/A ☒
12. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☐
13. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☐ Not Met ☐ N/A ☒
14. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
15. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
16. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
17. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☐ Not Met ☐ N/A ☒
18. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
19. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
20. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
21. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☐ Not Met ☒

Standard	Status
Findings: Although the health plan detailed their internal process for identification and investigation of Fraud, Waste, and Abuse, the health plan should include additional detail in future reports to describe the volume of cases reviewed, the success of the program, and any opportunities for improvement.	
22. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
23. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☒ Not Met ☐ N/A ☐

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
17	2	4	89% (16/19)

General Requirements	Status
1. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
2. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☐ Not Met ☐ N/A ☒
3. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
4. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
5. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
6. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Standard Element 4: The health plan report did not include analysis of QI program structure.	The health plan should ensure that its FY2021 report includes detailed analysis of the quality improvement structure and program.
Standard Element 21: Although the health plan detailed their internal process for identification and investigation of Fraud, Waste, and Abuse; the plan did not provide the number of investigations completed and results of the FWA investigations.	Although the health plan detailed their internal process for identification and investigation of Fraud, Waste, and Abuse, the health plan should include additional detail in future reports to describe the volume of cases reviewed, the success of the program, and any opportunities for improvement.

Health Plan Name: Blue Cross Blue Shield of Illinois

Date of Review: 1/5/2021

Standard	Status
24. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
25. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
26. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
27. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
28. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
29. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
30. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☒ Not Met ☐ N/A ☐
31. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
32. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
33. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
34. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
35. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☐
36. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
37. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
38. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
39. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
40. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
41. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
42. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
43. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
44. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
45. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
46. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☒ Not Met ☐ N/A ☐

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
23	0	0	100% (23/23)

General Requirements	Status
7. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
8. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
9. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
10. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
11. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
12. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Not Applicable – no findings	Not Applicable – no findings

Health Plan Name: CountyCare

Date of Review: 1/7/2021

Standard	Status
47. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
48. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
49. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
50. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
51. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
52. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
53. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☐ Not Met ☐ N/A ☒
54. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
55. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
56. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
57. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
58. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☒
59. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
60. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
61. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
62. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
63. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
64. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
65. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
66. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
67. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
68. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
69. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☐ Not Met ☐ N/A ☒

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
20	0	3	100% (20/20)

General Requirements	Status
13. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
14. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
15. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
16. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
17. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
18. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**

Health Plan Name: Humana

Date of Review: 1/7/2021

Standard	Status
70. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
71. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
72. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
73. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
74. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
75. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☐ Not Met ☐ N/A ☒
76. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☒ Not Met ☐ N/A ☐
77. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
78. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
79. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
80. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☐ Not Met ☐ N/A ☒
81. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☐
82. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☐ Not Met ☐ N/A ☒
83. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
84. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☐ Not Met ☒
Finding: The report did not include a detailed analysis of chronic conditions, the effectiveness of the health plan's program, or the impact to the population served. **Repeat finding.**	
85. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
86. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☐ Not Met ☐ N/A ☒
87. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
88. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
89. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
90. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
91. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐

Standard	Status
92. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☒ Not Met ☐ N/A ☐

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
18	1	4	95% (18/19)

General Requirements	Status
19. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
20. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☐ Not Met ☐ N/A ☒
21. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
22. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
23. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
24. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Standard Element 15: The report did not include a detailed analysis of chronic conditions, the effectiveness of the health plan's program, or the impact to the population served. The section related to chronic conditions reported mainly on efforts related to completion of the health risk screenings, health risk assessments, and unable to contact members and did not provide information regarding the health plan's management of members with chronic conditions. The health plan did not reference any appendices to direct the reader to additional information that would provide more detailed analysis. **Repeat finding.**	In its FY2021 report, the health plan should consider including additional information to further inform the reader of its management of chronic conditions, including but not limited to case management, the effectiveness of the program, and the impact to the population served.
The health plan had an opportunity to reference appendices in its report. For instance, appendices III and IV included population assessment and population health management. Both appendices would have been appropriate to reference in the health plan's section	The health plan should consider areas of the report that would benefit by referencing the reader to an appendix for additional information.

Findings and Recommendations	
related to analysis of chronic conditions and the impact to the population served. **Repeat finding.**	
The plan utilized the provided QA/UR/PR Annual Report Outline as a template for reporting. The plan followed the prescribed outline under each section of the provided instead of customizing to better convey the overall picture and the impact to the population served. Data/tables were copied and pasted into the sections of the report which resulted in typos and formatting errors. The health plan did not consistently provide narrative information describing the tables or the results. **Repeat finding.**	The health plan is encouraged to correlate information from different outline areas to determine relationships among the data reported, and how those relationships and/or data might affect QI initiatives. The health plan should determine if its report would benefit from restructuring to "tell the story," which would allow the health plan to include all outline elements but in a different order set.

Health Plan Name: IlliniCare

Date of Review: 1/7/2021

Standard	Status
93. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
94. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
95. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
96. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
97. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
98. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
99. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☐ Not Met ☐ N/A ☒
100. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
101. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
102. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
103. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
104. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☐ Not Met ☐ N/A ☒
105. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
106. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
107. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
108. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
109. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
110. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
111. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
112. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
113. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
114. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
115. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☐ Not Met ☐ N/A ☒

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
20	0	3	100% (20/20)

General Requirements	Status
25. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
26. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
27. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
28. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
29. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
30. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
While this did not impact scoring of the element, the health plan had an opportunity to reference appendices in its report. For instance, appendices IX included cultural competency which would have provided a more robust demonstration of cultural competency for the population health and care coordination.	The health plan should consider areas of the report that would benefit by referencing the reader to an appendix for additional information.

Health Plan Name: Meridian

Date of Review: 1/7/2021

Standard	Status
116. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
117. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
118. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
119. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
120. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
121. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
122. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☒ Not Met ☐ N/A ☐
123. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
124. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
125. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
126. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
127. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☐
128. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
129. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
130. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
131. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
132. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
133. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
134. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
135. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
136. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
137. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
138. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☒ Not Met ☐ N/A ☐

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
23	0	0	100% (22/23)

General Requirements	Status
31. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
32. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
33. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
34. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
35. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
36. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Not Applicable – no findings	Not Applicable – no findings

Health Plan Name: Molina

Date of Review: 1/25/2021

Standard	Status
139. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☐ Not Met ☒
Finding: The health plan detailed its FY2020 successes; however, did not provide analysis of barriers.	
140. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
141. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
142. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☐ Not Met ☒
Finding: The health plan report did not include a detailed analysis of the QI program structure.	
143. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
144. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
145. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☒ Not Met ☐ N/A ☐
146. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☐ Not Met ☒
Finding: The health plan did not include an analysis of cultural competency.	
147. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐

Standard	Status
148. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8* *MMAI Three-Way 1/1/18, 2.13.5.1.2.8*	Met ☒ Not Met ☐
149. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
150. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☒ Not Met ☐ N/A ☐
151. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
152. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☐ Not Met ☒
Finding: The health plan submitted its work plan; however, the work plan did not include analysis or the status of the elements included.	
153. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
154. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
155. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
156. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
157. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
158. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
159. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
160. Does the report include a detailed analysis of delegation?	Met ☒ Not Met ☐

Standard	Status
HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20 *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	
161. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☐ Not Met ☒ N/A ☐
Finding: The health plan report did not include ADA monitoring activities conducted, analysis, substantive activity or trends identified for FY2020.	

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
18	5	0	78% (18/23)

General Requirements	Status
37. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
38. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
39. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
40. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
41. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
42. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Standard Element 1: The health plan detailed its FY2020 successes; however, did not provide analysis of barriers or resulting FY 2021 quality improvement (QI) goals.	The health plan should ensure that its annual report includes a narrative description of barriers to accomplishing QI goals.
Standard Element 4: The health plan provided some information related to the Quality Improvement program but did not provide adequate detail of the program resources, the structure of the Quality Improvement Committee, or level of practitioner participation and leadership involvement. Although some information is included in the Work Plan, the work plan does not include status on the elements and does not provide specificity of the structure.	The health plan should ensure that its annual report reflects the organizational structure to support and accomplish its Quality Improvement program, including any QI program restructuring or changes.
Standard Element 8: The health plan did not include a detailed analysis of cultural competency.	The health plan should include a detailed analysis of how the health plan includes cultural competency in

Findings and Recommendations	
	services provided to enrollees and/or provide its CLAS analysis in future reports.
Standard 14: The health plan submitted its work plan; however, the work plan did not include analysis or the status of the elements included.	The health plan should include an analysis of the progress of its work plan, which would assist the health plan in identifying successes or opportunities for improvement.
Standard 23: The health plan provided detail of the structure of ADA compliance monitoring; however, the narrative did not include efforts to assess ADA compliance, for example, the number of site visits completed to assess ADA compliance and the results of those visits (*ADA: Americans with Disabilities Act*).	The health plan should ensure that its annual report includes information regarding outcomes of the ADA site assessments. The health plan has an opportunity to not only report data but to report their analysis of data to inform themselves and HFS of any trends, patterns, and opportunities for improvement.

Health Plan Name: NextLevel

Date of Review: 1/6/2021

Standard	Status
162. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2*	Met ☒ Not Met ☐
163. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1* *MMAI Three-Way 1/1/18, 2.13.5.1.2.1*	Met ☒ Not Met ☐
164. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2* *MMAI Three-Way 1/1/18, 2.13.5.1.2.2*	Met ☒ Not Met ☐
165. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6* *MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*	Met ☒ Not Met ☐
166. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3* *MMAI Three-Way 1/1/18, 2.13.5.1.2.3*	Met ☒ Not Met ☐
167. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*	Met ☒ Not Met ☐ N/A ☐
168. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*	Met ☐ Not Met ☐ N/A ☒
169. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5* *MMAI Three-Way 1/1/18, 2.13.5.1.2.5*	Met ☒ Not Met ☐
170. Does the report include a detailed population profile? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7* *MMAI Three-Way 1/1/18, 2.13.5.1.2.7*	Met ☒ Not Met ☐
171. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8*	Met ☒ Not Met ☐

Standard	Status
MMAI Three-Way 1/1/18, 2.13.5.1.2.8	
172. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*	Met ☒ Not Met ☐ N/A ☐
173. Does the report include a detailed analysis of findings on initiatives and quality reviews? *MMAI Three-Way 1/1/18, 2.13.5.1.2.9*	Met ☐ Not Met ☐ N/A ☒
174. Does the report include a detailed summary of monitoring conducted pertaining to Attachment XI, including issues or barriers addressed or pending remediation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.11*	Met ☒ Not Met ☐ N/A ☐
175. Does the report include a detailed analysis of the comprehensive quality improvement work plans? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.12* *MMAI Three-Way 1/1/18, 2.13.5.1.2.11*	Met ☒ Not Met ☐
176. Does the report include a detailed analysis of Chronic Health Conditions? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.13* *MMAI Three-Way 1/1/18, 2.13.5.1.2.12*	Met ☒ Not Met ☐
177. Does the report include a detailed analysis of Behavioral Health (includes mental health and substance use services)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.14* *MMAI Three-Way 1/1/18, 2.13.5.1.2.13*	Met ☒ Not Met ☐
178. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*	Met ☒ Not Met ☐ N/A ☐
179. Does the report include a detailed discussion of health education programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.16* *MMAI Three-Way 1/1/18, 2.13.5.1.2.14*	Met ☒ Not Met ☐
180. Does the report include a detailed analysis of member satisfaction? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.17* *MMAI Three-Way 1/1/18, 2.13.5.1.2.15*	Met ☒ Not Met ☐
181. Does the report include a detailed analysis of enrollee safety? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.18* *MMAI Three-Way 1/1/18, 2.13.5.1.2.16*	Met ☒ Not Met ☐
182. Does the report include a detailed analysis of the Fraud, Waste, and Abuse program? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.6 and 1.1.3.7.19* *MMAI Three-Way 1/1/18, 2.13.1.6, 2.13.5.1.2.6, 2.13.5.1.2.17*	Met ☒ Not Met ☐
183. Does the report include a detailed analysis of delegation? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.20* *MMAI Three-Way 1/1/18, 2.13.5.1.2.18*	Met ☒ Not Met ☐
184. Does the report include a detailed analysis of ADA compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*	Met ☒ Not Met ☐ N/A ☐

Scoring Summary – Outline Elements			
Number Met	Number Not Met	Number N/A	Performance Score
21	0	2	100% (21/21)

General Requirements	Status
43. Does the report address all populations served by the health plan?	Met ☒ Not Met ☐
44. Does the report address 1915(b) waiver populations, MLTSS and SNC, if applicable? *HealthChoice only*	Met ☒ Not Met ☐ N/A ☐
45. Did the health plan submit all applicable appendices?	Met ☒ Not Met ☐
46. Is the Executive Summary no more than five pages?	Met ☒ Not Met ☐
47. Is the entire report (excluding appendices) no more than 75 pages?	Met ☒ Not Met ☐
48. Does the report cover the correct time period (SFY2020, HEDIS CY2019)	Met ☒ Not Met ☐

Findings and Recommendations	
Finding	**Recommendation**
Not Applicable – no findings	Not Applicable – no findings