





Department of Healthcare & Family Services
HealthChoice Illinois
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EXTERNAL QUALITY REVIEW ANNUAL REPORT

State Fiscal Years 2020-2021
(July 1, 2020-June 30, 2021)

Illinois Department of Healthcare
and Family Services
Division of Medical Programs

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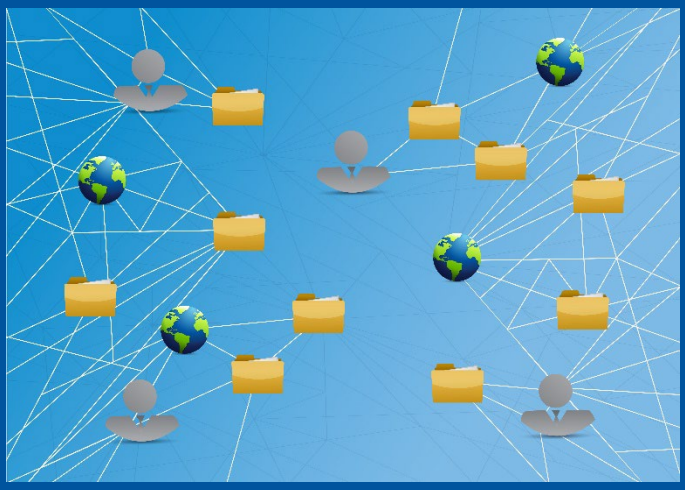
1. Executive Summary

Overview

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

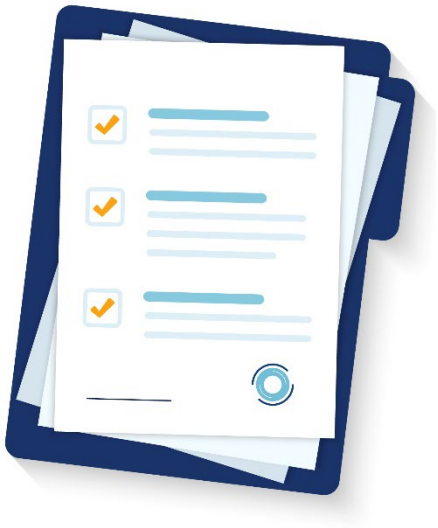


Purpose of This Report

The Centers for Medicare & Medicaid Services (CMS) regulates requirements and procedures for the EQRO. This state fiscal year (SFY) 2021 External Quality Review (EQR) Technical Report focuses on federally mandated EQR activities that HSAG performed from July 1, 2020, to June 30, 2021. See the federal requirements for this report in Appendix A1.

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 2021 are described in Appendix A1. This report includes methodologically appropriate, comparative information to provide an assessment of each health plans' strengths and opportunities for improvement 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 A2, this report includes 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.



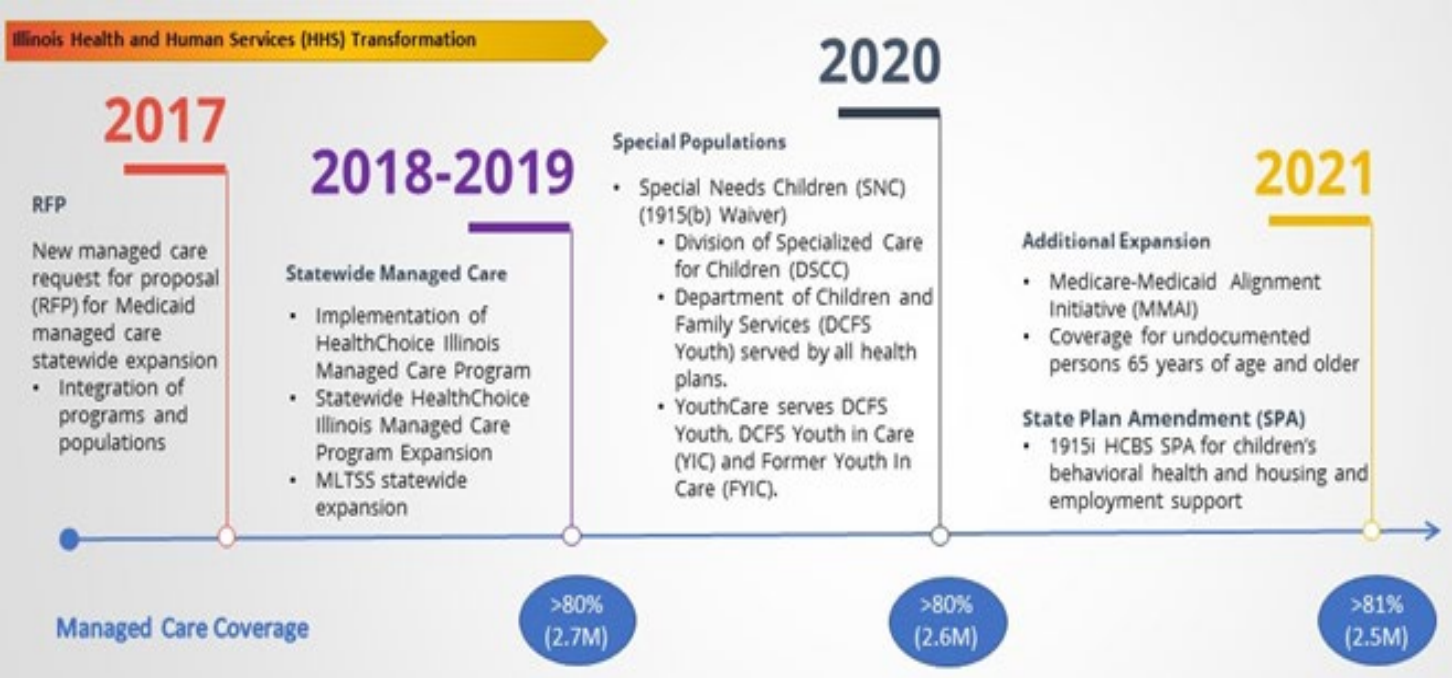
Illinois Medicaid Overview

Illinois Medicaid Expansion

As shown in Figure 1-1 below, HFS implemented both the Illinois Medicaid reform legislation (P.A. 096-1501) and the federal Patient Protection and Affordable Care Act (Pub. L. 111-148). In 2018, HFS expanded its managed care program to cover all counties with the statewide launch of the HealthChoice Illinois Managed Care Program (HealthChoice Illinois) to serve approximately 2.6 million residents. The full spectrum of Medicaid covered services is provided through HealthChoice Illinois.

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 A1.

Figure 1-1—Illinois Medicaid Expansion



Impact of COVID-19 Pandemic

Medicaid Managed Care Health Plans (Health Plans)

HealthChoice

Originally, HFS contracted with six health plans to provide healthcare services to HealthChoice Illinois beneficiaries. In July 2020, NextLevel Health Partners, LLC, dissolved and the health plan's membership was acquired by MeridianHealth (whose parent company is Centene). In 2021, IlliniCare Health Plan was acquired by and rebranded as Aetna Better Health of Illinois (Aetna). Therefore, HealthChoice Illinois is now served by five health plans. Four of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only, as shown in Table 1-1 below.

Table 1-1—HealthChoice Illinois Health Plans for SFY 2021

Health Plan Name	Abbreviation
Aetna Better Health of Illinois (formerly known as IlliniCare Health Plan)	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

In addition, HFS announced that the DCFS population transitioned to the new YouthCare program on September 1, 2020. The DCFS Youth in Care are automatically enrolled in the YouthCare health plan, a specialized HealthChoice Illinois Health Plan for DCFS Youth in Care. Working with the youth's caseworker, YouthCare is designed to improve access to care through active coordination and a more robust provider network. With YouthCare, DCFS Youth in Care receive additional benefits, such as care coordination for behavioral health (BH) needs, including trauma-informed care, and a specialized program for adoptive families, including an adoption-competent network of therapists to support the different phases of adoption and child development.

Medicare-Medicaid Alignment Initiative

HFS contracted with six health plans to administer the Illinois Medicare-Medicaid Alignment Initiative (MMAI), a demonstration designed to improve healthcare for dually eligible beneficiaries in Illinois. Jointly administered by CMS and HFS, MMAI allows eligible beneficiaries in Illinois to receive their Medicare Parts A and B benefits, Medicare Part D benefits, and Medicaid benefits from a single Medicare-Medicaid Plan. Table 1-2 displays the MMAI health plans. Note that subsequent to Centene's acquisition of WellCare and the Meridian subsidiary, IlliniCare's MMAI product was rebranded to MeridianTotal.

Table 1-2—MMAI Health Plans for SFY 2021

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
Humana Health Plan, Inc.	Humana
MeridianComplete	Meridian
MeridianTotal (previously IlliniCare Health Plan)	MeridianTotal
Molina Healthcare of Illinois	Molina

Quality Strategy

In 2021, in accordance with 42 CFR §438.200 et seq., HFS developed a transformative, person-centered, integrated, equitable Comprehensive Medical Programs Quality Strategy (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy included 12 quality framework goals as shown in Figure 1-2.[1-1]

Figure 1-2—Quality Framework Goals

Better Care

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

Healthy People/Healthy Communities

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

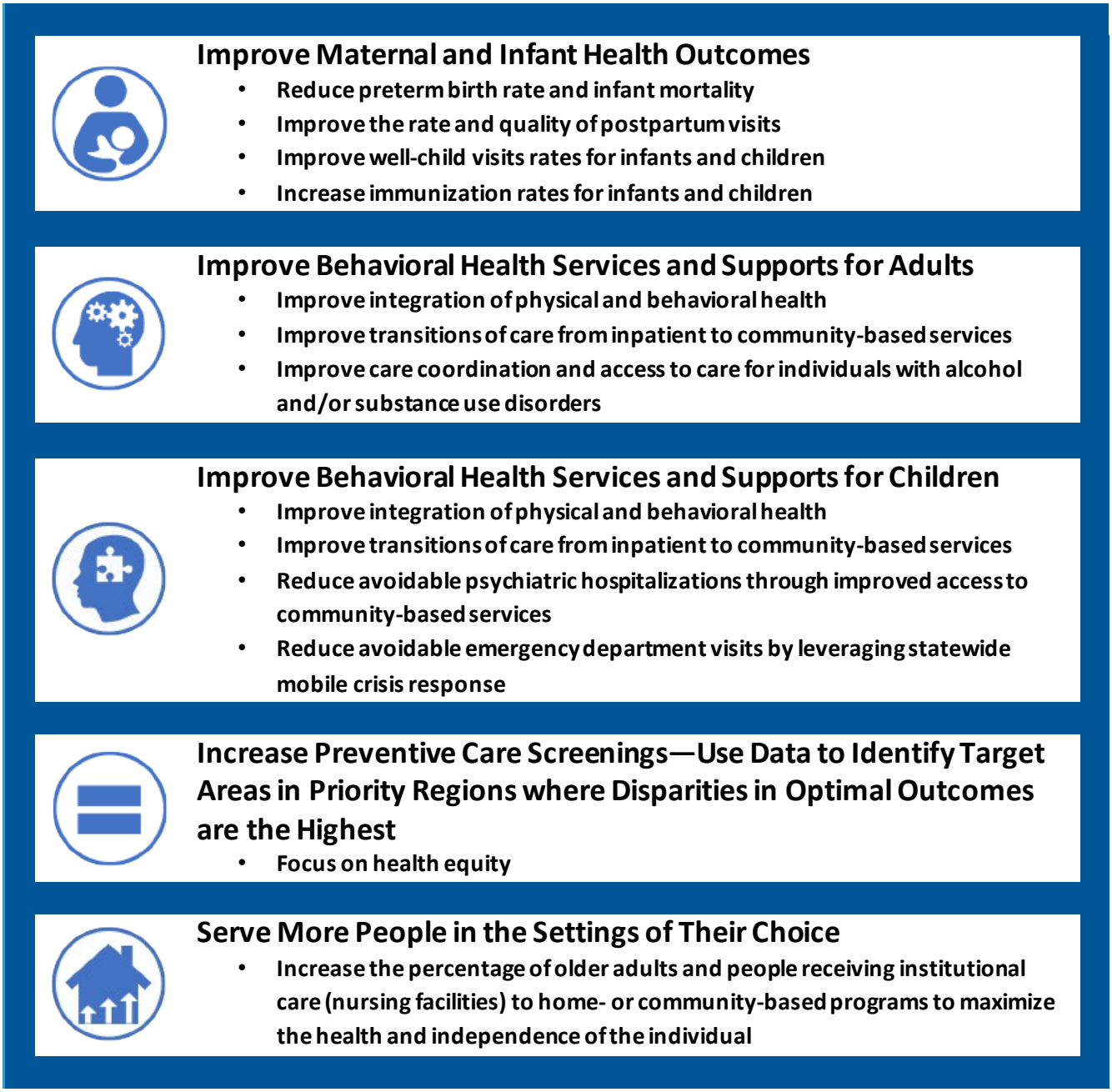
Affordable Care

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

[1-1] Illinois Department of Healthcare & Family Services. 2021 Comprehensive Medical Programs Quality Strategy. Available at: https://www2.illinois.gov/hfs/SiteCollectionDocuments/IL20212024ComprehensiveMedicalProgramsQualityStrategyD1.pdf. Accessed on: Jan 25, 2022.

The Quality Strategy identified five pillars of improvement inclusive of the populations served by Medicaid, including women and infant health, consumers with behavioral health needs, consumers with chronic conditions, and healthy children and adults with a central focus on health equity. Vision for improvement program goals were identified for each pillar, as shown in Figure 1-3. This report provides a review of health plan performance in comparison to the Quality Strategy goals.

Figure 1-3—Vision for Improvement Program Goals[1-2]



[1-2] Ibid.

Aggregating and Analyzing Statewide Data

42 CFR §438.364(a)(1) requires this technical report to include a description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of care furnished by the health plans. HSAG follows a three-step process to aggregate and analyze data conducted from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of care furnished by each managed care health plan (health plan), as well as the program overall. First, HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and opportunities for improvement in each domain of quality, timeliness, and access. Second, from the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and draws conclusions. Lastly, HSAG identifies any patterns and commonalities that exist across the program to draw overall conclusions about the quality, timeliness, and accessibility of care for the program. Detailed information about each activity's methodology is provided in the appendices of this report. For a detailed, comprehensive discussion of the strengths, opportunities for improvement, conclusions, and recommendations for each health plan, please refer to the results of each activity in Sections 2 through 7 of this report, as well as in Appendix A3 for health plan-specific analyses.

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

Performance Domains

Results are presented to demonstrate the overall strengths and opportunities for improvement regarding the quality, timeliness, and accessibility of the care provided by the health plans serving Illinois' Medicaid beneficiaries. Descriptions of the three performance domains can be found in Appendix A1.

Scope of External Quality Review (EQR) Activities

HSAG used the results of mandatory and optional EQR activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by CMS.[1-3] The purpose of these activities, in general, is to improve states' ability to oversee and manage plans they contract with for services, and help health plans improve their performance with respect to quality of, timeliness of, and access to care. Effective implementation of the EQR-related activities will facilitate state efforts to purchase high-value care and to achieve higher-

[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 25, 2022.

performing healthcare delivery systems for their Medicaid and Children's Health Insurance Program (CHIP) members. For the SFY 2021 assessment, HSAG used findings from the mandatory EQR activities displayed in Table 1-3 below and the optional activities described in sections 6 and 7 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each health plan.

Table 1-3—EQR Mandatory Activities

Activity	Description	CMS Protocol
Mandatory Activities		
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a health plan used sound methodology in its design, implementation, analysis, and reporting.	**Protocol 1.** Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	This activity assesses whether the performance measures (PMs) calculated by a health plan are accurate based on the measure specifications and State reporting requirements.	**Protocol 2.** Validation of Performance Measures
Compliance With Standards	This activity determines the extent to which a Medicaid and CHIP health plan is in compliance with federal standards and associated state-specific requirements, when applicable.	**Protocol 3.** Review of Compliance With Medicaid and CHIP Managed Care Regulations
Validation of Network Adequacy*	CMS' network adequacy validation (NAV) protocol is currently reserved. See Section 5 for more information about HFS' network adequacy activities.	**Protocol 4.** Validation of Network Adequacy

* This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol.

Performance Snapshot

Table 1-4 and Table 1-5 provide a high-level snapshot of statewide performance for Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] measures, compliance monitoring, PIPs, and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-5] results for SFY 2021. The HEDIS results represent the HFS priority measures (listed in Appendix A1), and percentiles refer to national Medicaid percentiles. Additional details about these results can be found in subsequent sections of this report.

[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 1-4—Performance Snapshot SFY 2021

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	55 Quality Measure Indicator Rates[i]	31 Timeliness Measure Indicator Rates[ii]	33 Access Measure Indicator Rates[iii]
Strengths 	HEDIS	**90th Percentile and Above** • 1 of 55 measure rates (1.82%) ○ *Follow-Up After Emergency Department Visit for Mental Illness (FUM)—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 7 of 55 measure rates (12.73%) ○ *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* ○ *Statin Therapy for Patients With Diabetes—Received Statin Therapy* ○ *FUM—7-Day Follow-Up—Ages 18–64, Ages 65+; 30-Day Follow-Up—Ages 6–17, Ages 65+* ○ *Follow-Up After High Intensity Care for Substance Abuse Disorder (FUI)—7-Day Follow-Up—Ages 65+* **Between the 50th and 74th Percentiles** • 16 of 55 measure rates (29.10%)	**90th Percentile and Above** • 1 of 31 measure rates (3.23%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 5 of 31 measure rates (16.13%) ○ *FUM—7-Day Follow-Up—Ages 18–64, Ages 65+; 30-Day Follow-Up—Ages 6–17, Ages 65+* ○ *FUI—7-Day Follow-Up—Ages 65+* **Between the 50th and 74th Percentiles** • 12 of 31 measure rates (38.71%)	**90th Percentile and Above** • 1 of 33 measure rates (3.03%) ○ *FUM—7-Day Follow-Up—Ages 6–17* **Between the 75th and 89th Percentiles** • 5 of 33 measure rates (15.15%) ○ *FUM—7-Day Follow-Up—Ages 18–64, Ages 65+; 30-Day Follow-Up—Ages 6–17, Ages 65+* ○ *FUI—7-Day Follow-Up—Ages 65+* **Between the 50th and 74th Percentiles** • 12 of 33 measure rates (36.36%)
	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 84% and 100%.		
	PIPs	The health plans progressed to reporting PIP outcomes and submitted Module 4 (testing and evaluating interventions) and Module 5 (results) for two mandatory PIPs, *Follow-Up After Hospitalization for Mental Illness* and *Transitions of Care—Patient Engagement After Inpatient Discharge.*		
	CAHPS	• Child aggregate results for *Rating of Health Plan* showed statistically significant improvement. • The statewide program aggregate results (for Illinois Medicaid and All Kids combined) showed statistically significant improvement for *Customer Service.*	Adult aggregate results for *Getting Needed Care* showed statistically significant improvement.	

Table 1-5—Performance Snapshot SFY 2020

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
	HEDIS	55 Quality Measures Rates[i]	31 Timeliness Measures Rates[ii]	33 Access Measures Rates[iii]
Opportunities for Improvement 	**HEDIS**	**Below 25th Percentile** • 15 of 55 measure rates (27.27%) ○ *Childhood Immunization Status (CIS)—Combination 3* and *Combination 10* ○ *Comprehensive Diabetes Care—HbA1c Control (<8.0%), HbA1c Poor Control (>9.0%),* and *Blood Pressure Control (<140/90 mm Hg)* ○ *Controlling High Blood Pressure* ○ *FUI—7-Day Follow-Up—Ages 13–17* ○ *Follow-Up After Hospitalization for Mental Illness (FUH —7-Day Follow-Up—Ages 18–64; 30-Day Follow-Up—Ages 18–64, Ages 65+* ○ *Pharmacotherapy for Opioid Use Disorder—Ages 65+* and *Total* ○ *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* **Between the 25th and 50th Percentiles** • 16 of 55 measure rates (29.10%)	**Below 25th Percentile** • 6 of 31 measure rates (19.35%) ○ *FUI—7-Day Follow-Up—Ages 13–17* ○ *FUH—7-Day Follow-Up—Ages 18–64; 30-Day Follow-Up—Ages 18–64, Ages 65+* ○ *Pharmacotherapy for Opioid Use Disorder—Ages 65+* and *Total* **Between the 25th and 50th Percentiles** • 7 of 31 measure rates (22.58%)	**Below 25th Percentile** • 6 of 33 measure rates (18.18%) ○ *FUI—7-Day Follow-Up—Ages 13–17* ○ *FUH—7-Day Follow-Up—Ages 18–64; 30-Day Follow-Up—Ages 18–64, Ages 65+* ○ *Pharmacotherapy for Opioid Use Disorder—Ages 65+ and Total* **Between the 25th and 50th Percentiles** • 9 of 33 measure rates (27.27%)
	Compliance	A Compliance Review for a subset of standards for HealthChoice Illinois identified opportunities for improvement in the provider agreement file review for four of the five health plans included in the review. A Compliance Review for MMAI identified opportunities for improvement for five of the six health plans related to provider directory requirements, and all six health plans had opportunities for improvement in ensuring oversight of delegates.		

	Indicators of Performance	Overall Domain Performance		
		Quality	Timeliness	Access
Opportunities for Improvement 	PIPs	The validation results show that all the health plans' PIPs received levels of *low confidence*. PIPs receive a level of *low confidence* when the PIP (1) was methodologically sound, but the SMART Aim goal was not achieved; or (2) the SMART Aim goal was achieved, but the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.		
	CAHPS	**< 25th Percentile** Adult Aggregate Results: • *How Well Doctors Communicate* • *Customer Service* Child Aggregate Results: • *How Well Doctors Communicate* • *Customer Service* • *Rating of Health Plan* **At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Rating of Personal Doctor* • *Rating of Specialist Seen Most Often* • *Rating of Health Plan* Child Aggregate Results: • *Rating of Specialist Seen Most Often*	**At or Between 25th and 49th Percentiles** Adult Aggregate Results: • *Getting Care Quickly* **< 25th Percentile** 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®[1-6] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2020. Refer to Appendix A2 for a list of the performance measure indicators that are included in the quality, timeliness, and access domains. Thirty-three quality measure indicator rates (12 measures) are also included in the timeliness and access domains.

ii. Thirty-one timeliness measure rates were compared to national Medicaid percentiles for HEDIS MY 2020, but please note that all 31 measure rates are also included in the quality and access domains.

iii. Thirty-three access measure rates were compared to national Medicaid percentiles for HEDIS MY 2020, but please note that all 33 measure rates are also included in the quality and timeliness domains.

[1-6] Quality Compass® is a registered trademark of the NCQA.

Program Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from SFY 2021 to comprehensively assess the health plans' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. For each health plan reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the health plan's performance, which can be found in sections 2 through 7 of this report. The overall findings and conclusions for all health plans were also compared and analyzed to develop overarching conclusions and recommendations. Table 1-6 highlights substantive findings and actionable state-specific recommendations, when applicable, for HFS to further promote its Quality Strategy goals and objectives.

Table 1-6—Substantive Findings

	Program Strengths
Strengths	**Quality** • Overall, health plans have effective systems and processes to identify, report, address, and seek to prevent critical incidents (CIs) as determined by quarterly reviews of CI records. • A majority of members who have clinical atherosclerotic cardiovascular disease (ASCVD) received and adhered to statin therapy, which helps reduce cardiovascular disease. • The statewide average and measure rates for four of five HealthChoice health plans ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020; one of the five plans ranked at or above the 90th percentile. • The HealthChoice Statewide average of 95 percent and MMAI Statewide average of 90 percent for compliance review performance indicated that health plans' policies and procedures (P&Ps) are generally compliant with federal standards and the State contract requirements. • Health plans demonstrated increased compliance with case management staffing and training requirements, including qualifications and related experience, caseload assignments, and training. • All HealthChoice health plans were fully compliant with all HEDIS Information System (IS) standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the audit received a *Reportable* designation. • Child experience survey (CAHPS) results showed a statistically significant improvement from last year for *Rating of Health Plan* and *Customer Service*, which indicates that parents/caretakers of child members perceived greater overall experiences with the quality of their child's health plan from 2020 to 2021. • All but one health plan in both HealthChoice and MMAI performed at or above 90 percent in demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.

Program Strengths

Strengths

Access and Timeliness

- HealthChoice Illinois, including MLTSS and MMAI health, contracted with a sufficient number of required provider types within each service region as verified by the analysis and monitoring of the provider networks.
- Members have access to most types of pediatric providers within a reasonable amount of time or distance as validated by the pediatric time/distance analysis.
- Health plans are ensuring members seen in the emergency department with a mental health diagnosis or a principal diagnosis of alcohol or other drug abuse or dependence are receiving timely follow-up care (as indicated by several HEDIS measure indicators across age groups).
- HEDIS performance suggests that a majority of woman who gave birth received timely and adequate access to prenatal and postpartum care.
- The statewide average and measure rates for all five HealthChoice health plans demonstrated a decrease in rates of 10 or more percentage points for the *Ambulatory Care—ED Visits—Total* measure indicator for MY 2020, demonstrating better performance since ED utilization was decreased. This may partly be due to the impact of COVID-19 as members were more likely to utilize outpatient care, including telehealth visits, during the pandemic.
- Experience survey (CAHPS) results showed a statistically significant improvement from last year for *Getting Needed Care*, which indicates that adult members perceived they had a greater overall experience with access to the care they needed from 2020 to 2021.

Program Opportunities for Improvement

Opportunities for Improvement

Quality

- Women are not receiving timely access to mammograms to screen for breast cancer as indicated by a decrease in *Breast Cancer Screening* rates.
- Members are not receiving services needed for proper diabetes management as indicated by low rates for *HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators.
- Members with hypertension are not adequately controlling their blood pressure as indicated by low rates for the *Controlling High Blood Pressure* measure.
- The statewide average and rates for four of five health plans decreased for the *Childhood Immunization Status—Combination 3* measure indicator for MY 2020, suggesting that children were not receiving these immunizations, which are a critical aspect of preventable care for children.
- There was an overall decrease in rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, indicating children and adolescents are not receiving counseling and guidance for encouraging healthy lifestyle habits, which can lower the risk of becoming obese and developing related diseases.
- Compliance review results indicated MMAI health plans are not conducting adequate oversight of their delegated subcontractors.
- The health plans demonstrated continued opportunity for improvement related to oversight of Children's Behavioral Health services care management program elements.

Opportunities for Improvement	Program Opportunities for Improvement

Access

- Adult members are not obtaining preventive or ambulatory visits, indicating that acute issues are not being addressed or chronic conditions are not being managed (as demonstrated by decreased rates for *Adults' Access to Preventive/Ambulatory Health Services—Total)*.
- Members may have difficulty locating providers via provider directories, as indicated by overall low scores for the provider directory compliance file review and some health plans' low rates in the provider directory validation study.
- The time/distance study identified regional gaps in access to oral surgery providers and pharmacies.

Access and Timeliness

- Members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness as indicated by overall low rates across all age groups for the *Follow-Up After Hospitalization for Mental Illness (FUH)* measure and levels of *low confidence* validation results across all health plans' *FUH* PIPs.[1-7]
- Parents/caretakers of child members may have difficulty obtaining access to the care or treatment their child needs, as well as difficulty scheduling the care their child needs with a provider or at a facility in a timely manner (as indicated by lower rates in the Child CAHPS measures).
- Adult consumer experience survey results were below the 50th percentile for every measure except one, which indicates that members perceive a lack of access and timeliness of care, as well as an overall lack of quality of care.

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
Quality	Require health plans to conduct a root cause analysis or focus study to determine why members are not receiving breast cancer screenings and services needed to manage diabetes and high blood pressure. • Require health plans to use analysis to implement targeted outreach and/or incentives to those members not receiving services.	**Goal 1:** Improve population health. **Goal 4:** Improve participation in preventive care and screenings.

[1-7] PIPs receive a level of *low confidence* when (1) the PIP was methodologically sound, but the SMART Aim goal was not achieved; or (2) the SMART Aim goal was achieved, but the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.

Domain	Program Recommendations	Quality Strategy Goal
Quality	Require health plans to conduct a root cause analysis or focus study to determine why child members are not receiving immunizations or counseling and guidance for encouraging healthy lifestyle habits. • Require health plans to use analysis to implement targeted outreach and/or incentives to those members not receiving services.	**Goal 1:** Improve population health. **Goal 4:** Improve participation in preventive care and screenings
	Monitor health plan oversight of delegated subcontractors to ensure health plans: • Conduct annual audits and monthly meetings. • Review vendor performance quarterly. • Revise delegation agreements to include all required language. • Ensure completion of required training.	**Goal 6:** Create consumer-centric healthcare delivery system.
	Monitor health plans to validate provision of care management for children receiving behavioral services to: • Establish a joint oversight process to streamline oversight and monitoring of the crisis line provider. • Ensure health plans have mechanisms to exchange assessments, crisis plans, and enrollee contact information with mobile crisis response providers. • Encourage assignment of transition of care staff to collaborate and facilitate communication with hospitals for effective discharge planning.	**Goal 3:** Increase effective coordination of care. **Goal 5:** Promote integration of behavioral and physical healthcare.
Access	Lead a program-wide focus group that includes members of each health plan to identify barriers/facilitators to members accessing preventive or ambulatory visits, including how to increase utilization of telehealth services.	**Goal 2:** Improve access to care. **Goal 4:** Improve participation in preventive care and screenings.
	Conduct biannual audits to improve the accuracy of the health plans' provider directories. Audits should assess if provider website addresses are available to ensure members have access to the provider websites in addition to the health plan provider directory. • Conduct a secret shopper appointment availability survey to evaluate open panels and member access to appointments.	**Goal 6:** Create consumer-centric healthcare delivery system.
	Conduct an in-depth review of time/distance access for oral surgery providers and pharmacies to determine if there is a lack of providers or an inability to contract with providers in the geographic area.	**Goal 2:** Improve access to care.

Domain	Program Recommendations	Quality Strategy Goal and/or Objective
Access & Timeliness	Although PIP results showed that all health plans' rates improved compared to baseline for *Follow-Up After Hospitalization for Mental Illness*, performance remains low. • Health plans should evaluate the impact of COVID-19 and member use of telehealth services to determine best practices or opportunities to improve access that may be reproduceable. • Lead a program-wide focus group that includes members of each health plan and key community stakeholders to identify barriers/facilitators to members accessing follow-up care.	**Goal 5:** Promote integration of behavioral and physical healthcare. **Goal 2:** Improve access to care.
	Lead a program-wide focus group that includes health plan enrollees to address results of child CAHPS experience surveys and identify barriers/facilitators to obtaining access to the care or treatment their child needs, as well as difficulty scheduling the care their child needs with a provider or at a facility in a timely manner.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.
	Lead a program-wide focus group that includes health plan enrollees to address results of adult CAHPS experience surveys and identify barriers/facilitators to perceptions of access and timeliness of care, as well as an overall lack of quality of care.	**Goal 2:** Improve access to care. **Goal 6:** Create consumer-centric healthcare delivery system.

2. Performance Measures

Overview

HSAG validates performance measures for each health plan to assess the accuracy of performance measures reported by the health plans, determine the extent to which these measures follow HFS' specifications and reporting requirements, and validate the data collection and reporting processes used to calculate the performance measure rates.

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

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

- Access to Care
- Child Health
- Women's and Maternal Health
- Living With Illness
- Adult and Child Behavioral Health

Health Plans

Table 2-1 displays the health plans for which performance measures were reported in SFY 2021.

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

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (Serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

Performance Measure Validation (PMV)

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's MY 2020 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2020, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, which outlines the accepted approach for auditors to use when conducting an Information Systems Capabilities Assessment (ISCA) and an evaluation of compliance with HEDIS specifications for a health plan. HFS selected a specific set of performance measures for HSAG's validation based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. Additional details about the methodology and measure selection for PMV are in Appendix B1.

Results

HSAG conducted a MY 2020 NCQA HEDIS Compliance Audit of the health plans' data collection and reporting processes for the HealthChoice Illinois population. As shown in Table 2-2 HSAG determined all health plans were fully compliant with all HEDIS Information System (IS) standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the audit received an *R* designation.

Table 2-2—MY 2020 NCQA HEDIS Compliance Audit Results for All Health Plans

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

Performance Measure Results

Understanding Results

HEDIS is a nationally recognized set of performance measures used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service.[2-1] 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 NCQA's HEDIS protocols.

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

HFS contracted with five health plans to provide healthcare services to the general HealthChoice Illinois population in SFY 2021. Four of the HealthChoice Illinois health plans serve beneficiaries statewide, and one health plan serves beneficiaries in Cook County only. Of note, IlliniCare Health rebranded and changed its name to Aetna Better Health of Illinois.

In this report, Illinois health plans' performance for required HEDIS measurement year (MY) 2020 measures is compared to NCQA's Quality Compass®[2-2] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2020, when available, which is an indicator of health plan performance on a national level (referred to as "percentiles" throughout this section of the report).

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

Due to significant changes in the technical specifications for some measures for HEDIS MY 2020 (e.g., *Controlling High Blood Pressure, Comprehensive Diabetes Care—Blood Pressure Control <140/90 mm Hg, Child and Adolescent Well-Care Visits,* and *Well-Child Visits in the First 30 Months of Life—First 15 Months of Life*), NCQA recommends a break in trending between HEDIS MY 2020 and prior years; therefore, prior year rates are not displayed.

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

[2-1] NCQA. HEDIS & Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Nov 17, 2021.
[2-2] Quality Compass® is a registered trademark of the NCQA.

retrospective, HEDIS MY 2019 results are calculated using calendar year (CY) 2019 data and HEDIS MY 2020 results are calculated using CY 2020 data.

Star Ratings

Star ratings represent the following percentile comparisons.

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

COVID-19-Related Considerations

The COVID-19 pandemic impacted patient care during MY 2020. HFS continued to allow health plans to choose the appropriate data collection methodology for reporting measures with Hybrid and Administrative specifications as it has for several years, which allowed health plans to determine the method that yields higher performance rates based on their structure and practices.

To support increased use of telehealth necessitated by the pandemic and to align with telehealth guidance from the Centers for Medicare & Medicaid Services (CMS) and other stakeholders, NCQA updated telehealth guidance in 40 HEDIS measures for MY 2020 and continues to monitor the impact of COVID-19 on health plan business operations, including its potential effect on medical record data collection due to imposed travel bans, limited access to provider offices, quarantines, and risk to health plan staff. Due to the pandemic, healthcare practices deferred elective visits, modified their practices to safely accommodate in-person visits, and increased the use of telemedicine; however, members may not have chosen or had the ability to access care during 2020 due to health concerns and factors relating to the pandemic, which may have impacted health plans' HEDIS performance measure results.

Measures

Table 2-3 identifies the measures in each of the Pillars of Care domains that are presented in this section of the report. HFS selected these measures as priorities for improvement.

Table 2-3—HFS-Required Measures by Pillars of Care Domains for HEDIS MY 2020

Measures
Access to Care
Adults' Access to Preventive/Ambulatory Health Services
Total
Ambulatory Care—Per 1,000 Member Months
Emergency Department (ED) Visits—Total
Outpatient Visits—Total
Child Health
Annual Dental Visit
Total
Child and Adolescent Well-Care Visits
Total
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1 (Meningococcal, Tdap)
Combination 2 (Meningococcal, Tdap, HPV)
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
Body Mass Index (BMI) Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months—Six or More Visits
Well-Child Visits for Age 15 Months–30 Months—Two or More Visits

Measures
Women's Health
Breast Cancer Screening
Breast Cancer Screening
Cervical Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women
Total
Maternal Health
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care
Living With Illness
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Control (<8.0%)
HbA1c Poor Control (>9.0%)
HbA1c Testing
Eye Exam (Retinal) Performed
Blood Pressure Control (<140/90 mm Hg)
Controlling High Blood Pressure
Controlling High Blood Pressure
Statin Therapy for Patients With Diabetes
Received Statin Therapy
Statin Adherence 80%
Adult Behavioral Health
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
7-Day Follow-Up—Ages 18+
30-Day Follow-Up—Ages 18+
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+

Measures
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Follow-Up After High Intensity Care for Substance Use Disorder
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Ages 18–64
7-Day Follow-Up—Ages 65+
30-Day Follow-Up—Ages 18–64
30-Day Follow-Up—Ages 65+
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment
Initiation of AOD Treatment—18+ Years
Engagement of AOD Treatment—18+ Years
Mental Health Utilization
Any Service—Ages 18–64
Any Service—Ages 65+
Any Service—Unknown
Inpatient—Ages 18–64
Inpatient—Ages 65+
Inpatient—Unknown
Intensive Outpatient or Partial Hospitalization—Ages 18–64
Intensive Outpatient or Partial Hospitalization—Ages 65+
Intensive Outpatient or Partial Hospitalization—Unknown
Outpatient—Ages 18–64
Outpatient—Ages 65+
Outpatient—Unknown
ED—Ages 18–64
ED—Ages 65+
ED—Unknown

Measures
Telehealth—Ages 18–64
Telehealth—Ages 65+
Telehealth—Unknown
Pharmacotherapy for Opioid Use Disorder*
Ages 16–64
Ages 65+
Total (Ages 16+)
Child Behavioral Health
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence
7-Day Follow-Up—Ages 13–17
30-Day Follow-Up—Ages 13–17
Follow-Up After Emergency Department Visit for Mental Illness
7-Day Follow-Up—Ages 6–17
30-Day Follow-Up—Ages 6–17
Follow-Up After High Intensity Care for Substance Use Disorder
7-Day Follow-Up—Ages 13–17
30-Day Follow-Up—Ages 13–17
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Ages 6–17
30-Day Follow-Up—Ages 6–17
Initiation and Engagement of AOD Abuse or Dependence Treatment
Initiation of AOD Treatment—Ages 13–17
Engagement of AOD Treatment—Ages 13–17
Mental Health Utilization
Any Service—Ages 0–12
Any Service—Ages 13–17
Inpatient—Ages 0–12
Inpatient—Ages 13–17
Intensive Outpatient or Partial Hospitalization—Ages 0–12
Intensive Outpatient or Partial Hospitalization—Ages 13–17
Outpatient—Ages 0–12

Measures
Outpatient—Ages 13–17
ED—Ages 0–12
ED—Ages 13–17
Telehealth—Ages 0–12
Telehealth—Ages 13–17
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose Testing—Total
Cholesterol Testing—Total
Blood Glucose and Cholesterol Testing—Total

** The total rate for this measure includes ages 16 and older.*

Summary of Performance

Access to Care

Access to and utilization of primary and preventive care is essential for Illinois Medicaid beneficiaries to achieve the best health outcomes. Obtaining good access to care often requires Medicaid beneficiaries to find a trusted primary care physician (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 2-4 presents the HEDIS MY 2019 and HEDIS MY 2020 rates for the measures in the Access to Care domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that member access to care due to restrictions from the pandemic may have impacted health plans' MY 2020 performance.

Table 2-4—Access to Care Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
Total	MY 2019	★★ 77.04%	★★★★ 85.49%	★★ 79.24%	★★ 81.23%	★ 76.02%	★★ 79.78%
	MY 2020	★ 71.43%	★★ 78.20%	★★ 73.63%	★★ 77.32%	★ 71.91%	★★ 75.24%
Ambulatory Care (per 1,000 Member Months)							
*ED Visits—Total**	MY 2019	★★ 65.23	★★★ 54.31	★★ 58.42	★★★ 58.14	★★ 65.03	★★ 59.51
	MY 2020	★ 48.95	★★★ 38.70	★★ 45.73	★★ 41.63	★ 48.03	★★ 43.50
Outpatient Visits—Total	MY 2019	★ 303.56	★★★ 386.38	★ 281.39	★★ 333.33	★ 302.62	★★ 324.10
	MY 2020	★★★ 303.73	★★★★ 381.10	★★ 271.31	★★ 279.90	★ 249.65	★★★ 301.74

^ *The MY 2019 Statewide Averages include rates for six health plans (i.e., BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel), and the MY 2020 Statewide Averages include rates for five health plans (i.e., Aetna, BCBSIL, CountyCare, Meridian, and Molina); therefore, exercise caution when comparing MY 2020 Statewide Averages to historical Statewide Averages.*

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

[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 17, 2021.

Strengths	• The statewide average and measure rates for all five health plans demonstrated a decrease in rates of 10 or more percentage points for the *Ambulatory Care—ED Visits—Total* measure indicator for MY 2020, demonstrating better performance since ED utilization was decreased. This may partly be due to the impact of COVID-19 as members were more likely to use outpatient care, including telehealth visits, during the pandemic. • BCBSIL performed at or above the 75th percentile for the *Ambulatory Care—Outpatient Visits—Total* measure rate for MY 2020, indicating the health plan's members have access to and use primary and preventive care. • The statewide average ranked at or above the 50th percentile for one measure rate in this domain (*Ambulatory Care—Outpatient Visits—Total*), and although performance for that measure decreased from HEDIS MY 2019 to HEDIS MY 2020, this may be partly due to the impact of COVID-19 as members may have been less likely to utilize in-person visits.
Opportunities for	**Opportunity:** Molina performed below the 25th percentile for every reportable measure indicator in this domain for MY 2020. **Why the Opportunity Exists:** Although adults appear to have access to PCPs for preventive and ambulatory services, these members were not consistently using preventive and ambulatory services, which can significantly reduce nonurgent ED visits. **Recommendation:** HSAG recommends that Molina conduct a root cause analysis or focus study to determine why its members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, Molina should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that Molina work with its members to increase the use of telehealth services, when appropriate.
	Opportunity: All five health plans and the statewide average demonstrated a decrease in performance for the *Adults Access to Preventive/Ambulatory Health Services—Total* measure. **Why the Opportunity Exists:** Members are not obtaining preventive or ambulatory visits, indicating that acute issues are not being addressed or chronic conditions are not being managed. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends that health plans work with their members to increase the use of telehealth services, when appropriate.

Child Health

Illinois Medicaid provides healthcare to over 1.4 million children, nearly half of the population HFS serves.[2-4] Appropriate standardized measures of health are needed to improve the overall quality of child healthcare, as the health status of children and adolescents is important for society, helping to determine the health of the next generation.[2-5]

Table 2-5 presents the HEDIS MY 2019 and HEDIS MY 2020 rates for the measures in the Child Health domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable. Please note that due to the pandemic, health plan performance may have been impacted for preventive care measures that require in-person visits.

Table 2-5—Child Health Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Child Health							
Annual Dental Visit							
Annual Dental Visit	MY 2019	★★ 55.93%	★★★★ 69.12%	★★★★ 64.84%	★★ 55.08%	★★ 54.81%	★★★ 59.33%
	MY 2020	★★ 37.45%	★★★★ 53.08%	★★★ 47.50%	★★ 43.38%	★★ 37.02%	★★ 44.68%
Child and Adolescent Well-Care Visits[1]							
Total	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★ 39.53%	★★★ 49.54%	★★ 43.10%	★★★ 47.81%	★★ 42.75%	★★★ 45.79%
Childhood Immunization Status							
Combination 3	MY 2019	★ 61.80%	★ 61.80%	★★★ 73.24%	★ 64.37%	★★ 69.59%	★ 64.30%
	MY 2020	★ 60.83%	★★ 63.50%	★★ 67.64%	★ 56.93%	★ 58.15%	★ 60.33%

[2-4] Illinois Department of Healthcare and Family Services. Annual Report, April 1, 2021. Available at: https://www2.illinois.gov/hfs/SiteCollectionDocuments/2020MedicalAssistanceAnnualReportFinal.pdf. Accessed on: Nov 17, 2021.

[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 17, 2021.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Combination 10	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 25.79%	★★ 32.36%	★★★ 39.66%	★ 31.39%	★ 26.76%	★ 31.57%
Immunizations for Adolescents							
Combination 1 (Meningococcal, Tdap)	MY 2019	★★★ 85.64%	★★★★ 86.86%	★★★ 85.16%	★★★★ 88.32%	★★★ 85.89%	★★★★ 86.63%
	MY 2020	★★★★ 88.08%	★★★★ 88.81%	★★★ 85.16%	★★★★ 88.08%	★★★★★ 89.05%	★★★★ 87.88%
Combination 2 (Meningococcal, Tdap, HPV)	MY 2019	★★ 30.17%	★★★ 39.90%	★★★★ 43.31%	★★ 34.31%	★★★ 38.93%	★★★ 36.86%
	MY 2020	★ 30.66%	★★★ 38.44%	★★★★ 46.72%	★ 30.66%	★★★ 37.23%	★★ 35.44%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile Documentation—Total[2]	MY 2019	★★ 77.62%	★ 61.56%	★★★ 84.74%	★★ 70.98%	★★ 77.62%	★★ 72.11%
	MY 2020	★ 58.15%	★ 66.18%	★★ 70.49%	★ 66.67%	★★★ 76.64%	★ 66.98%
Counseling for Nutrition—Total	MY 2019	★★ 69.34%	★ 50.61%	★★★★ 81.31%	★★ 64.25%	★★ 69.59%	★★ 64.63%
	MY 2020	★ 50.61%	★ 56.93%	★★ 65.63%	★ 59.61%	★★ 65.94%	★ 59.28%
Counseling for Physical Activity—Total	MY 2019	★★★ 66.91%	★ 48.91%	★★★★ 78.19%	★★ 61.61%	★★ 63.26%	★★ 61.85%
	MY 2020	★ 46.72%	★ 49.88%	★★ 61.81%	★ 55.72%	★★ 65.69%	★ 55.04%
Well-Child Visits in the First 30 Months of Life[1]							
Well-Child Visits in the First 15 Months—Six or More Visits	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 55.92%	★ 39.27%	★★★ 55.23%	★★★ 58.24%	★★★ 60.00%	★★ 54.00%
Well-Child Visits for Age 15 Months–30 Months—Two or More Visits	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 63.23%	★★ 68.20%	★ 65.17%	★★ 69.96%	★ 63.38%	★★ 67.49%

^ The MY 2019 Statewide Averages include rates for six health plans (i.e., BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel), and the MY 2020 Statewide Averages include rates for five health plans (i.e., Aetna, BCBSIL, CountyCare, Meridian, and Molina); therefore, exercise caution when comparing MY 2020 Statewide Averages to historical Statewide Averages.

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

[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

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

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the HEDIS MY 2019 rate is not displayed.

Strengths	• The statewide average and measure rates for all four of five health plans ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020; one of the five health plans ranked at or above the 90th percentile.
Opportunities for Improvement	**Opportunity:** The statewide average and rates for four of five health plans decreased for the *Childhood Immunization Status—Combination 3* measure indicator for MY 2020, suggesting that children were not receiving these immunizations, which are a critical aspect of preventable care for children. **Why the Opportunity Exists:** Immunization declines may have coincided with the rapid increase of COVID-19 cases in 2020. Factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including immunizations. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their child members are not receiving all recommended vaccines. Health plans could consider if there are disparities within its populations that contribute to lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Health plans could also consider if a particular vaccine or vaccines within the combination were missed more often than others, contributing to lower rates. Upon identification of a root cause, health plans should implement appropriate interventions to improve the performance related to the *Childhood Immunization Status* measure. **Opportunity:** There was an overall decrease in rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators, suggesting that children and adolescents are not receiving counseling and guidance for encouraging healthy lifestyle habits, which can lower the risk of becoming obese and developing related diseases. **Why the Opportunity Exists:** Children and adolescents are not receiving preventive visits with counseling for weight, nutrition, and physical activity and/or physicians are not documenting BMI and nutrition counseling in patient records. In addition, factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including preventive visits. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their children and adolescent members are not receiving counseling for healthy lifestyle habits and weight assessment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure.

Women's and Maternal Health

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

Table 2-6 presents the HEDIS MY 2019 and HEDIS MY 2020 rates for the measures in the Women's Health and Maternal Health domains for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable.

Table 2-6—Women's Health and Maternal Health Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Women's Health							
Breast Cancer Screening[1]							
Breast Cancer Screening	MY 2019	★★ 53.87%	★★ 57.92%	★★★★ 65.09%	★★★ 59.01%	★ 50.99%	★★ 57.23%
	MY 2020	★★ 48.07%	★★ 53.27%	★★ 53.50%	★★ 52.29%	★★ 49.45%	★★ 51.83%
Cervical Cancer Screening[1]							
Cervical Cancer Screening	MY 2019	★ 51.58%	★★ 55.72%	★★★ 61.22%	★★★ 60.72%	★★ 56.20%	★★ 57.59%
	MY 2020	★ 45.50%	★★ 52.80%	★★★ 60.71%	★★★ 60.10%	★★★ 59.12%	★★ 56.08%
Chlamydia Screening in Women							
Total	MY 2019	★★ 57.35%	★★ 56.82%	★★★★ 67.72%	★★ 55.60%	★★ 58.06%	★★★ 58.39%
	MY 2020	★★ 54.07%	★★★ 54.91%	★★★ 61.61%	★ 45.01%	★★★ 56.10%	★★ 52.63%

[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 17, 2021.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Maternal Health							
Prenatal and Postpartum Care[1]							
Timeliness of Prenatal Care	MY 2019	NC 86.62%	NC 87.83%	NC 93.92%	NC 93.19%	NC 98.05%	NC 91.56%
	MY 2020	★★★ 86.86%	★★★★ 91.00%	★ 77.78%	★★★★ 89.54%	★★ 84.91%	★★★ 87.30%
Postpartum Care	MY 2019	NC 76.16%	NC 81.27%	NC 78.83%	NC 83.45%	NC 76.40%	NC 80.15%
	MY 2020	★★ 75.18%	★★★★ 80.54%	★★★ 76.90%	★★★ 79.08%	★★★ 76.64%	★★★ 78.29%

^ *The MY 2019 Statewide Averages include rates for six health plans (i.e., BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel), and the MY 2020 Statewide Averages include rates for five health plans (i.e., Aetna, BCBSIL, CountyCare, Meridian, and Molina); therefore, exercise caution when comparing MY 2020 Statewide Averages to historical Statewide Averages.*

[1] *Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.*

NC indicates that the measure was not compared to national percentiles, due to NCQA's recommendation for a break in trending for this measure in HEDIS MY 2019.

Strengths

- The statewide average and measure rates for three of five health plans ranked at or above the 50th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator for MY 2020. Four of five health plans and the statewide average met or exceeded the 50th percentile for the *Prenatal Postpartum Care—Postpartum Care* measure indicator. This performance suggests that women are receiving timely and adequate access to prenatal and postpartum care, which prevents pregnancy-related deaths and creates a foundation for the long-term health and well-being of new mothers and their infants.
- Three health plans met or exceeded the 50th percentile in MY 2020 for *Cervical Cancer Screening*, demonstrating the health plans' overall commitment to screening and early detection of cervical pre-cancers, which leads to a significant reduction in this death rate.
- Three health plans met or exceeded the 50th percentile in MY 2020 for *Chlamydia Screening in Women—Total,* indicating a commitment to reducing preventable infections and irreversible complications that can result from not being treated.

Opportunities for Improvement

Opportunity: There was a decrease in *Breast Cancer Screening* rates in MY 2020 for all health plans and the statewide average. Three of five health plans and the statewide average had a decrease of more than 5 percentage points.

Why the Opportunity Exists: Women are not receiving timely access to mammograms to screen for breast cancer. Early detection reduces the risk of dying from breast cancer and can lead to a greater range of treatment options and lower healthcare costs. In addition, factors that may have contributed to the declines during this time include site closures and the temporary suspension of nonurgent services due to COVID-19. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also likely deterred individuals from seeking healthcare services, including preventive screenings.

Recommendation: HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their female members are not receiving timely screenings for breast cancer. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to this measure.

Living With Illness

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

Table 2-7 presents the HEDIS MY 2019 and HEDIS MY 2020 rates for the measures in the Living With Illness domain for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable.

Table 2-7—Living With Illness Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Living With Illness							
Comprehensive Diabetes Care							
HbA1c Control (<8.0%)[2]	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 26.03%	NR	★ 34.79%	★ 35.77%	★★ 39.66%	★ 33.93%
HbA1c Poor Control (>9.0%)[*,2]	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 68.61%	NR	★★★ 38.93%	★ 57.18%	★ 52.55%	★ 54.61%
HbA1c Testing[2]	MY 2019	★★★ 88.56%	★★★★ 91.00%	★★★ 88.81%	★★ 88.08%	★★★ 89.29%	★★★ 89.06%
	MY 2020	★★ 82.24%	★★★★ 86.62%	★★★ 83.94%	★★ 80.29%	★★ 82.73%	★★★ 82.99%
Eye Exam (Retinal) Performed[2]	MY 2019	★★ 58.39%	★★ 55.59%	★★ 55.96%	★★★ 60.88%	★★ 53.28%	★★ 56.68%
	MY 2020	★ 44.53%	★★★ 52.31%	★★★ 52.07%	★★ 45.01%	★ 44.04%	★★ 47.87%

[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 17, 2021.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Blood Pressure Control (<140/90 mm Hg)[1]	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 42.09%	NR	★ 43.80%	★ 47.93%	★★ 57.66%	★ 46.84%
Controlling High Blood Pressure[1]							
Controlling High Blood Pressure	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 36.01%	★ 44.53%	★ 43.80%	★ 43.80%	★★ 51.09%	★ 43.35%
Statin Therapy for Patients With Diabetes[2]							
Received Statin Therapy	MY 2019	★★★★★ 71.50%	★★★★★ 73.48%	★★★★ 68.95%	★★★★★ 70.30%	★★★★ 68.20%	★★★★★ 70.73%
	MY 2020	★★★ 68.80%	★★★★★ 72.41%	★★★★ 70.56%	★★★ 68.51%	★★★ 66.54%	★★★★ 69.71%
Statin Adherence 80%	MY 2019	★★★ 66.38%	★★★ 62.89%	★★★ 63.87%	★★★ 63.84%	★★★ 62.38%	★★★ 63.69%
	MY 2020	★★ 68.44%	★★ 67.02%	★★★★ 73.83%	★★★ 71.72%	★★ 65.17%	★★★ 70.04%

^ The MY 2019 Statewide Averages include rates for six health plans (i.e., BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel), and the MY 2020 Statewide Averages include rates for five health plans (i.e., Aetna, BCBSIL, CountyCare, Meridian, and Molina); therefore, exercise caution when comparing MY 2020 Statewide Averages to historical Statewide Averages.

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

[2] Due to changes in the technical specifications for this measure indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

NC indicates that the measure was not compared to national percentiles, due to NCQA's recommendation for a break in trending for this measure in HEDIS MY 2019.

NR indicates the health plan chose not to report the measure.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the HEDIS MY 2019 rate is not displayed.

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

Strengths

- BCBSIL met or exceeded the 75th percentile for the *Comprehensive Diabetes Care—HbA1c Testing* measure indicator for both MY 2019 and MY 2020, suggesting its members are managing diabetes and avoiding serious complications including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death.
- All five health plans met or exceeded the 50th percentile for the *Statin Therapy for Patients With Diabetes—Received Statin Therapy* measure indicator for MY 2020. The statewide average and two of the five health plans met or exceeded the 75th percentile, with one of these health plans meeting or exceeding the 90th percentile. This performance indicates members are receiving statin therapy, which helps reduce cardiovascular disease.

Opportunities for Improvement	
	Opportunity: Three of four health plans with reportable rates and the statewide average ranked below the 25th percentile for the *HbA1c Control (<8.0%)* and the *Blood Pressure Control (<140/90 mm Hg)* measure indicators for MY 2020. **Why the Opportunity Exists:** This low performance suggests members are not receiving services needed for proper diabetes management. Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations, and premature death. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their members are not receiving timely screenings for the *HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.
	Opportunity: Four of five health plans and the statewide average ranked below the 25th percentile for the *Controlling High Blood Pressure* measure for MY 2020. **Why the Opportunity Exists:** This low performance suggests members with hypertension are not adequately controlling their blood pressure. Left unmanaged, high blood pressure can damage a person's heart and cause health problems, such as heart disease and stroke, if it stays high for a long period of time. **Recommendation:** HSAG recommends that health plans conduct a root cause analysis or focus study to determine if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to this measure.

Adult and Child Behavioral Health

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

Table 2-8 and Table 2-9 present the HEDIS MY 2019 and HEDIS MY 2020 rates for the measures in the Adult and Child Behavioral Health domain for the health plans and the statewide average, which represents the average of all health plans' performance measure rates weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable.

Adult Behavioral Health Results

Table 2-8—Adult Behavioral Health Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence[2]							
7-Day Follow-Up—Ages 18+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 14.91%	★★★ 16.25%	★★ 11.79%	★★★ 15.46%	★★★ 15.24%	★★★ 14.90%
30-Day Follow-Up—Ages 18+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 22.13%	★★★ 23.58%	★★ 17.49%	★★★ 22.53%	★★★ 22.39%	★★★ 21.84%
Follow-Up After Emergency Department Visit for Mental Illness[2]							
7-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★★ 51.17%	★★★★ 46.09%	★★ 33.09%	★★★★ 50.56%	★★★★ 50.55%	★★★★ 48.35%

[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 17, 2021.

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
7-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	NA	NA	NA	★★★★ 43.75%
30-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★★ 60.48%	★★★ 56.69%	★★ 41.91%	★★★★ 61.07%	★★★★ 60.06%	★★★ 58.34%
30-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	NA	NA	NA	★★★★ 56.25%
Follow-Up After High Intensity Care for Substance Use Disorder[2]							
7-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 40.47%	★★★★ 44.22%	★★★ 38.33%	★★★ 37.81%	★★★ 42.13%	★★★ 40.01%
7-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	★★★★ 33.33%	NA	NA	★★★★ 32.94%
30-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 56.91%	★★★ 60.01%	★★ 53.99%	★★★ 55.03%	★★★ 55.51%	★★★ 56.01%
30-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	★★★ 45.45%	NA	NA	★★★ 44.71%
Follow-Up After Hospitalization for Mental Illness[2]							
7-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 24.21%	★ 20.67%	★ 20.05%	★★ 29.78%	★ 24.97%	★ 24.57%
7-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	★★ 18.18%	★★★ 26.67%	NA	★★ 23.21%
30-Day Follow-Up—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 40.25%	★ 37.75%	★ 35.16%	★★ 51.82%	★ 44.32%	★ 42.88%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
30-Day Follow-Up—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	★ 30.30%	★★ 46.67%	NA	★ 38.39%
Initiation and Engagement of AOD Abuse or Dependence Treatment[2]							
Initiation of AOD Treatment—18+ Years	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★ 41.91%	★★ 43.76%	★★★★★ 59.95%	★★ 42.99%	★★ 41.89%	★★★ 45.27%
Engagement of AOD Treatment—18+ Years	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 14.83%	★★★ 14.09%	★★ 12.03%	★★ 12.77%	★★ 11.80%	★★ 13.20%
Mental Health Utilization[1,2]							
Any Service—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 14.26%	NC 12.60%	NC 11.47%	NC 15.03%	NC 14.24%	NC 13.68%
Any Service—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 9.48%	NC 6.90%	NC 8.21%	NC 9.24%	NC 10.50%	NC 8.61%
Any Service—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
Inpatient—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 2.50%	NC 1.93%	NC 1.85%	NC 1.90%	NC 1.94%	NC 2.01%
Inpatient—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 3.90%	NC 1.84%	NC 1.76%	NC 3.27%	NC 6.47%	NC 3.06%
Inpatient—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
Intensive Outpatient or Partial Hospitalization—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.49%	NC 0.46%	NC 0.00%	NC 0.51%	NC 0.68%	NC 0.43%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Intensive Outpatient or Partial Hospitalization—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.06%	NC 0.03%	NC 0.00%	NC 0.08%	NC 0.06%	NC 0.05%
Intensive Outpatient or Partial Hospitalization—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
Outpatient—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 12.51%	NC 10.83%	NC 8.53%	NC 13.40%	NC 11.44%	NC 11.65%
Outpatient—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 5.75%	NC 5.00%	NC 5.63%	NC 6.18%	NC 3.95%	NC 5.46%
Outpatient—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
ED—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.12%	NC 0.03%	NC 0.08%	NC 0.17%	NC 1.06%	NC 0.22%
ED—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.05%	NC 0.01%	NC 0.08%	NC 0.08%	NC 0.21%	NC 0.07%
ED—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
Telehealth—Ages 18–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 3.74%	NC 3.58%	NC 4.80%	NC 3.76%	NC 4.45%	NC 3.96%
Telehealth—Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 1.75%	NC 1.23%	NC 2.54%	NC 1.47%	NC 1.04%	NC 1.62%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Telehealth—Unknown	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	—	—	—	—	—	NA
Pharmacotherapy for Opioid Use Disorder[2]							
Ages 16–64	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★ 26.83%	★★★ 31.53%	★★ 22.86%	★ 19.81%	★ 11.78%	★★ 22.25%
Ages 65+	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★ 29.09%	★★ 28.13%	★ 25.81%	★ 11.90%	NA	★ 23.83%
Total (Ages 16+)	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★ 26.89%	★★★ 31.39%	★★ 22.99%	★ 19.70%	★ 11.69%	★ 22.29%

Child Behavioral Health Results

Table 2-9—Child Behavioral Health Domain Results for HEDIS MY 2019 and HEDIS MY 2020

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence[2]							
7-Day Follow-Up—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★★ 9.78%	★★★ 6.56%	★ 1.72%	★★★ 6.70%	★★★ 8.00%	★★★ 6.79%
30-Day Follow-Up—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 14.13%	★★★ 10.66%	★ 5.17%	★★★ 12.29%	★★ 8.00%	★★★ 10.98%
Follow-Up After Emergency Department Visit for Mental Illness[2]							
7-Day Follow-Up—Ages 6–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★★★ 77.61%	★★★★★ 78.52%	★★★★ 70.48%	★★★★★ 78.92%	★★★★★ 79.14%	★★★★★ 78.00%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
30-Day Follow-Up—Ages 6–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★★ 81.97%	★★★★ 83.27%	★★★ 76.19%	★★★★★ 85.28%	★★★★★ 84.36%	★★★★ 83.51%
Follow-Up After High Intensity Care for Substance Use Disorder[2]							
7-Day Follow-Up—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	NA	NA	NA	★★ 15.15%
30-Day Follow-Up—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NA	NA	NA	NA	NA	★ 18.18%
Follow-Up After Hospitalization for Mental Illness[2]							
7-Day Follow-Up—Ages 6–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 36.94%	★ 40.83%	★★ 49.59%	★★ 47.98%	★★ 48.69%	★★ 44.98%
30-Day Follow-Up—Ages 6–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★ 60.82%	★ 62.96%	★★ 70.95%	★★★ 75.51%	★★★ 76.35%	★★ 70.08%
Initiation and Engagement of AOD Abuse or Dependence Treatment[2]							
Initiation of AOD Treatment—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 49.86%	★★★ 45.57%	★★★★ 56.20%	★★★ 50.66%	★★ 41.89%	★★★ 49.26%
Engagement of AOD Treatment—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	★★★ 13.22%	★★★ 12.87%	★★ 9.12%	★★ 9.89%	★ 5.41%	★★ 10.52%
Mental Health Utilization[1,2]							
Any Service—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 5.32%	NC 4.04%	NC 4.09%	NC 5.49%	NC 5.39%	NC 4.92%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Any Service—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 12.78%	NC 10.70%	NC 10.16%	NC 13.35%	NC 13.73%	NC 12.23%
Inpatient—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.26%	NC 0.16%	NC 0.18%	NC 0.21%	NC 0.21%	NC 0.20%
Inpatient—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 1.75%	NC 1.31%	NC 1.20%	NC 1.56%	NC 1.53%	NC 1.47%
Intensive Outpatient or Partial Hospitalization—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.58%	NC 0.44%	NC 0.00%	NC 0.48%	NC 0.52%	NC 0.41%
Intensive Outpatient or Partial Hospitalization—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 2.54%	NC 2.03%	NC 0.00%	NC 2.42%	NC 2.45%	NC 1.99%
Outpatient—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 5.00%	NC 3.71%	NC 3.36%	NC 5.19%	NC 4.74%	NC 4.51%
Outpatient—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 12.03%	NC 9.88%	NC 8.12%	NC 12.62%	NC 12.26%	NC 11.20%
ED—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.01%	NC 0.00%	NC 0.01%	NC 0.01%	NC 0.13%	NC 0.02%
ED—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.07%	NC 0.01%	NC 0.06%	NC 0.07%	NC 0.72%	NC 0.12%
Telehealth—Ages 0–12	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 0.90%	NC 0.86%	NC 1.46%	NC 0.93%	NC 1.33%	NC 1.04%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average^
Telehealth—Ages 13–17	MY 2019	NC —	NC —	NC —	NC —	NC —	NC —
	MY 2020	NC 2.71%	NC 2.71%	NC 4.26%	NC 2.82%	NC 3.66%	NC 3.08%
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	MY 2019	NC 60.64%	NC 63.38%	NC 60.30%	NC 57.19%	NC 57.39%	NC 59.14%
	MY 2020	★★★ 49.49%	★★★★ 59.73%	★★★★ 55.75%	★★★ 51.78%	★★ 48.15%	★★★ 52.40%
Cholesterol Testing—Total	MY 2019	NC 37.40%	NC 44.73%	NC 41.83%	NC 33.11%	NC 35.77%	NC 37.01%
	MY 2020	★ 25.47%	★★★★ 39.54%	★★★ 36.63%	★★ 29.07%	★ 25.05%	★★ 30.11%
Blood Glucose and Cholesterol Testing—Total	MY 2019	★★★ 36.25%	★★★★ 44.06%	★★★ 39.70%	★★ 32.09%	★★ 32.97%	★★★ 35.74%
	MY 2020	★★ 24.96%	★★★★ 38.81%	★★★ 35.82%	★★ 28.00%	★ 24.18%	★★ 29.24%

^ The MY 2019 Statewide Average rates represent rates for six health plans (i.e., BCBSIL, CountyCare, IlliniCare, Meridian, Molina, and NextLevel), and the MY 2020 Statewide Average rates represent rates for five health plans (i.e., Aetna, BCBSIL, CountyCare, Meridian, and Molina); therefore, exercise caution when comparing MY 2020 Statewide Averages to historical Statewide Averages.

[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 indicator, NCQA recommends that trending between HEDIS MY 2020 and prior years be considered with caution.

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

NA indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.

— Indicates that the health plan was not previously required to report this measure or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the HEDIS MY 2019 rate is not displayed.

Strengths

- In the Child Behavioral Health domain, four of five health plans and the statewide average ranked at or above the 50th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total* measure indicator for MY 2020, with two health plans meeting or exceeding the 75th percentile. Of note, BCBSIL met or exceeded the 75th percentile for all three measure indicators. This demonstrates that children and adolescent members with ongoing antipsychotic medication use are receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood.
- For the *Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Ages 18+* and *30-Day Follow-Up—Ages 18+* measure indicators, four of five health plans and the statewide average met or exceeded the 50th percentile for MY 2020.

Similarly, for the *7-Day Follow-Up—Ages 13–17* and *30-Day Follow-Up—Ages 13–17* measure indicators, several health plans and the statewide average met or exceeded the 50th percentile. This demonstrates that the majority of members who were seen in the ED and classified as having a principal diagnosis of alcohol or other drug abuse or dependence are receiving timely follow-up care. Timely follow-up care for members with substance abuse disorders is associated with a reduction in substance use, future ED use, hospital admissions, and bed stays.

- For the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18–64* measure indicator, four of five health plans and the statewide average met or exceeded the 75th percentile for MY 2020, while four of five health plans and the statewide average met or exceeded the 90th percentile for the *7-Day Follow-Up—Ages 6–17* measure indicator. Four of five health plans and the statewide average also met or exceeded the 75th percentile for the *30-Day Follow-Up—Ages 6–17* measure indicator. This performance demonstrates a commitment to mental health services overall for health plans' members ages 6 to 64 years. This performance demonstrates that health plans are ensuring members seen in the ED with a mental health diagnosis are receiving follow-up visits, resulting in fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.
- All five health plans and the statewide average ranked at or above the 50th percentile for the *Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 18–64* measure indicator, and four of five health plans and the statewide average ranked at or above the 50th percentile for the *30-Day Follow-Up—Ages 18–64* measure indicator, indicating members in this age group are receiving timely follow-up care, which is associated with a reduction in substance use, future ED use, hospital admissions, and bed stays.

Opportunities for Improvement

Opportunity: Overall, measures in this domain demonstrated low performance for member ages 65 and older, including *Follow-Up After Hospitalization for Mental Illness* and *Pharmacotherapy for Opioid Use Disorder*. However, for several measures in this domain, this age group did not have enough members in the eligible population to report a valid rate and therefore was assigned an *NA (Not Applicable)*.

Why the Opportunity Exists: The low performance for the 65 and older age group shows that members in this age group with mental illness are not accessing or receiving follow-up care for mental illness and that members diagnosed with a new opioid use disorder are not accessing or receiving pharmacotherapy treatment, which is used to reduce the intensity of withdrawal symptoms, to manage cravings, and to reduce the likelihood of a lapse or relapse by blocking a drug or addictive behavior's effect. The requirement or recommendation to stay at home and the fear of contracting COVID-19 also

likely deterred individuals in this age group from seeking healthcare services, including mental health and opioid use disorder treatment.

Recommendation: HSAG recommends that health plans conduct a root cause analysis or focus study to determine why their members ages 65 and older with mental health diagnoses are not receiving mental health services or why members with opioid use disorder are not receiving or adhering to pharmacotherapy treatment. Upon identification of a root cause, health plans should implement appropriate interventions to improve performance related to these measures.

Opportunity: The *Follow-Up After Hospitalization for Mental Illness* measure demonstrated overall low performance across all age groups.

Why the Opportunity Exists: The low performance indicates that members hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness.

Recommendations:

- Conduct a root cause analysis to determine why members who were hospitalized for mental illness are not accessing or receiving timely follow-up care for mental illness and establish potential performance improvement strategies and solutions.
- Enhance communication and collaboration with hospitals to improve effectiveness of transitions of care, discharge planning, and handoffs to community settings for members with behavioral health needs.

3. Evaluation of Administrative and Compliance Processes

This section presents a description of the activities HSAG conducted to comply with 42 Code of federal Regulations (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.

HealthChoice Illinois 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 (QAPI) requirements described in 42 CFR §438.330. In state fiscal year (SFY) 2020, 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. The Compliance Review assessed each health plan's compliance with federal standards and the State contract requirements found in the Department of Healthcare and Family Services (HFS) Model Contract 2018-24-001. In SFY 2021, the Compliance Review covered the remaining standards that were not assessed, thereby completing the required comprehensive compliance review once in a three-year period. A full set of standards was also reviewed for the Medicare-Medicaid Alignment Initiative (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 and MMAI enrollees.

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

Standards

The 2021 Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. Many standards include requirements that address elements of accessibility, timeliness, and quality of care; therefore, HSAG grouped the standards into operational domains of access, structure and operations, and measurement and improvement for the Compliance Review. Policies and procedures (P&Ps) related to the standards were reviewed via desk review, virtual interviews were conducted with key operational health plan staff, and two file reviews were 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 Standards and File Reviews 2021

Standards	File Review
Access	
Standard I—Availability of Services	Provider Agreement
Standard II—Assurances of Adequate Capacity and Services	None
Standard V—Credentialing and Recredentialing	None

Standards	File Review
Structure and Operations	
Standard VIII—Enrollee Information/Enrollee Rights	Enrollee Handbook
Standard IX—Confidentiality	None
Standard X—Enrollment and Disenrollment	None
Standard XIII—Fraud, Waste, and Abuse	None
Standard XIV—Health Information Systems	None
Measurement and Improvement	
Standard XVI—Critical Incidents	None
Standard XVII—Practice Guidelines and Required Minimum Standards of Care	None

Health Plans

The Compliance Review was conducted with the six HealthChoice Illinois health plans shown in Table 3-2. Four of the six 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

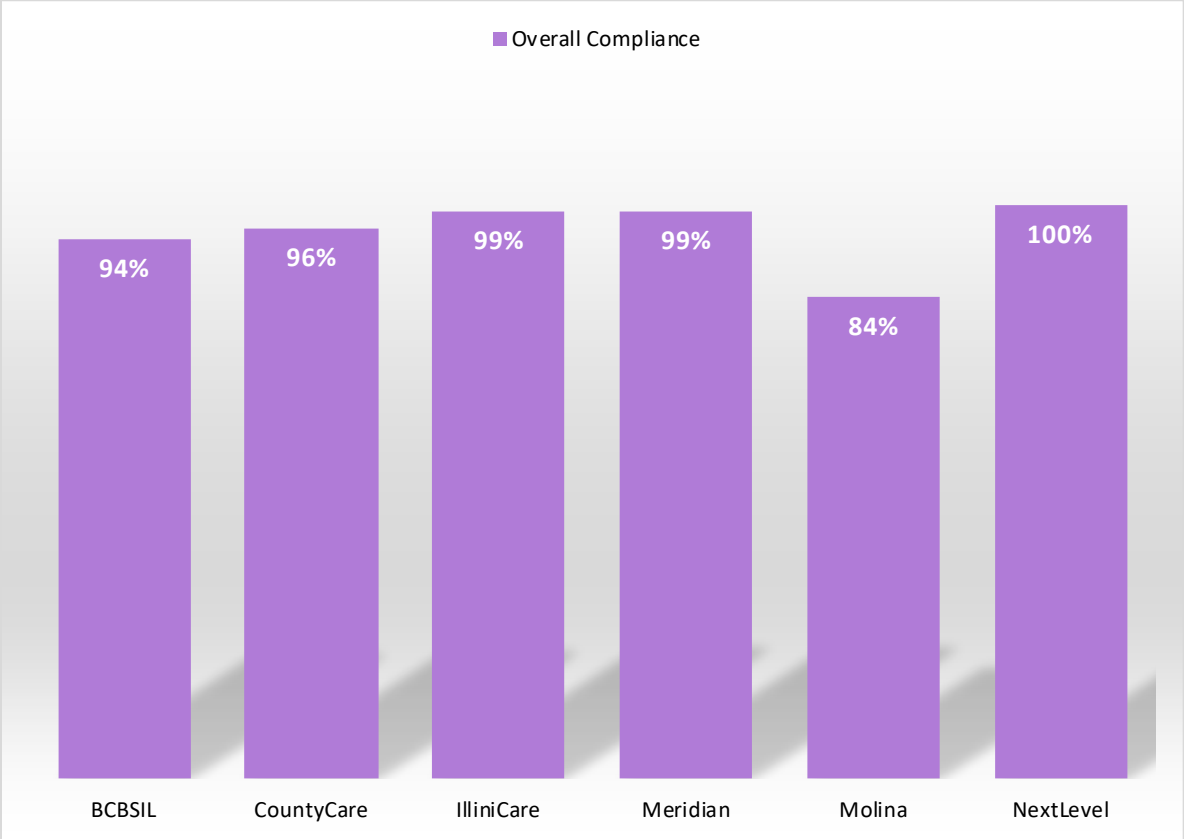
* In 2021, IlliniCare Health Plan rebranded as Aetna Better Health of Illinois (Aetna).

It should be noted that at the time of the 2021 Compliance Review, NextLevel had dissolved and the health plan's membership was acquired by Meridian. Therefore, the scope of NextLevel's 2021 review was limited to a desk review for each of the standards under review.

Initial Compliance With Standards

Figure 3-1 details the overall initial HealthChoice Illinois health plan-specific compliance score for all 10 standards reviewed during the 2021 Compliance Review.

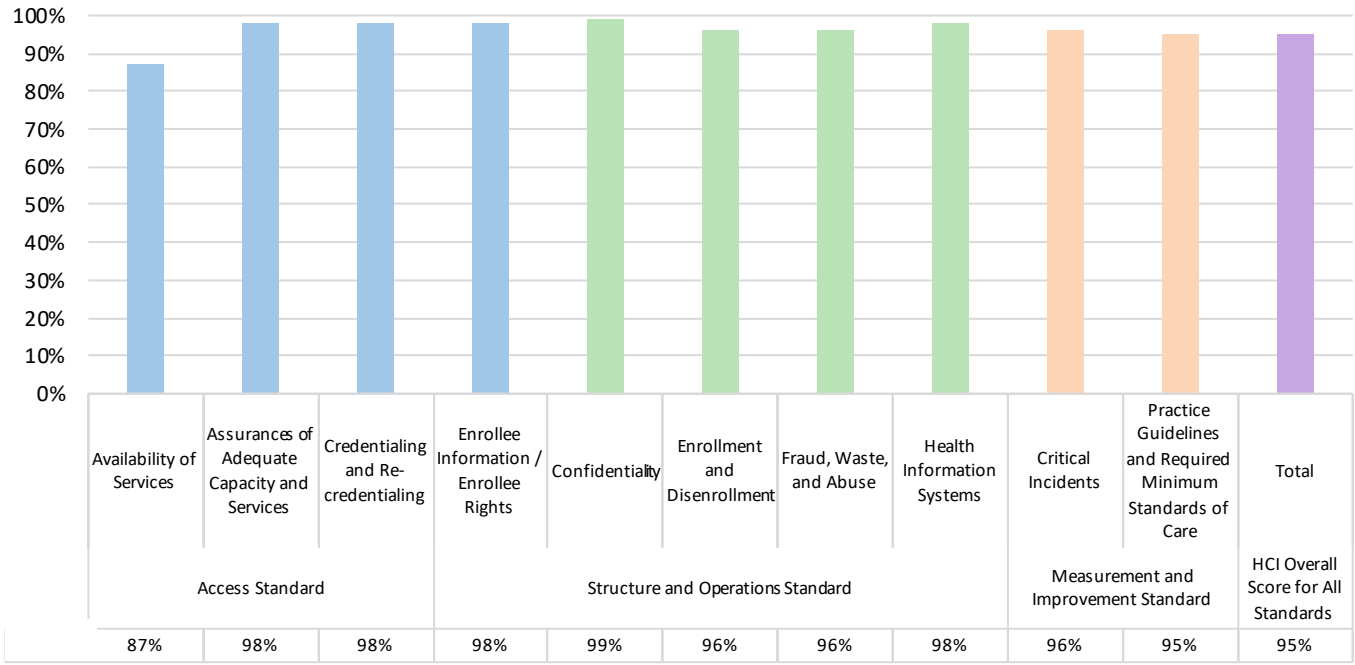
Figure 3-1—Overall Compliance Ratings by Health Plan



As shown in Figure 3-1, all health plans achieved an overall compliance score between 84 percent and 100 percent. Generally, the health plans were compliant with P&Ps as well as file reviews. However, opportunities for improvement were identified for the provider agreement file review for four of the five health plans included in the review.

Figure 3-2 details the overall initial 2021 Compliance Review scores for all HealthChoice Illinois health plans for each standard.

Figure 3-2—Overall HealthChoice Illinois Health Plan Compliance Ratings by Standard

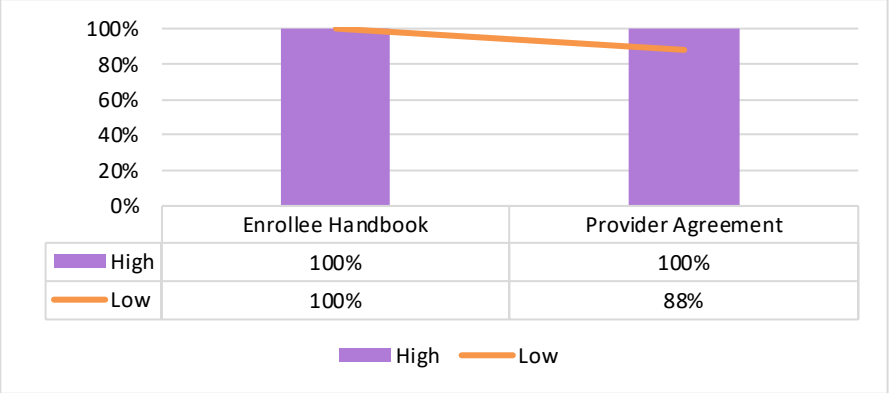


As shown in Figure 3-2, nine of the 10 standards scored at or above 95 percent, and the total score for all standards was 95 percent. The standard identified as needing the most improvement was the access standard Availability of Services. Four of five health plans failed to include all contract requirements in their provider agreements; therefore, health plans were required to revise their provider agreements to comply with all contract requirements.

Initial Compliance With File Reviews

Figure 3-3 displays the initial scores across the HealthChoice Illinois health plans for the enrollee handbook and provider agreement file reviews.

Figure 3-3—HealthChoice Illinois File Review Scores



As shown in Figure 3-3, all health plans complied with the enrollee handbook requirements, and opportunities to improve compliance with contract requirements for the provider agreements were identified for four of the five health plans included in the review.

CBH Services Findings

The Children's Behavioral Health (CBH) Services program requirements were reviewed during the 2020 Compliance Review for the HealthChoice Illinois 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 additional care coordination requirements. The HealthChoice Illinois statewide overall compliance rating for the CBH standard was 70 percent. Opportunities for improvement were identified 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.

As a result of the Compliance Review outcomes, HFS required HSAG to conduct remediation follow-up for the CBH program requirements as part of the 2021 Compliance Review. The 2021 follow-up review included assessment of the health plans' remediation actions, supporting P&Ps and reports, and an interview with health plan staff which confirmed implementation of remediation actions as outlined in the health plans' corrective action plans (CAPs). An overall summary of compliance with remediation actions conducted by the health plans is included below.

- Improved oversight of the state-funded Crisis and Referral Entry Services (CARES) crisis line (Chrysalis) through review of call center reporting to monitor compliance with telephone response

times and timely referral to Mobile Crisis Response (MCR) providers for children requiring mental health crisis services.

- Health plans are working with HFS to establish a joint oversight process of Chrysalis to streamline oversight and monitoring of the crisis line provider.
- Increased collaboration and communication with MCR providers for enrollees who are community stabilized or hospitalized through assignment of a health plan point of contact; and establishing mechanisms for exchange of the Illinois Medicaid-Crisis Assessment Tool (IM-CAT), Illinois Medicaid Comprehensive Assessment of Needs and Strengths (IM+CANS), crisis safety plans, and enrollee contact information.
- Increased collaboration and communication with inpatient psychiatric hospitals to improve participation in discharge planning and transitional services to reduce recidivism and length of stay in psychiatric hospitals while increasing post-discharge engagement in community-based treatment and support.
- Assigned transition of care staff/behavioral health advocates to hospitals to establish collaborative relationships and facilitate effective communication for discharge planning through a single point of contact.
- Established meetings of the Family Leadership Council (FLC) to engage enrollees and their families to provide a forum to discuss issues encountered in navigating and accessing care within the children's mental health system.

Overall Health Plan-Specific Strengths, Opportunities for Improvement, and Recommendations

Many standards include requirements that address elements of accessibility, timeliness, and quality of care; therefore, HSAG grouped the standards into operational domains of access, structure and operations, and measurement and improvement for the Compliance Review.

BCBSIL

In the access domain, BCBSIL achieved an overall score of 100 percent and a score of 94 percent for the provider agreement file review. Opportunities were identified to include all required language in provider agreements.

Review of structure and operations requirements identified 95 percent overall compliance for the five standards reviewed and 100 percent compliance with enrollee handbook file review requirements. Opportunities were identified for BCBSIL to improve compliance with requirements for specific P&Ps.

In the measurement and improvement domain, BCBSIL failed to meet requirements for nine practice guidelines for minimum standards of care. The health plan's overall score for this domain was 85 percent.

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

- Revise provider agreements to include the required time frame for notifying providers of modifications regarding payments, procedures, and documents.
- Revise P&Ps to include requirements regarding safeguards for confidential information.
- Revise policy to include all covered services for child behavioral health and requirements regarding termination of coverage during disenrollment.
- Revise policy to include the correct time period for notification of overpayment.
- Develop or revise practice guidelines to meet requirements for minimum standards of care.

CountyCare

CountyCare achieved an overall score of 90 percent for the access domain and 88 percent compliance for the provider agreement file review. Opportunities were identified to improve compliance with provider agreements and evaluating provider appointment access and after-hours accessibility.

Review of structure and operations requirements identified that CountyCare achieved 100 percent compliance.

In the measurement and improvement domain, CountyCare achieved an overall score of 97 percent. Opportunities were identified to improve compliance with internal critical incident (CI) reporting.

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

- Revise provider agreements to include required language.
- Implement a process to annually evaluate enrollee access to provider time-specific appointments.
- Implement an annual after-hours survey to evaluate provider compliance with after-hours access for enrollees.
- Develop and implement a process to monitor provider compliance with primary care physician (PCP) panel requirements.
- Conduct training on identification and reporting for all categories of CIs.
- Evaluate and revise the process for CI reporting to include all CI categories.

IlliniCare

IlliniCare achieved 98 percent compliance for the access domain and 88 percent compliance for the provider agreement file review.

IlliniCare also demonstrated high compliance with structure and operations requirements (99 percent) and 100 percent compliance in the measurement and improvement domain.

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

- Revise provider agreements to include required language to educate providers on identifying and preventing abuse, neglect, exploitation (ANE) and CIs; and the time frame for notifying providers of modifications regarding payments, procedures, and documents.
- Revise the fraud, waste, and abuse (FWA) P&P to include the correct time frame for notification of overpayment.

Meridian

In the access domain, Meridian achieved an overall score of 100 percent and 88 percent for the provider agreement file review. Opportunities were identified to improve provider agreements to include all requirements.

Review of structure and operations requirements identified that Meridian's P&Ps were generally compliant with program requirements (99 percent compliance).

In the measurement and improvement domain, Meridian achieved an overall score of 98 percent.

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

- Revise provider agreements to include a mechanism to educate providers on identifying and preventing ANE and CIs; and the requirement for a 30-day notification from the health plan to the provider for any modifications regarding payments, procedures, and documents.
- Revise policy to comply with admission, discharge, and transfer system requirements.
- Revise postnatal care practice guidelines to include provision of services for 24 months following delivery.

Molina

In the access domain, Molina achieved an overall score of 68 percent, while the provider agreement file review demonstrated 100 percent compliance. Opportunities were identified to submit or revise policies to comply with requirements.

Review of structure and operations requirements identified that Molina achieved an overall score of 90 percent. Opportunities were identified to submit or revise policies to comply with contract requirements and to improve P&Ps regarding program integrity case and eligibility reporting and enrollee rights and protections.

In the measurement and improvement domain, Molina achieved an overall score of 92 percent. Opportunities were identified to revise P&Ps to improve compliance with CI reporting and practice guidelines for minimum standards of care.

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

- Demonstrate compliance with access and availability monitoring requirements, including time and distance standards, appointment availability and after-hours access, PCP panel capacity, and open and closed panels.
- Revise policy to include 24/7 coverage requirements for primary care and specialty providers.
- Submit access monitoring reports and documentation to demonstrate compliance with requirements.
- Revise policy to include provider termination guidelines or to comply with personal emergency response system and automated medication dispenser requirements.
- Revise P&Ps to include that HFS will provide contractors with a weekly extract file listing approved and authorized providers that are delivering covered services under home and community-based services (HCBS) waivers.
- Submit a P&P for enrollee engagement.
- Revise P&Ps to include basic information requirements that are missing from the policies.
- Update the handbook disclaimer chapter to insert nondiscrimination and language tag lines.
- Revise policies to specify that the ID card will include the enrollee's recipient identification number.
- Revise policies to describe requirements related to the reporting of program integrity cases and notification to the Office of Inspector General regarding information that may affect enrollee or provider eligibility.
- Submit or develop a policy to demonstrate that the health plan will be responsible for the installation, configuration, and troubleshooting of any firewall devices required on the contractor's side of the data communication link.
- Revise the Critical Incident Reporting policy to include the process for the health plan to comply with decisions made by the investigating authority within the time frame given.
- Revise the Critical Incident Reporting policy to include restrictive interventions as a reportable CI.
- Revise policy to include informing eligible families of scheduled health, vision, hearing, and dental screening periods.
- Revise practice guidelines to include pregnant women and new mothers, or their legal guardians, to enroll their newborns in Medicaid, and to identify a PCP for each newborn and consider using HFS Form 4691 as an educational tool.
- Revise policy to include screening for, diagnosing, and treating depression before, during, and after pregnancy with a standard screening tool.

NextLevel

As NextLevel had exited the Medicaid program at the time of the 2021 Compliance Review, the scope of its review was limited to a desk review for each of the standards under review. NextLevel demonstrated strong compliance for the desk review of P&Ps with the federal and State requirements contained in its managed care contract, as demonstrated by an overall compliance score of 100 percent.

Additional Information

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

Overall Strengths, Opportunities for Improvement, and Recommendations

Strengths	• The statewide average for nine of the 17 standards scored at 95 percent or above. • Generally, the health plans were compliant with P&Ps, as well as program descriptions.
Opportunities for Improvement	**Opportunity:** The statewide average for Subcontractual Relationships and Delegation was 67 percent. **Why the Opportunity Exists:** Health plans did not include all contractually required language in provider agreements. **Recommendation:** Improve oversight of provider agreement required language.
	Opportunity: The statewide average for CBH Services was 70 percent in 2020. **Why the Opportunity Exists:** The health plans lacked monitoring processes, outreach to community providers and PCPs, timely completion of crisis safety plans, interdisciplinary care team meetings, enrollee contact follow-up, and oversight of mobile crisis response providers. **Recommendation:** This standard was reassessed in the 2021 review which confirmed implementation of remediation actions as outlined in the health plans' CAPs. The health plans should continue efforts to improve oversight, monitoring, care coordination, and transitions of care for CBH services.
	Opportunity: Although the statewide average for Grievance and Appeal Systems was 88 percent, file review identified opportunities to improve timeliness of processing appeals, timely acknowledgement of grievances, use of approved HFS template letters, and compliance with reading requirements. **Why the Opportunity Exists:** Health plans are not conducting adequate monitoring of the appeal and grievance process. **Recommendation:** Establish a monitoring process for processing appeal and grievance letters to ensure timeliness, use of HFS-approved templates, required reading levels, and personalized responses to enrollees.

Results for Three-Year Compliance Review Cycle

Initial Results

The Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. A total of 17 standards were assessed. Table 3-3 displays health plan-specific results.

Table 3-3—Initial Compliance Review Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

			BCBSIL		CountyCare		IlliniCare (now Aetna)		Meridian		Molina		NextLevel		Total
#	CFR	Standard Name	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	
I	438.206	Availability of Services*		100%		85%		96%		100%		38%		100%	**87%**
II	438.207	Assurances of Adequate Capacity and Services		100%		93%		100%		100%		93%		100%	**98%**
III	438.208	Coordination and Continuity of Care (including Transitions of Care)	88%		88%		88%		90%		90%		92%		**89%**
IV	438.210	Coverage and Authorization of Services	90%		93%		93%		93%		90%		93%		**92%**
V	438.214	Credentialing and Recredentialing		100%		100%		100%		100%		86%		100%	**98%**
VI		CBH Services	65%		71%		75%		71%		71%		69%		**70%**
VIII	438.100	Enrollee Information/ Enrollee Rights		100%		100%		100%		100%		85%		100%	**98%**
IX	438.224	Confidentiality		93%		100%		100%		100%		100%		100%	**99%**
X	438.56	Enrollment and Disenrollment		83%		100%		100%		100%		92%		100%	**96%**
XI	438.228	Grievance and Appeal Systems	95%		90%		85%		85%		85%		90%		**88%**

			BCBSIL		CountyCare		IlliniCare (now Aetna)		Meridian		Molina		NextLevel		Total
#	CFR	Standard Name	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	2020	2021	
XII		Organization and Governance	90%		97%		100%		93%		73%		100%		**92%**
XIII		Fraud, Waste, and Abuse		95%		100%		95%		100%		84%		100%	**96%**
XIV	438.242	Health Information Systems		100%		100%		100%		93%		93%		100%	**98%**
XV	438.230	Subcontractual Relationships and Delegation	64%		73%		55%		73%		73%		64%		**67%**
XVI		Critical Incidents		100%		88%		100%		100%		88%		100%	**96%**
XVII	438.236	Practice Guidelines and Minimum Standards of Care		80%		100%		100%		98%		93%		100%	**95%**
XVIII	438.330	QAPI** Program	78%		87%		93%		93%		85%		90%		**88%**
TOTAL SCORE			**89%**		**92%**		**93%**		**93%**		**83%**		**94%**		**91%**

* Standard I included Emergency and Poststabilization Services.

** QAPI = Quality Assessment and Performance Improvement

Remediation

Each health plan was issued a CAP Items Report that listed each element to which HSAG assigned a *Not Met* score, the associated file review findings, and recommendations to bring the health plan's performance into full compliance with federal and State requirements.

Health plans were required to use HSAG's web-based administrative compliance review application to complete the corrective actions and submit supporting documentation to bring any elements scored *Not Met* into compliance with the applicable standard(s). Health plan responses were required to be completed no later than 60 calendar days after receipt of each health plan's administrative review report.

The following criteria were used to evaluate the sufficiency of the CAP remediation:

- The completeness of the remediation response in addressing each required action, a timeline, and specific plans of action/interventions that the health plan will implement to bring the element into compliance.

- The degree to which the planned activities/interventions and supporting documentation meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the health plan into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Final Results

All health plans successfully completed CAP remediations for their compliance activities, resulting in full compliance for all standards for all health plans as shown in Table 3-4

Table 3-4—Final Compliance Review Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

	BCBSIL	CountyCare	IlliniCare (now Aetna)	Meridian	Molina	NextLevel
TOTAL SCORE *(all standards)*	100%	100%	100%	100%	100%	100%

MMAI 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 QAPI requirements described in 42 CFR §438.330. In SFY 2021, HSAG conducted a Compliance Review in accordance with §438.358 on a full set of standards for all Medicare-Medicaid Plans (MMPs).

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

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

Standards

The 2020 Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. Many standards include requirements that address elements of accessibility, timeliness, and quality of care; therefore, HSAG grouped the standards into operational domains of access, structure and operations, and measurement and improvement within the Compliance Review. P&Ps related to the standards were reviewed via desk review, virtual interviews were conducted with key operational health plan staff, and file reviews were completed to assess how well the MMP operationalized and followed those P&Ps, as listed in Table 3-1.

Table 3-5—Summary of Standards and File Reviews 2020

Standards	File Review
Access	
Standard I—Availability of Services	Provider Agreement
Standard II—Assurances of Adequate Capacity and Services	Provider Directory
Standard III—Coordination and Continuity of Care (including Transition of Care)	Care Management (CM), Care Management Program Description (CMPD)
Standard IV—Coverage and Authorization of Services	Denials, Utilization Management Program Description (UMPD), and Peer Review Program Description (PRPD)
Standard V—Credentialing and Recredentialing	None

Standards	File Review
Structure and Operations	
Standard VIII—Enrollee Information/Enrollee Rights	Enrollee Handbook
Standard IX—Confidentiality	None
Standard X—Enrollment and Disenrollment	None
Standard XI—Grievance and Appeal Systems	Grievances Appeals State Fair Hearing (SFH)/Independent Review Entity (IRE)
Standard XII—Organization and Governance	None
Standard XIII—Fraud, Waste, and Abuse	None
Standard XIV—Health Information Systems	None
Standard XV—Subcontractual Relationships and Delegation	Delegated Vendors File Review
Measurement and Improvement	
Standard XVI—Critical Incidents	None
Standard XVII—Practice Guidelines and Required Minimum Standards of Care	None
Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)	Quality Assurance Program Description (QAPD)

Medicare-Medicaid Health Plans

The Compliance Review was conducted with the six MMPs shown in Table 3-6.

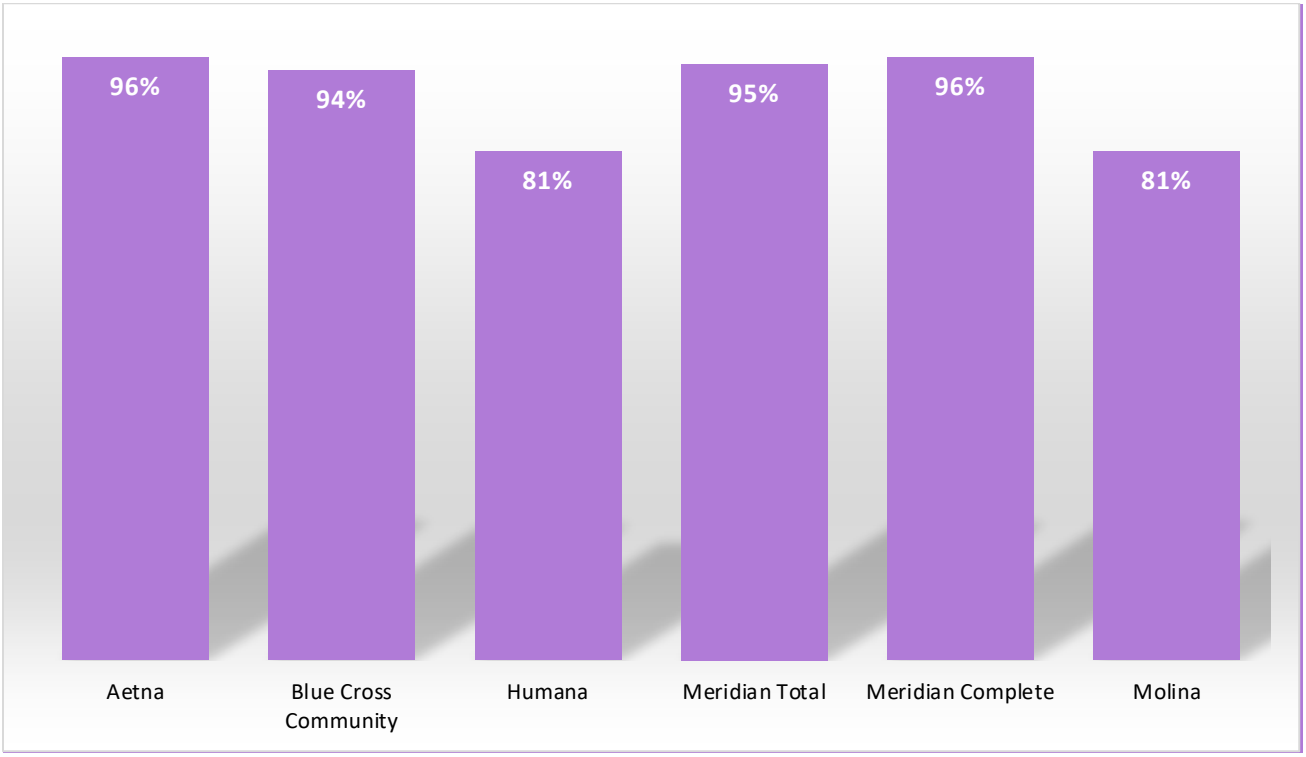
Table 3-6—MMPs

Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community	None
Humana Gold Integrated Plan	Humana
Meridian Total	None
Meridian Complete	None
Molina Healthcare	Molina

Initial Compliance With Standards

Figure 3-4 details the overall initial MMP-specific compliance score for all 16 standards reviewed during the 2020 Compliance Review.

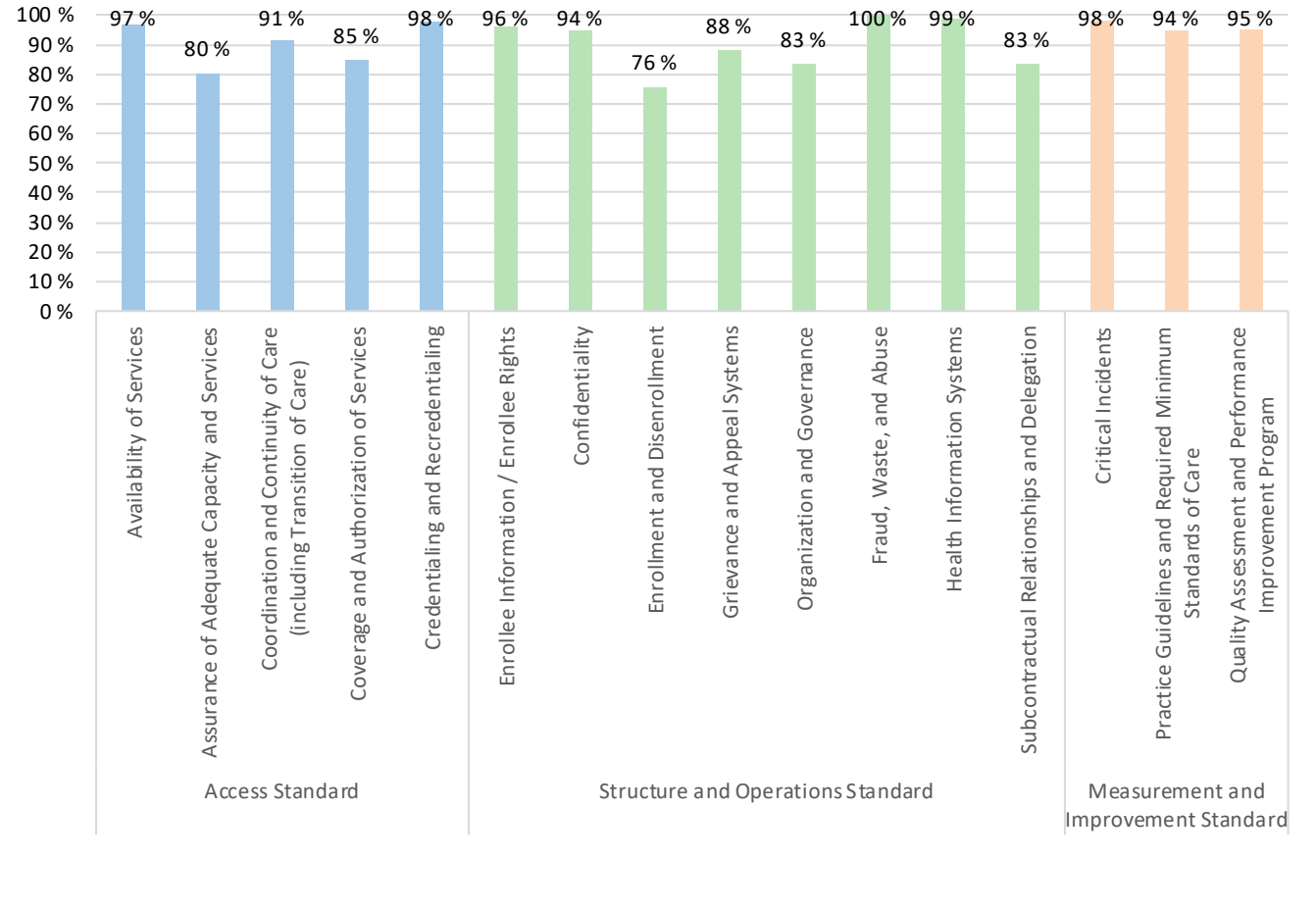
Figure 3-4—Overall Initial Compliance Ratings by MMP



As shown in Figure 3-4, all MMPs achieved an overall compliance score at or between 81 percent and 96 percent. Generally, the MMPs were compliant with P&Ps, as well as program descriptions. However, opportunities for improvement were identified in file reviews.

Figure 3-5 details the overall initial 2020 Compliance Review scores for all MMPs for each standard.

Figure 3-5—Overall MMP Initial Compliance Ratings by Standard

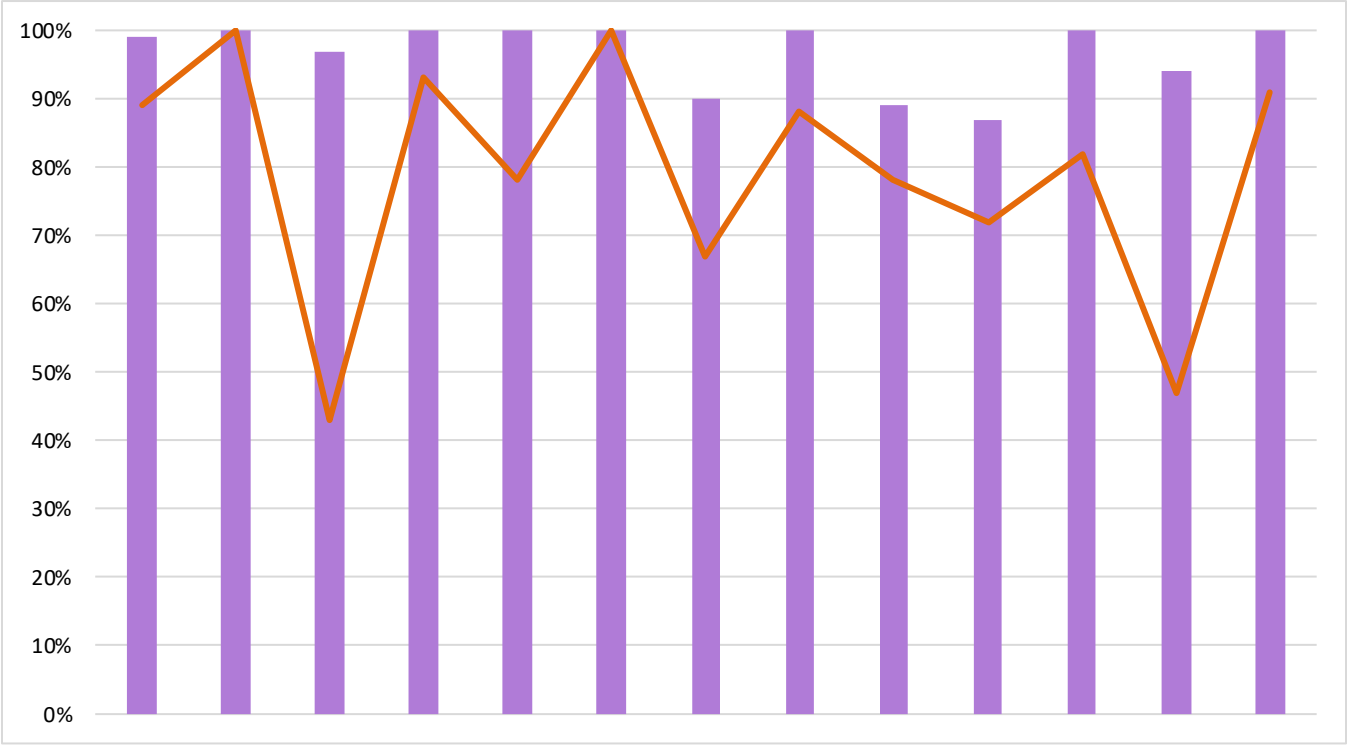


As shown in Figure 3-5, 10 of the 16 standards scored at or above 90 percent. Although the Enrollment and Disenrollment standard received the lowest score, this low score was mainly due to noncompliance of one health plan. The standard identified as needing the most improvement across all the MMPs was Assurances of Adequate Capacity and Services. Most MMPs failed to meet all requirements for the provider directory. For the Subcontractual Relationships and Delegation standard, MMPs did not ensure that delegates complete required trainings, and delegation agreements did not include all required language.

Initial Compliance With File Reviews

Figure 3-6 displays the high and low scores across the MMPs for the file reviews and program description reviews to demonstrate the range of compliance identified in the review. HFS established a performance benchmark of 80 percent compliance for all file reviews.

Figure 3-6—MMP Initial File Review Scores



	CM Record Review	CMPD Review	Denials	UMPD Review	PRPD Review	Enrollee Handbook	Appeals	SFH/IRE	Grievances	Delegation	Provider Agreements	Provider Directory	QAPD Review
High	99%	100%	97%	100%	100%	100%	90%	100%	89%	87%	100%	94%	100%
Low	89%	100%	43%	93%	78%	100%	67%	88%	78%	72%	82%	47%	91%

As shown in Figure 3-6, file reviews identified that quality improvement efforts are needed in these areas: grievances, denials, appeals, provider agreements, provider directory, PRPD, and delegation, as detailed below.

MMP-Specific Strengths and Opportunities for Improvement

The findings from the Compliance Review show how well the MMPs have interpreted federal regulations and the managed care contract requirements and developed the necessary P&Ps and plans to carry out the required functions of the MMP.

Access Domain

- Two MMPs (Molina and Humana) scored below 90 percent compliance with requirements for access-related P&Ps.
- One MMP (Molina) demonstrated 100 percent compliance with requirements for provider agreements. The other MMPs failed to include a mechanism to educate providers on identifying and preventing ANE and CIs.
- All six MMPs were identified as noncompliant regarding inclusion of all provider directory requirements based on the findings of provider directory file reviews. Specifically, sample cases could not be located in the health plan's online provider directory or were missing required provider information such as gender, address, board certification, transportation information, training and experience for behavioral health providers, and evidence of cultural competency training.
- All six MMPs were identified as noncompliant with care management/care coordination (CM/CC) processes based on desk review, including enrollee outreach, timely completion of screenings and assessments, completion and sharing of the care plan, and lack of care coordination with the PCP; overall, however, the health plans demonstrated strong compliance with CM/CC requirements for the file reviews.
- All six MMPs were identified as noncompliant with sixth-grade reading level requirements for denial determination language.
- Four MMPs (Aetna, Blue Cross Community, Humana, and Molina) had coverage and authorization policies that failed to meet requirements.

Structure and Operations Domain

- Four MMPs scored between 94 and 97 percent compliance with requirements for P&Ps assessed in this domain.
- Humana and Molina achieved 76 percent and 77 percent compliance, respectively, demonstrating noncompliance with submission of required documents for desk review and/or not all policies submitted contained all contract requirements.
- While five MMPs achieved full compliance with confidentiality requirements, Blue Cross Community achieved 67 percent compliance, demonstrating noncompliance with submission of required documents for desk review and/or not all policies submitted contained all contract requirements.
- Two MMPs (Molina and Humana) demonstrated poor compliance with requirements for enrollment and disenrollment P&Ps, demonstrating 40 percent and 20 percent compliance, respectively.

- None of the MMPs met the sixth-grade reading level requirement for appeal determination and grievance resolution language.
- Three MMPs (Meridian Total, Meridian Complete, and Molina) demonstrated inconsistent compliance for timely decisions for resolving grievances, and two MMPs (Humana and Meridian Complete) demonstrated inconsistent compliance regarding timely decisions for standard or expedited appeals.
- Four MMPs (Aetna, Humana, Meridian Complete, and Meridian Total) demonstrated 100 percent compliance with requirements for P&Ps related to organization and governance.
- All MMPs demonstrated 100 percent compliance with requirements for P&Ps for the FWA and Health Information Systems standards.
- Noncompliance with delegation training requirements for one or more delegates was identified for all six MMPs.
- Noncompliance with delegation agreement language requirements was identified for all six MMPs.

Measurement and Improvement Domain

- Across all six MMPs, 96 percent compliance was achieved for this domain, demonstrating strengths and adherence to most requirements measured in the areas of CIs, practice guidelines and standards of care, and the QAPI Program. Some of the submitted P&Ps did not comply with all contract requirements.
- All MMPs achieved full compliance with requirements for the enrollee handbook file review.
- Three MMPs' QAPDs (Blue Cross Community, Humana, and Molina) did not include required language for monitoring enrollees, and Molina failed to submit a complete 2020 Quality Improvement Workplan.

Quarterly Health, Safety, and Welfare and Critical Incident Monitoring

HFS provides quality oversight of health plans that provide services for the HealthChoice Illinois, Managed Long-Term Services and Supports (MLTSS), and MMAI populations. To provide feedback and analysis on the health plans' compliance with health, safety, and welfare (HSW) and CI requirements, HFS requested that HSAG conduct quarterly reviews of HSW/CI records. The HSW/CI reviews evaluate the health plans' compliance with all HSW/CI requirements required by contract, State and federal statutes and regulations, and 1915(b) and 1915(c) waiver conditions.

The results of the quarterly reviews are used to highlight strengths and identify areas that require immediate and/or additional attention. Health plans are required to remediate any findings identified during the quarterly reviews following the receipt of their reports. HSAG conducts a review of the remediation actions and provides written feedback to the health plans.

The findings of the SFY 2021 HSW/CI quarterly reviews are presented in Section 7 of this report.

HSW/CI Monitoring Follow-Up Findings

During the Compliance Review, HSAG conducted a review of the corrective actions implemented by the health plans as a result of the quarterly HSW/CI reviews. The follow-up review identified the health plans' quality improvement efforts to improve the CI reporting process.

Follow-up on the quarterly CI monitoring remediation actions identified improved compliance with the following CI reporting requirements:

- Appropriate categorization and reporting of CIs.
- Communication and follow-up with the investigating authority (IA).
- Care coordination staff follow-up with the enrollee after a CI has been reported.
- Consistency in use of the unable-to-reach process to locate enrollees after a CI has been reported.
- Compliance with updating the care plan/service plan when a change in condition or need is identified.
- Monitoring and oversight of staff compliance with CI requirements and reeducation of staff on CI requirements, reporting, and documentation.
- Improved accuracy in CI documentation.
- Revision of P&Ps to clarify reporting requirements and unable-to-reach processes.
- Improved accuracy in the submission of the CI data universe file in preparation for the CI review.

As a result of the improvement actions taken by the health plans, it is expected that future CI quarterly monitoring review results will demonstrate improved compliance with CI requirements.

Health Plan-Specific Recommendations

Based on the findings of the 2020 Compliance Review, HSAG identified the following recommendations.

Access Domain

- All MMPs except Molina should revise the network provider agreements to comply with federal and State requirements.
- All MMPs should establish a process to conduct monitoring and oversight of the provider directory for compliance with directory requirements and updates and changes to the online provider directory.
- All MMPs should improve CM/CC processes by:
  - Monitoring timely completion of health risk screenings to ensure care managers are making sufficient outreach attempts to locate enrollees.
  - Implementing organization-wide strategies such as flagging enrollees who need screenings in the member services system.

  - Evaluating effectiveness of enrollee outreach programs to improve timely enrollee contact.
  - Developing a consistent process for completing enrollee care plans within 90 days and implementing an oversight and monitoring process to ensure care plans are completed with the required elements.
  - Implementing a process to ensure enrollees' needs and preferences are included in the Interdisciplinary Care Team (ICT) process for nonwaiver and low-risk enrollees.
- All MMPs should develop P&Ps to monitor denial letters to ensure appropriate reading levels and improve readability of communication with enrollees regarding benefit determinations.

Structure and Operations Domain

- Humana and Molina should revise P&Ps to comply with contract requirements for this domain.
- Blue Cross Community should revise P&Ps to comply with contract requirements for the Confidentiality standard.
- All MMPs should establish a process to ensure both appeal determination language and grievance resolution language meet the sixth-grade reading level requirement.
- Meridian Total, Meridian Complete, and Molina should establish processes to ensure timely decisions for resolving grievances, and Humana and Meridian Complete should establish processes to ensure timely decisions for standard and expedited appeals.
- All MMPs should implement processes to ensure all delegates complete required training, including cultural competence, ANE, FWA, and false claims education.
- MMPs should revise delegation agreement language to meet contract requirements.

Measurement and Improvement Domain

- Blue Cross Community, Humana, and Molina should revise their policies to include required language for monitoring enrollees.

Additional Information

HSAG produced individual reports for each MMP to detail strengths, opportunities for improvement, and recommendations. Those reports are available upon request.

Initial Results for Three-Year Compliance Review Cycle

The Compliance Review included requirements that addressed federal Medicaid managed care regulations and State standards. A total of 16 standards were assessed. Table 3-6 displays health plan-specific results.

Table 3-7—Initial Compliance Review Standards and Scores for the Three-Year Period: SFY 2019–SFY 2021

			Aetna	Blue Cross	Humana	Meridian Complete	Meridian Total	Molina	Total
#	CFR	Standard Name	2021	2021	2021	2021	2021	2021	
I	438.206	Availability of Services*	100%	100%	100%	100%	100%	80%	**97%**
II	438.207	Assurances of Adequate Capacity and Services	76%	95%	81%	90%	62%	76%	**80%**
III	438.208	Care Coordination	97%	92%	77%	92%	100%	90%	**91%**
IV	438.210	Coverage and Authorization of Services	92%	81%	73%	92%	96%	73%	**85%**
V	438.214	Credentialing and Recredentialing	100%	100%	100%	100%	100%	86%	**98%**
VIII	438.100	Enrollee Information/ Enrollee Rights	100%	100%	88%	94%	94%	100%	**96%**
IX	438.224	Confidentiality	100%	67%	100%	100%	100%	100%	**94%**
X	438.56	Enrollment and Disenrollment	100%	93%	20%	100%	100%	40%	**76%**
XI	438.228	Grievance and Appeal Systems	94%	94%	81 %	94%	92%	72%	**88%**
XII		Organization and Governance	100%	67%	100%	100%	100%	33%	**83%**
XIII		Fraud, Waste, and Abuse	100%	100%	100%	100%	100%	100%	**100%**
XIV	438.242	Health Information Systems	100%	100%	92%	100%	100%	100%	**99%**
XV	438.230	Subcontractual Relationships and Delegation	75%	100%	75%	75%	100%	75%	**83%**
XVI		Critical Incidents	100%	100%	94%	100%	100%	94%	**98%**

#	CFR	Standard Name	Aetna 2021	Blue Cross 2021	Humana 2021	Meridian Complete 2021	Meridian Total 2021	Molina 2021	Total
XVII	438.236	Practice Guidelines and Minimum Standards of Care	100%	100%	67%	100%	100%	100%	**94%**
XVIII	438.330	QAPI Program	100%	98%	88%	100%	100%	83%	**95%**
TOTAL SCORE			**96%**	**94%**	**81%**	**96%**	**95%**	**81%**	**91%**

* Standard I included Emergency and Poststabilization Services.

Overall Strengths, Opportunities for Improvement, and Recommendations

Strengths

- The statewide average for 10 of the 16 standards scored at 90 percent or above.
- Generally, the MMPs were compliant with P&Ps, as well as program descriptions.

Opportunities for Improvement

Opportunity: The statewide average for Assurances of Adequate Capacity and Services was 80 percent.

Why the Opportunity Exists: Most MMPs failed to meet all requirements for the provider directory.

Recommendation: MMPs need to implement a process to conduct monitoring and oversight of the provider directory for compliance with directory requirements and updates and changes to the online provider directory.

Opportunity: The statewide average for Subcontractual Relationships and Delegation was 83 percent.

Why the Opportunity Exists: MMP delegates did not complete required trainings, and delegation agreements did not include all required language.

Recommendation: MMPs need to implement oversight and monitoring processes to ensure all delegates complete required trainings and revise delegation agreements to include all required language.

The overall low score for the Enrollment and Disenrollment standard was due to one MMP's noncompliance.

Remediation

The same remediation process described above for the HealthChoice Illinois health plans was followed for the MMPs.

Final Results

All MMPs successfully completed CAP remediations for their compliance activities, resulting in full compliance for all standards for all MMPs.

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 2021, HFS required MMPs to participate in a readiness review prior to Illinois' statewide expansion of the MMAI program. The details of the review are included below.

MMAI

Introduction

The purpose of the readiness review is to assess whether MMPs had the structural and operational capacity to perform the MMAI managed care functions described in the Illinois MMAI Demonstration Three Way Contract (MMAI Contract) between CMS, HFS, and the MMPs for the statewide expansion of the MMAI program scheduled for July 1, 2021. The purpose of the MMAI initiative is to provide Medicare-Medicaid enrollees with a better care experience by testing a person-centered, integrated care program that provides a more easily navigable and seamless path to all covered Medicare and Medicaid services.

To ensure readiness to serve the MMAI population, HSAG incorporated and built on the results of the 2020 MMAI Evaluation of Administrative Processes & Compliance and the remediation actions performed by the MMPs as a result of those reviews.

Scope of Review

The MMAI readiness review tool was developed to comply with the MMAI Contract and 42 CFR §438.66 readiness review requirements. The readiness review tool was used to assess the MMPs in the five key domains listed below to ensure they had the capacity to manage the increased enrollment of the Medicare-Medicaid enrollees.

- Operations/Administration—administrative staffing and resources, delegation and oversight of entity responsibilities, enrollee and provider communications, enrollee rights and protections, grievance and appeal systems, member services and outreach, program integrity/compliance, and provider network management.
- Systems management—information systems, claims, encounter data, and provider payments.
- Service delivery—utilization management, case management/care coordination/service planning, and quality improvement.
- Financial management—financial reporting and monitoring and financial solvency (assessed by HFS).
- Staffing—The MMPs were required to provide hiring and training updates for all key operational areas identified in the MMAI Readiness Review tool. These key operational areas included call

center operations, grievance and appeal operations, UM operations, care coordination, program integrity/compliance, quality improvement, and network management. The MMPs were required to submit monthly staffing updates until the July 1, 2021 implementation. HSAG analyzed staff acquisition and training and updated HFS prior to program implementation.

MMPs

The readiness review was conducted with the five MMAI MMPs shown in Table 3-7.

Table 3-8—HealthChoice Illinois Health Plans

Health Plan Name	Abbreviation
Aetna Better Health Premier Plan	Aetna
Blue Cross Community	None
Humana Gold Integrated Plan	Humana
Meridian Complete*	None
Molina Healthcare	Molina

* Meridian Total membership was included in Meridian Complete at the time of the readiness review (but not at the time of the compliance review).

Remediation

HSAG recorded all readiness review findings in the MMAI Readiness Review Tool. All elements within the readiness review tool that were reviewed during the Compliance Review and evaluated as *Not Met* were required to be remediated by the MMP. The MMP's remediation period began upon receipt of the readiness review report and continued until program implementation on July 1, 2021. MMPs were required to remediate all critical elements prior to the MMAI statewide program implementation and demonstrate progress toward full compliance for all elements following implementation.

Results

The findings of the readiness review and subsequent remediation activities indicated that all MMPs demonstrated compliance with the requirements for structural and operational capacity to perform the managed care functions for the MMAI program expansion. Detailed results were published in MMP-specific reports that are available upon request.

Ongoing Monitoring

MMPs were required to submit updates on care coordination staffing and the provider network to monitor ongoing compliance with contract requirements. Staffing and the provider network were monitored until September 2021. At the direction of HFS, HSAG will conduct a post-implementation review approximately six to 12 months after implementation.

4. Performance Improvement Projects (PIPs)

Overview

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

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

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. This structured method of assessing and improving health plan processes can have a favorable effect on member health outcomes and satisfaction.

Objectives

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

Statewide Mandatory Topics

In SFY 2021, the health plans submitted two state-mandated PIPs for validation: *Follow-Up After Hospitalization for Mental Illness (FUH),* 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 health plans use data analyses to determine a narrowed focus for each PIP. The topics addressed CMS' requirements related to quality outcomes, specifically the timeliness of and access to care and services. The health plans continued the topics from the prior fiscal year and concluded the PIPs on December 31, 2020.

Validation of PIPs

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019. [4-1]

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 health plans 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.

Implementation and Training

Prior to the health plans completing the PIPs and submitting Module 4 and Module 5 for validation, HSAG provided training to the health plans and HFS on requirements of the targeted module and validation criteria. The health plans were also provided the opportunity to seek individualized technical assistance throughout the PIP process.

[4-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 13, 2022.

Description of Data Obtained

Each health plan defines the data collection method for its rapid-cycle PIP SMART Aim measure in the Module 2 submission form. The data collection methodology differs for each PIP, and examples of ways that data may be collected include medical record review, automated claims pull, real-time tracking log, and member or provider survey. The health plans must collect and report the data in alignment with the approved PIP methodology.

HSAG obtained the data needed to conduct the PIP validation from the health plans' module submissions. The health plans complete the modules as far as the PIP has progressed and submit the forms to HSAG for validation. In SFY 2021, the health plans finished the PIPs, reported data results in Module 5, and HSAG assessed the results for improvement.

A detailed description of data sources is described in the intervention section below.

COVID-19 Related Considerations

The COVID-19 pandemic may have impacted the PIP results. The health plans reported the following challenges related to the pandemic in their PIP submissions:

- No longer allowed in-person visits with members while hospitalized
- Members experienced technological issues that impacted telehealth appointments
- Stay-at-home orders and members' fear of contracting COVID-19
- Providers putting projects on hold
- Outpatient clinics offering limited appointments
- Hospital staffing was impacted
- Disruption of standard workflow processes
- Decreased member engagement
- Interventions were delayed
- Inability to establish a collaborative relationship with the provider partner

Health Plan-Specific Validation Results

Table 4-1 and Table 4-2 summarize the health plans' performance for each PIP topic validated during SFY 2021. During SFY 2021, the health plans' primary PIP activities were completing intervention testing by the SMART Aim end date of 12/31/2020 and summarizing the PIP results in Module 5. In SFY 2021, the PIP validation included a formal evaluation of the SMART Aim measure outcomes and the PIPs received a final validation status confidence level.

In SFY 2021, the health plans progressed to reporting outcomes for their PIPs and submitted Module 4 and Module 5 to HSAG for validation. The Module 4 submissions contained the data for intervention evaluation and the Module 5 submissions contained the SMART Aim measure results. HSAG validated Module 4 and Module 5 and assessed whether the SMART Aim goal was achieved and if there was demonstrated improvement in the SMART Aim measure results that could be linked with an intervention tested for the PIP.

Follow-Up After Hospitalization for Mental Illness

Table 4-1—Health Plan-Specific Validation Results

Health Plan	SMART Aim Statement	Baseline	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
BCBSIL	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.	33.4%	43.4%	43.3%	*Low confidence*
CountyCare	By 12/31/2020, increase the percentage of acute inpatient discharges for members assigned to Care Management Entity (CME)-Complex Care Coordination (CCC) 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%.	34.84%	50%	40.5%	*Low confidence*

Health Plan	SMART Aim Statement	Baseline	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Aetna	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 48.11% to 59.66%.	48.11%	59.66%	54.99%	*Low confidence*
Meridian	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%.	52.80%	57.23%	61.26%	*Low confidence*
Molina	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 within 30 days of discharge with a mental health practitioner from 43.3% to 59.7%.	43.3%	59.7%	54.21%	*Low confidence*

Transitions of Care—Patient Engagement After Inpatient Discharge

Table 4-2—Health Plan-Specific Validation Results

Health Plan	SMART Aim Statement	Baseline	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
BCBSIL	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%.	58%	60%	55%	*Low confidence*
CountyCare	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%.	64.74%	70%	52.73%	*Low confidence*
Aetna	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 48.7% to 63.31%.	48.7%	63.31%	59.17%	*Low confidence*
Meridian	By 12/31/2020, increase the percentage of acute or non-acute discharges for which the member 18 years of age and older with an APP Advocate's PHO assigned PCP had patient engagement follow-up within 30 days of discharge from 41.75 percent to 45.44 percent.	41.75%	45.44%	49.35%	*Low confidence*

Health Plan	SMART Aim Statement	Baseline	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Molina	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%.	50.40%	54.42%	53.17%	*Low confidence*

As described in Table 4-1 and Table 4-2, the validation results show that all the health plans' PIPs received a level of *low confidence*. PIPs receive a *low confidence* level when the PIP (1) was methodologically sound, but the SMART Aim goal was not achieved; or (2) the SMART Aim goal was achieved, but the quality improvement processes conducted and/or intervention(s) tested were poorly executed and could not be linked to the improvement.

Based on the SFY 2021 validation of the health plans' Module 4 and Module 5 submissions, HSAG had the following recommendations. The health plans should:

- Document an Intervention Plan that includes all the required components.
- Provide the data for the approved intervention effectiveness measure(s).
- Provide complete and accurate data for the SMART Aim and intervention testing results reported.
- Explain any variances in the data that may have impacted the interpretation of the SMART Aim measure results.
- Provide the link for reported improvement to the intervention(s) tested in the supporting narrative.
- Update the key driver diagram over the course of the PIP, and provide the final key driver diagram with the final module submission at the end of the project.
- Use the Rapid-Cycle Reference Guide as the modules are completed to ensure all required documentation has been addressed.

Interventions and Data Sources

Table 4-3 and Table 4-4 summarize the health plans' interventions for each PIP topic validated during SFY 2021. The tables include the interventions that each health plan selected for testing; the health plan's decision for the intervention based on the evaluation results (i.e., adopt, adapt, abandon, or continue testing); and the source of the data obtained.

Follow-Up After Hospitalization for Mental Illness PIP

Table 4-3—Health Plan-Specific Interventions and Data Sources

Health Plan	Interventions	Intervention Status	Data Source
BCBSIL	Utilization Management (UM) and Care Coordination (CC) teams identify, track monthly, and analyze trending communication and discharge planning issues at Hartgrove Hospital.	Abandoned	Care coordination tracking log Claims data
CountyCare	Transition of care (TOC) coordinators make face-to-face visit while inpatient seeing every member admitted to Ingalls Hospital, Loretto Hospital, Norwegian American Hospital, Presence Saints. Mary and Elizabeth Hospital, and St. Bernard Hospital for mental illness. Due to COVID-19, intervention was adapted to telehealth visits.	Adapted	Hospital admissions, discharges, and transfers report Care coordination contact log
Aetna	On-site care coordination to assist in discharge planning process and appointment scheduling prior to member's discharge.	Abandoned	Claims data Behavioral health appointment request tracking log
	Confirmation of follow-up appointment attendance and member reengagement.	Abandoned	Claims data, lab results, screenings/ assessments, service authorizations Member engagement tracking log

Health Plan	Interventions	Intervention Status	Data Source
Meridian	Ensure appropriate training of Behavioral Health 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 the 30-day post-discharge mark.	Adopted	Hospital discharge report Meridian's Managed Care System
Molina	Aftercare resources contact card is provided to members nearing discharge by Methodist Medical Center staff. The listed items on the card included the following: • Help scheduling a follow-up visit with provider • Help with medication refills • Help setting up transportation to and from appointment • Help connecting member to nearby resources and supportive services near the member • A reminder of the assistance Molina can provide for follow-up care and who member can reach out to for assistance with scheduling or rescheduling a follow-up appointment.	Abandoned	Claims data Member admission, discharge, and 30-day follow-up spreadsheet

Transitions of Care–Patient Engagement After Inpatient Discharge PIP

Table 4-4—Health Plan-Specific Interventions

Health Plan	Interventions	Intervention Status	Data Source
BCBSIL	Health Care Services Cooperation (HCSC) care coordinator developed a notification system in collaboration with Christ Advocate Hospital that provides real-time notification of member admission.	Adopted	Hospital census data Care coordinator outreach and appointment data table
CountyCare	Care Management Entity (CME) Cook County Health Complex Care Coordination (CCC) care managers completed standardized TOC documents when providing TOC services to members who are inpatient. The documentation template is titled Project Re-Engineered Discharge (RED) Toolkit. The care manager completed the Project RED documents with the member, shared them with the member, and uploaded the documents into the care management system called Texture.	Adapted	Electronic care management system Discharge assessments report

Health Plan	Interventions	Intervention Status	Data Source
Aetna	On-site care coordination assisted in discharge planning process and appointment scheduling prior to member's discharge.	Abandoned	Discharge report Claims data
	Confirmation of follow-up appointment attendance and member reengagement	Abandoned	Claims data, lab results, screenings/ assessments, service authorizations Member engagement tracking log
Meridian	Care coordinators completed at least one outreach attempt within seven days after discharge, using a best practice checklist when completing outreach after an acute or non-acute inpatient discharge. The checklist coupled with Meridian's TOC process used to ensure comprehensive follow-up is completed to locate and provide services to unable-to-reach members.	Adopted	Discharge report Meridian's MCS
Molina	Worked with discharge planner to ensure TOC coach contact information was included with the discharge plan.	Abandoned	Discharge data MCO's member contact data

Strengths, Opportunities for Improvement, and Recommendations

This section assesses the strengths and opportunities for improvement of health plan performance and makes recommendations for improvement.

Overall Program

Strengths	• Three health plans (BCBSIL, CountyCare, and Molina) developed a methodologically sound intervention effectiveness measure. • For the *FUH* PIP, all five health plans' performance on the SMART Aim goal improved over baseline. • For the *Transitions of Care—Patient Engagement After Inpatient Discharge* PIP, three of the five health plans' performance on the SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** All the health plans' PIPs received a level of *low confidence*. **Why the Opportunity Exists:** Improper documentation, the SMART Aim goal was not achieved, or the SMART Aim goal was achieved and interventions could not be linked to the improvement. **Recommendation:** Review PIP Module 4 and Module 5 instructions and Rapid-Cycle PIP Reference Guide.
	Opportunity: Some health plans only tested one intervention. **Why the Opportunity Exists:** Time frame used for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plans should consider testing more than one intervention during the duration of the PIP. This will help the health plans address additional identified opportunities for improvement and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plans will positively impact the timeliness and quality of care for members.

Health Plan-Specific

Aetna Better Health

Follow-Up After Hospitalization for Mental Illness PIP

Strengths	• Planned the duration of intervention testing to allow for two interventions to be tested. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Did not provide complete data. **Why the Opportunity Exists:** Did not document the numerators and denominators for the final SMART Aim run chart in Module 5. **Recommendation:** Review PIP Module 5 instructions and Rapid-Cycle PIP Reference Guide.

Transitions of Care—Patient Engagement After Inpatient Discharge PIP

Strengths	• Planned the duration of intervention testing to allow for two interventions to be tested. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Data issues identified with the rolling 12-month SMART Aim measure methodology during the Module 4 check-in process that required recalculating the baseline data. **Why the Opportunity Exists:** Different analytic staff working on the PIP. **Recommendation:** Have all analytical staff working on the PIP review the Rapid Cycle PIP Reference Guide section that outlines the baseline and rolling 12-month SMART Aim measure methodology.

Blue Cross Blue Shield of Illinois

Follow-Up After Hospitalization for Mental Illness PIP

Strengths	• Developed methodologically sound intervention effectiveness measures. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Did not provide complete data. **Why the Opportunity Exists:** Did not document the last three rolling 12-month SMART Aim measurement periods of October 2020, November 2020, and December 2020. **Recommendation:** Follow the rolling 12-month SMART Aim methodology documented in Module 1 throughout the duration of the PIP.
	Opportunity: Ten-month intervention testing period. **Why the Opportunity Exists:** Time frame used for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and failure modes and effects analysis (FMEA) and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.

Transitions of Care—Patient Engagement After Inpatient Discharge PIP

Strengths	• Developed methodologically sound intervention effectiveness measures.
Opportunities for Improvement	**Opportunity:** Six-month intervention testing period. **Why the Opportunity Exists:** Time frame used for intervention testing. **Recommendation:** The health plan should consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.
	Opportunity: Randomly selecting members for the outreach intervention. **Why the Opportunity Exists:** Health plan's decision to use random selection of members. **Recommendation:** Using all members would produce faster intervention testing results, allowing the health plan to revise the intervention quickly and test other interventions.

CountyCare Health Plan

Follow-Up After Hospitalization for Mental Illness PIP

Strengths	• Developed a methodologically sound intervention effectiveness measure. • Thorough graphical and tabular analyses of intervention testing data. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Eleven-month intervention testing period. **Why the Opportunity Exists:** Time frame determined for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.

Transitions of Care—Patient Engagement After Inpatient Discharge PIP

Strengths	• Developed a methodologically sound intervention effectiveness measure. • Thorough graphical and tabular analysis of intervention testing data.
Opportunities for Improvement	**Opportunity:** Eleven-month intervention testing period. **Why the Opportunity Exists:** Time frame determined for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.

MeridianHealth

Follow-Up After Hospitalization for Mental Illness PIP

Strengths	• Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Did not follow the approved methodology. **Why the Opportunity Exists:** Did not follow the approved methodology for measuring intervention effectiveness. **Recommendation:** Review feedback from the previous modules and check-ins before submitting final modules for validation.
	Opportunity: Did not follow the approved PIP methodology. **Why the Opportunity Exists:** The final rolling 12-month SMART Aim measurement period data table did not align with the baseline data or the final SMART Aim run chart. **Recommendation:** Review all feedback from all modules/check-ins, and review the final module instructions and Rapid-Cycle PIP Reference Guide prior to completing the final modules for validation.

Transitions of Care—Patient Engagement After Inpatient Discharge PIP

Strengths	• Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Did not follow the approved methodology. **Why the Opportunity Exists:** Did not follow the approved methodology for measuring intervention effectiveness. **Recommendation:** Review feedback from the previous modules and check-ins before submitting final modules for validation.
	Opportunity: Did not follow the approved PIP methodology. **Why the Opportunity Exists:** The final rolling 12-month SMART Aim measurement period data table did not align with the baseline data or the final SMART Aim run chart. **Recommendation:** Review all feedback from all modules/check-ins, and review the final module instructions and Rapid-Cycle PIP Reference Guide prior to completing the final modules for validation.

Molina Healthcare of Illinois

Follow-Up After Hospitalization for Mental Illness PIP

Strengths	• Developed a methodologically sound intervention effectiveness measure. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Ten-month intervention testing period. **Why the Opportunity Exists:** Time frame determined for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.
	Opportunity: Did not document the correct data in the final SMART Aim run chart. **Why the Opportunity Exists:** Documented the intervention effectiveness data in the final SMART Aim run chart instead of the rolling 12-month SMART Aim measure data. **Recommendation:** Review the final module instructions and Rapid-Cycle PIP Reference Guide prior to completing the final module for validation.

Transitions of Care—Patient Engagement After Inpatient Discharge PIP

Strengths	• Developed a methodologically sound intervention effectiveness measure. • Performance on SMART Aim goal improved over baseline.
Opportunities for Improvement	**Opportunity:** Ten-month intervention testing period. **Why the Opportunity Exists:** Time frame determined for intervention testing. **Recommendation:** Consider shorter intervention testing periods to allow quicker data gathering to make data-driven revisions to existing interventions and to allow time to test other interventions. Additionally, the health plan should consider testing more than one intervention during the duration of the PIP. This will help the health plan address additional identified opportunities for improvement from the process map and FMEA and increase the likelihood of achieving the SMART Aim goal and desired outcomes for the project. By achieving the desired goals for the PIPs, the health plan will positively impact the timeliness and quality of care for its members.
	Opportunity: Did not document the correct data in the final SMART Aim run chart. **Why the Opportunity Exists:** Documented the intervention effectiveness data in the final SMART Aim run chart instead of the rolling 12-month SMART Aim measure data. **Recommendation:** Review the final module instructions and Rapid-Cycle PIP Reference Guide prior to completing the final module for validation.

5. Network Adequacy Validation

Validation of network adequacy is a mandatory EQR activity, and states must begin conducting this activity, described in §438.358(b)(1)(iv), no later than one year from the issuance of the associated EQR protocol. While a federal protocol has yet to be released, HFS contracted HSAG to conduct several activities to validate and monitor the health plans' provider network adequacy during the preceding SFY to comply with federal and State requirements.

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Network Adequacy Monitoring

HealthChoice Illinois Network Monitoring

Introduction

HFS and HSAG have established a process for health plans to submit provider network data. The process includes contracted providers within each health plan's service areas, including providers in contiguous counties that provide support to the health plan provider network. Each quarter, health plans are required to submit a Provider File Layout (PFL) that includes a range of provider types. HSAG uses the provider network data submissions to conduct biannual analyses and monitoring of the provider network to ensure compliance with the Medicaid Model contract and federal requirements.

For additional details of the network adequacy monitoring methodology see Appendix 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 2021 verified that the health plans contracted with a sufficient number of required providers types within each service region. SFY 2021 biannual provider network reports are available upon request.

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

Managed Long-Term Services and Supports (MLTSS) Network Monitoring

Introduction

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

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

During this reporting period, the health plans' most recent submission of MLTSS provider network data was on June 15, 2021.

Results

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.

Medicare-Medicaid Alignment Initiative (MMAI) Network Monitoring

Introduction

HFS and HSAG have established a process for health plans to submit provider network data. The process includes contracted providers within each health plan's service areas, including providers in contiguous counties that provide support to the health plan provider network. Each quarter, health plans are required to submit a PFL that includes a range of provider types. HSAG uses the provider network data submissions to conduct biannual analysis and monitoring of the provider network to ensure compliance with the MMAI Model contract and federal requirements.

Results

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

Analysis and monitoring of the MMAI provider network throughout SFY 2021 verified that the health plans contracted with a sufficient number of required providers types within each service region. SFY 2021 biannual provider network reports are available upon request.

For more detailed results, see the regional comparison in Appendix E4.

Provider Directory Validation

Introduction

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 that HSAG conduct a provider directory validation (PDV) of the health plans' online provider directories to ensure enrollees have appropriate access to provider information.

The goal of the PDV was to determine if the information in the health plans' online provider directories found on the respective health plans' websites matched the data in the health plans' provider files submitted to HSAG as part of the regular reporting process. As part of the PDV, HSAG compared the key elements (i.e., study indicators) published in the online provider directory with the data in the provider file, and HSAG confirmed that each health plan's website met the requirements found at CFR §438.10(h)(1) and the Medicaid Model Contract—2018-24-001 requirements (e.g., the website clearly states how the enrollee can obtain a paper copy of the directory).[5-1]

The health plans assessed in this analysis included:

- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare
- IlliniCare Health Plan (IlliniCare)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare

[5-1] State of Illinois Contract between the Department of Healthcare and Family Services and [MODEL CONTRACT] for Furnishing Health Services by a Managed Care Organization. 2018-24-001. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf. Accessed on: Jan 25, 2022.

Objectives

The PDV addressed four main objectives:

- Health plan directory validation: For each health plan, HSAG reviewed the health plan's online directory to assess the presence of specific federal and Medicaid health plan contract requirements.
- Identification of the providers in the online directory: Information on whether the sampled provider and the sampled provider location were found in the online directory. The information did not have to be an exact match to be considered identified (e.g., small variations in address and provider name misspellings were allowed). If the sampled provider could not be located at the sampled survey location in the online directory, the PDV review could not continue. For example, a provider could be sampled for a location at "123 E Main Street." If the reviewer could locate the provider in the online directory but could not find the specific location, then the validation could not continue.
- Provider data accuracy: For each health plan, HSAG assessed the degree to which the provider demographic information submitted by the health plans exactly matched the information found in the online provider directories.
- Provider data availability: For each health plan, HSAG assessed the degree to which the provider services information was available in the online provider directories.

Findings

Upon review of the health plan websites, HSAG found that several offered additional search criteria in addition to those reviewed specifically in this validation. The additional search options included telehealth services, after-hours appointment availability, patient ratings, and hospital affiliation. Also, all six websites conspicuously displayed a toll-free number and email address to which any individual may report an inaccuracy in the provider directory. The provider directory was available to enrollees and providers on all health plan websites via the Web portal. The reviewers located an option to request a paper form of provider directory on all websites except BCBSIL's website. Additionally, all health plans except CountyCare posted on their website the date the paper directory and website were last updated.

HSAG conducted 2,326 PDV reviews among the six participating health plans, identifying the frequency of providers found, providers not found, and providers' sampled locations not found in the respective health plan's online directory. Among the sampled providers, Meridian's providers were located in the directory most frequently, in 97.5 percent of reviews. YouthCare had the lowest rate of providers located during the reviews at 45.3 percent. The scores for the other health plans were as follows: BCBSIL, 85.5 percent; CountyCare, 79.3 percent; IlliniCare, 91.2 percent; and Molina, 72.8 percent.

HSAG also provided a summary of the identification of providers in the online directories for all health plans, by dental providers, obstetricians/gynecologists (OB/GYNs), and PCPs. The OB/GYN providers had the lowest rate of providers located in the directory (75.5 percent), PCPs had the highest rate of providers located in the directory (80.2 percent), and the rate for dental providers was 79.4 percent.

HSAG also reported the percentage of exact matches between the demographic information given by the providers to HSAG and information listed in the online provider directory. Reviewers validated each provider in the sample and assessed whether each of these indicators was present and matched the information in the submitted provider data. Overall, the demographic indicators had high match rates among all health plans.

Additionally, reviewers determined which information and service elements were present in the online provider directories for the providers found in the directory. The following seven elements were reviewed:

- Non-English Language-Speaking Provider
- Provider Accommodates Physical Disabilities
- Provider Completed Cultural Competency Training
- Provider Gender
- Provider Office Hours
- Provider Primary Language
- Provider Uniform Resource Locator (URL)

HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was listed as pending. There was a great degree of variability with regard to presence of service indicators. Provider Gender, Provider Office Hours, and Provider Primary Language were the most consistently reported indicators. Conversely, Provider Completed Cultural Competency Training and Provider URL were most consistently not present among the service indicators. CountyCare and Molina did not list Provider Completed Cultural Competency Training for any of the sampled providers. Overall, Provider Completed Cultural Competency Training was present in 38.9 percent of all health plan reviews. Provider URL was present at an overall rate of 0.4 percent among all health plan online provider directories.

Recommendations

Based on the results of the PDV, HSAG recommends the following:

- Health plans should follow the contract requirements and internal processes to verify the accuracy of the online provider directory.
- IlliniCare and Molina should conduct root cause analyses to determine the reason for the high number of discrepancies in the Provider Telephone Number (IlliniCare) and Provider Specialty (Molina) indicators and collaborate with the provider offices to ensure the correct information is received from the providers and updated within the provider directory and provider data file layout submissions.
- As a follow-up to this study, HSAG recommends conducting telephone surveys to validate the information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.

- The health plans should conduct outreach to their providers to ensure they collect updated information on all service indicators. For all health plans, provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.

Remediation

HFS required the health plans to submit CAPs to remediate the findings of the PDV study. Overall, the health plans implemented workplans which included multiple activities to achieve compliance with provider directory requirements. Workplans included timelines for completion as well as a description of activities that have been completed since the PDV audit. Health plans' remediation for the provider directory findings involves working with contracted providers to submit accurate and completed provider rosters to remediate the findings.

Additional Information

Detailed results of the PDV study were published in a final report located in Appendix E5.

Time/Distance Analysis

Introduction

As part of its provider network adequacy monitoring activities, HFS requested its EQRO, HSAG, to conduct a time/distance analysis between pediatric enrollees (younger than 21 years of age as of May 31, 2020) and providers serving pediatric enrollees in the health plans' networks. HSAG has been working with the health plans to validate the specific age groups seen by each of the pediatric specialty providers in the network to facilitate the assessment of the provider networks providing services to pediatric enrollees.

Specifically, the purpose of the pediatric 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.

Methodology

The health plans assessed in this analysis include:

- BCBSIL
- CountyCare
- IlliniCare
- Meridian
- Molina

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. 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, except for pharmacy providers, which requires that 100 percent of the enrollees must have access within the stated time/distance access 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 Pediatric Provider Network Time/Distance Analysis Report in Appendix E6.

Findings

HSAG validated the time/distance access standards for pediatric enrollees for 25 provider categories within each of five geographic regions. Overall results were summarized as follows:

- CountyCare was compliant with access standards for all provider categories in Region 4.
- IlliniCare and Meridian were compliant with access standards for 23 provider categories across all geographic regions.
- BCBSIL and Molina were compliant with access standards for 21 provider categories across all geographic regions.

Table 5-1 shows the health plans' statewide compliance with the time/distance standards. Additionally, the table shows the number of enrollees in each health plan in each region. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standards across all regions. Numeric values in red indicate regions in which the health plan did not meet the time/distance access standard.

Table 5-1—Summary of Pediatric Enrollee Access to Providers Within Time/Distance Standards by Region*

Health Plan	BCBSIL	IlliniCare	Meridian	Molina	CountyCare
Enrollment					
Region 1	8,916	36,560	75,788	23,054	NA
Region 2	13,142	24,311	57,452	28,942	NA
Region 3	7,216	21,995	56,880	22,273	NA
Region 4	141,173	45,074	162,854	39,568	171,129
Region 5	91,453	38,100	111,628	7,900	NA
All Regions	**261,900**	**166,040**	**464,602**	**121,737**	**171,129**
Provider Categories	**Statewide**			**Region 4⁺**	
Pediatric Primary Care Providers (PCPs)	✓	✓	✓	✓	✓
Pediatric Behavioral Health Service Providers	✓	✓	✓	✓	✓
Obstetrics/Gynecology (OB/GYN) Providers	✓	✓	✓	✓	✓
Pediatric Dentists	✓	✓	✓	✓	✓
Hospitals	✓	✓	✓	✓	✓
Pharmacies	1, 2, 5	2	2, 5	1, 2	✓

Health Plan	BCBSIL	IlliniCare	Meridian	Molina	CountyCare
Pediatric Specialists					
Allergy and Immunology	3	✓	✓	2	✓
Cardiology	✓	✓	✓	✓	✓
Cardiothoracic Surgery	✓	✓	✓	✓	✓
Dermatology	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓
Ear, Nose, and Throat (ENT) /Otolaryngology	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓
Infectious Disease	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓
Neurology	✓	✓	✓	✓	✓
Neurosurgery	1, 3	✓	✓	✓	✓
Oncology	✓	✓	✓	✓	✓
Ophthalmology	✓	✓	✓	✓	✓
Oral Surgery	1, 2, 3	3	1, 2, 3	3	✓
Orthopedic Surgery	✓	✓	✓	✓	✓
Pulmonology	✓	✓	✓	✓	✓
Rehabilitation Medicine	✓	✓	✓	2	✓
Rheumatology	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	✓

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

NA indicates not applicable because the health plan does not operate in the region.

+ Region 4 encompasses only Cook County. CountyCare operates exclusively in this county.

Recommendations

The following recommendations are provided based on the results of the provider network time/distance study.

- Future time/distance analyses should focus on identifying the specific locations of the enrollees without access to determine if outreach to providers in those areas can help close the gaps. HFS should consider conducting a saturation analysis for each time/distance standard in which a health

plan was noncompliant. A saturation analysis will assist HFS in determining the extent to which deficiencies in the provider network resulted from the health plan's failure to contract with available providers (i.e., providers contracted with a different HealthChoice Illinois health plan), versus a lack of available providers for the provider type and/or region.

- Section 5.7.4 of the Medicaid Model contract requires health plans to notify HFS when material gaps in the contractor's provider network are identified. As required by contract, health plans must notify HFS within five business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Based on the results of the previous and current time/distance studies, access to oral surgery providers was identified as a network gap in regions 1, 2, and 3; however, health plans have reported a limited number of oral surgery providers available for contracting. Health plans should continue to explore contracting opportunities for ensuring access to oral surgery.
- Health plans should examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.
- Health plans are required to work with contracted providers (i.e., dental and pharmacy) to ensure vendor provider data are accurate and complete.
- HFS should conduct an in-depth review of provider categories for which all statewide health plans struggled to meet the time/distance access standards (i.e., Oral Surgery—Region 3 and Pharmacies—Region 2), with the goal of determining whether failure to meet the time/distance access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
- 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 and PDVs to assess the accuracy of provider information available to enrollees. 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.

Remediation

HFS required the health plans to submit CAPs to remediate the findings of the pediatric time/distance study. Overall, health plans identified a limited availability of providers to remediate the findings for Oral Surgery providers for Region 3—Southern and Pharmacy providers for Region 2—Central. It was verified in remediation that all health plans had a process in place to establish single case agreements with out-of-network providers to provide oral surgery services to enrollees.

As required, the health plans implemented workplans which included multiple activities to achieve compliance with requirements. Workplans included timelines for completion as well as a description of activities that have been completed since the time/distance study. Health plans' remediation for the time/distance findings involves contracting with additional providers, continued evaluation of service areas, establishing single case agreements, and submitting revised data.

Provider Network Readiness Reviews

MMAI Expansion Readiness Review

To prevent duplication of network readiness review activities, HFS used the CMS MMAI provider network adequacy reports as validation of network capacity for the Medicare Advantage Medicare-Medicaid plans (MMPs) participating in the MMAI expansion. HFS required HSAG to conduct a review of the LTSS and behavioral health provider network capacity. HFS also required HSAG to conduct an analysis of the MMP's recruitment efforts for contracting with large hospital systems and associated providers operating in the expansion counties.

HFS required the MMPs to contract with LTSS and behavioral health providers in at least 80 percent of the Illinois counties. HSAG conducted a thorough analysis of the LTSS and behavioral health provider network data files and completed reports summarizing findings by provider type/region/county. HSAG and HFS maintained ongoing communication with the MMPs to address and correct any gaps in the MMAI LTSS and behavioral health network prior to July 1, 2021.

In addition, HSAG used a State source file to create a contracting workbook that included a list of large hospital systems and associated providers within the expansion counties, including contiguous counties. MMPs were required to complete and submit the contracting workbook to inform HFS of the MMPs' recruitment efforts based on the contract status and projected contract dates for hospital systems targeted for contracting. Results of the MMPs' contracting workbook were summarized by number of contracted hospital systems, pending contracts, and declined/unresponsive hospital systems.

A summary of the LTSS network, behavioral health network, and the contracting status for large hospital systems is included below.

Results

HSAG reviewed 16 LTSS provider categories across 102 Illinois counties. Review of the MMPs' provider network data demonstrated that the MMPs contracted with one or more providers across multiple LTSS service categories for all regions. All MMPs met the HFS requirement for contracting with LTSS providers in at least 80 percent of the Illinois counties.

Review of the MMPs' provider network data demonstrated that the MMPs had contracted with one or more behavioral health providers across multiple provider categories for all regions. Based on the results of the behavioral health provider network review prior to implementation on July 1, 2021, four of the five MMPs met the HFS requirement for contracting with behavioral health providers in at least 80 percent of Illinois counties.

Remediation

HFS required HSAG to develop a CAP requiring one MMP to contract with behavioral health providers in at least 80 percent of the Illinois counties. As part of the CAP, the MMP was required to continue recruitment efforts for additional behavioral health providers and continue submission of provider network data to reflect newly contracted providers in the expansion counties. The MMP's behavioral health delegate confirmed that the delegate will continue authorization of out-of-network services to allow access to care while enhancement of the behavioral health network throughout the State is completed.

Interviews with key MMP staff members verified that future provider network data submissions will include additional contracted LTSS and behavioral health providers as pending contracts are finalized and executed.

Although HFS and CMS determined network readiness review status in the MMAI expansion counties, HSAG's evaluation of the LTSS network identified that all MMPs met the HFS requirement to contract with providers in at least 80 percent of the Illinois counties while four of five MMPs met the HFS requirement to contract with providers in at least 80 percent of the Illinois counties for behavioral health.

Ongoing Monitoring

HSAG will continue to review the MMPs' provider network data file submissions for additional contracted providers and continue to monitor the MMPs' recruitment efforts and contracting progress with targeted large hospital systems.

Additional Information

HSAG produced individual health plan network reports which outlined the health plans' compliance with network readiness requirements and any recruitment efforts for providers in the expansion counties. The health plan network reports also included recommendations for improvement including health plan CAPs to remediate any network findings prior to statewide implementation. Those reports are available upon request.

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, impact analysis due to provider network terminations, health plan mergers, 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.

Analyses that were conducted in SFY 2021 in response to HFS provider network requests are listed below:

- Affordability Feasibility Study for the General Assembly: Assistance with the development of language for provider availability based on the health plan provider network data and NAV studies. Provided examples to summarize provider availability and challenges to network access for enrollees in rural counties.
- Dental Policy Review Committee: Provided a list of all dental providers contracted by HCI health plans and a count of statewide dental providers by region and health plan.
- MeridianHealth and NextLevel Merger Analysis: HSAG was required to conduct a network adequacy analysis to verify whether the MeridianHealth provider network was sufficient to support the membership transfer from NextLevel.
- Pharmacy Termination Analysis: IlliniCare Health Plan (IlliniCare) merged with Aetna Better Health (Aetna), which resulted in the termination of contracts with Walgreens pharmacies. HSAG provided a report to HFS which outlined the total pharmacies lost and the number of members without access based on the results of an ad hoc time and distance analysis completed by HSAG. HFS placed the health plan on a CAP following the results of HSAG's impact analysis of the pharmacy network.
- Linden Oaks Behavioral Health Hospital (Linden Oaks): Provided a list of health plans contracted with Linden Oaks for both HCI and MMAI.
- Hospital Network Comparison: Provided a report that included a regional hospital network comparison across the health plans.
- Health Plan Provider Network Data Files: Full provider network data files provided to the Department's Office of Inspector General.
- Member Access to OB/GYN Providers: Provided an analysis of the OB/GYN provider network in Champaign County and surrounding counties across all health plans.

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.

Originally, HFS contracted with six health plans to provide healthcare services to HealthChoice Illinois beneficiaries. In 2021, IlliniCare Health Plan was acquired by and rebranded as Aetna Better Health of Illinois (Aetna).

In 2020, NextLevel Health Partners, LLC, dissolved and the health plan's membership was acquired by MeridianHealth, so HealthChoice Illinois was served by five health plans in SFY 2021.[6-1,6-2] Four of the HealthChoice Illinois health plans serve enrollees statewide, and one health plan serves enrollees in Cook County only. Table 6-1 displays the health plans that reported CAHPS data for SFY 2021.

Table 6-1—HealthChoice Illinois Health Plans for 2021 CAHPS

Health Plan Name	Abbreviation
Aetna Better Health (formerly known as IlliniCare Health Plan)	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

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

[6-1] Please exercise caution when evaluating MeridianHealth's 2021 results, since NextLevel Health Partners, LLC, merged with MeridianHealth in 2021.

[6-2] HSAG included NextLevel Health Partners, LLC, along with the five health plans in the 2020 aggregate.

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 2021 top-box scores to the corresponding 2020 top-box scores. Top-box score results that were statistically significantly higher in 2021 than in 2020 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2021 than in 2020 are noted with downward (▼) triangles. Top-box scores in 2021 that were not statistically significantly higher or lower than scores in 2020 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

COVID-19 Related Considerations

Due to the increased use of telehealth services (e.g., phone and video calls) during the COVID-19 pandemic, AHRQ released the 5.1 version of the CAHPS Child Health Plan Survey in October 2020 to acknowledge that members may receive care in person, by phone, or by video. Based on this version, NCQA introduced a new HEDIS version of the survey with updates to the following questions: 3, 5, 6, 7, 25, 26, 30, 40, 41, 42, and 43; therefore, caution should be exercised when comparing 2021 results to prior years' results. Also, caution should be exercised when evaluating the results as the number of completed surveys may have been impacted by COVID-19, as well as members' perceptions of and experiences with the healthcare system.

Summary of Performance

Adult CAHPS Medicaid Results

To assess the adult population's experience of Medicaid services, health plans use NCQA-certified CAHPS survey vendors to survey a sample of adult beneficiaries. The aggregate results for all HealthChoice Illinois health plans combined are displayed in the table below; detailed results are available in Appendix F-2.

Table 6-3—Adult Aggregate Results

	2020	2021	Trending Results (2020–2021)
Composite Measures			
Getting Needed Care	79.5% ★	83.1% ★★	▲
Getting Care Quickly	80.1% ★★	80.5% ★★	—
How Well Doctors Communicate	92.9% ★★★	91.6% ★	—
Customer Service	88.5% ★★	86.6% ★	—
Global Ratings			
Rating of All Health Care	55.5% ★★★	59.3% ★★★	—
Rating of Personal Doctor	69.3% ★★★	67.3% ★★	—
Rating of Specialist Seen Most Often	66.2% ★★	70.0% ★★	—
Rating of Health Plan	58.1% ★★	58.6% ★★	—

▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
— Indicates the 2021 score is not statistically significantly higher or lower than the 2020 score.

Strengths

Experience survey results show a statistically significant improvement from last year for *Getting Needed Care*, which indicates that members perceived they had a greater overall experience with access to the care they needed from 2020 to 2021.

Opportunities for Improvement	
	Opportunity: Experience survey results were below the 50th percentile for every measure except *Rating of All Health Care*, which indicates that members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Members may have difficulty obtaining the care, tests, or treatments they need and getting an appointment with their provider or specialist in a timely manner. Additionally, providers and specialists may not be spending enough quality time with members or not satisfactorily communicating and addressing members' needs. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans conduct root cause analyses or focus studies to determine why members are not getting timely care or the quality of care they need, or do not have access to care. The HealthChoice Illinois health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need. Additionally, HSAG recommends that HealthChoice Illinois health plans determine if there is a shortage of specialists in the area or if specialists are unwilling to contract with the health plan.

Child CAHPS Medicaid Results

To assess the child population's experience of Medicaid services, health plans used NCQA-certified CAHPS survey vendors to survey a sample of child beneficiaries. The aggregate results for all HealthChoice Illinois health plans combined are displayed in the table below; detailed results are available in Appendix F-2.

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

	2020	2021	Trending Results (2020–2021)
Composite Measures			
Getting Needed Care	78.6% ★	80.2% ★	—
Getting Care Quickly	85.5% ★	82.6% ★	—
How Well Doctors Communicate	93.4% ★★	92.6% ★	—
Customer Service	85.0% ★	86.0% ★	—
Global Ratings			
Rating of All Health Care	70.5% ★★	73.8% ★★★	—
Rating of Personal Doctor	76.8% ★★	79.5% ★★★	—
Rating of Specialist Seen Most Often	73.8% ★★	71.9% ★★	—
Rating of Health Plan	65.4% ★	68.8% ★	▲

▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
— Indicates the 2021 score is not statistically significantly higher or lower than the 2020 score.

Strengths	Experience survey results show a statistically significant improvement from last year for *Rating of Health Plan*, which indicates that parents/caretakers of child members perceived greater overall experiences with the quality of their child's health plan from 2020 to 2021.
Opportunities for Improvement	**Opportunity:** Experience survey results were below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Rating of Health Plan*. This indicates that parents/caretakers of child members perceive a lack of access to and timeliness of care, as well as an overall lack of quality of care. **Why the Opportunity Exists:** Lower ratings in the above measures may indicate that parents/caretakers of child members have difficulty obtaining access to the care or treatment their child needs, as well as difficulty scheduling the care their child needs with a provider or at a facility in a timely manner. Additionally, when receiving care, providers may not be communicating well with parents/caretakers of child members or spending adequate time with the child to provide the quality of care the parent/caretaker anticipates or expects to meet the child's healthcare needs. **Recommendation:** HSAG recommends that the HealthChoice Illinois health plans conduct root cause analyses or focus studies to determine why child members are not getting timely care or the quality of care they need, or do not have access to care. The HealthChoice Illinois health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care child members need. Additionally, HSAG recommends that HealthChoice Illinois health plans evaluate child member access and determine if there is a shortage of overall providers or certain specialists in the area. Once potential provider gaps are identified, the health plans should take appropriate actions to fill gaps or evaluate why providers may not want to participate with the health plan.

Child Statewide Results

HSAG administers a CAHPS survey on behalf of HFS for the statewide Illinois Medicaid (Title XIX) and All Kids (Title XXI) programs. These child CAHPS surveys include questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines, access to specialized services). Results are calculated for the population of children identified as having a chronic condition and for the general child population. HFS does not require the health plans to administer the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set; however, HSAG uses this survey for Illinois Medicaid and All Kids.

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.[6-3]

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

	2020	2021	Trending Results (2020–2021)
Composite Measures			
Getting Needed Care	84.2% ★★	81.1% ★	—
Getting Care Quickly	88.3% ★★	81.5% ★	▼
How Well Doctors Communicate	94.2% ★★★	94.2% ★	—
Customer Service	79.1% ★	86.3% ★	▲
Global Ratings			
Rating of All Health Care	70.2% ★★	68.4% ★	—
Rating of Personal Doctor	76.3% ★★	76.5% ★★	—
Rating of Specialist Seen Most Often	75.9% ★★★	70.6% ★	—
Rating of Health Plan	61.3% ★	61.8% ★	—

▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
— Indicates the 2021 score is not statistically significantly higher or lower than the 2020 score.

[6-3] NCQA does not publish separate benchmarks for the CHIP population; therefore, caution should be exercised when interpreting the results of the national comparisons analysis (i.e., star ratings).

Experience With Care

Child Statewide

Strengths	Experience survey results show a statistically significant improvement from last year for *Customer Service*, which indicates that parents/caretakers of child members perceived better quality of care from their child's program when they needed assistance from 2020 to 2021.
Opportunities for Improvement	**Opportunity:** Experience survey results show a statistically significant decline from last year for *Getting Care Quickly*, which indicates that parents/caretakers of child members perceive a lack of timeliness of care for their child. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty trying to schedule appointments within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. **Recommendation:** HSAG recommends conducting secret shopper calls to a variety of provider specialties to determine if timeliness is an issue within certain provider specialty types. HSAG also recommends reviewing member-to-provider ratios within access requirements to determine if there are enough in-network providers available to allow for timely appointment scheduling. Upon identification of potential barriers to member experience, interventions or education can take place, such as adding providers to the network to distribute patient-to-provider ratios, educating providers, or soliciting provider feedback to identify areas for improvement.
	Opportunity: Experience survey results were below the 50th percentile for every measure, indicating that parents/caretakers of child members may perceive a lack of access to and timeliness of care for their child, as well as an overall lack of quality of care and services from providers and the programs. **Why the Opportunity Exists:** Lower ratings for each measure may indicate that parents/caretakers of child members have difficulty obtaining access to the care or treatment they need, as well as difficulty scheduling needed care with a provider or at a facility in a timely manner. When child members receive care, providers may not be spending an adequate amount of time with the child to provide the quality of care the parent/caretaker of the child member anticipates or expects to meet the child's healthcare needs. Member experiences related to quality of care could be related to frustrations with parents/caretakers' perception of a lack of access and availability of needed care or an overall need for quality care improvements. Additionally, lower experience scores with customer service and the program overall are likely related to member materials, interactions with program staff, and the level of assistance that was provided when parents/caretakers of child members were in need. **Recommendation:** HSAG recommends that the Illinois Medicaid and All Kids programs conduct root cause analyses or focus studies to determine why parents/caretakers of child members are potentially perceiving a lack of access to care, timeliness of needed care, and overall quality of care. Once a root cause or probable reasons for lower ratings are identified in each area, the Illinois Medicaid and All Kids programs can determine appropriate interventions, education, and actions to improve performance.

CCC Population

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

Table 6-6—Statewide Survey CCC Population Aggregate Results

	2020	2021	Trending Results (2020–2021)
Composite Measures			
Getting Needed Care	85.5% ★★	84.7% ★	—
Getting Care Quickly	90.7% ★	86.0% ★	▼
How Well Doctors Communicate	95.0% ★★★	95.2% ★★	—
Customer Service	84.7% ★	85.2% ★	—
Global Ratings			
Rating of All Health Care	67.6% ★★	61.6% ★	—
Rating of Personal Doctor	75.5% ★★	74.0% ★	—
Rating of Specialist Seen Most Often	76.3% ★★★	73.5% ★★	—
Rating of Health Plan	57.9% ★	57.9% ★	—
CCC Composites and Items			
Access to Specialized Services	70.5%+ ★+	60.6% ★	—
FCC: Personal Doctor Who Knows Child	89.9% ★	91.7% ★★	—
Coordination of Care for Children with Chronic Conditions	81.9%+ ★★★★★+	78.6% ★★★	—
Access to Prescription Medicines	90.3% ★★	89.0% ★	—
FCC: Getting Needed Information	92.4% ★★★	87.9% ★	▼

▲ Indicates the 2021 score is statistically significantly higher than the 2020 score.
▼ Indicates the 2021 score is statistically significantly lower than the 2020 score.
— Indicates the 2021 score is not statistically significantly higher or lower than the 2020 score.

Strengths	Experience survey results do not show any statistically significant improvements for any measure from 2020 to 2021, which indicates that parents/caretakers of child members do not perceive greater access to, timeliness of, or quality of care their child needs.
Opportunities for Improvement	**Opportunity:** Experience survey results show a statistically significant decline for *Getting Care Quickly* and *FCC: Getting Needed Information*, which indicates that parents/caretakers of child members perceive a lack of timeliness of care for their child and the information they need while getting care. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty trying to schedule appointments within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. Additionally, parents/caretakers of child members may feel they are not getting the time they need with the provider to obtain and understand needed information or are not being provided with adequate materials that offer further understanding. **Recommendation:** HSAG recommends the Illinois Medicaid and All Kids programs conduct secret shopper calls to a variety of provider specialties to determine if timeliness is an issue within certain provider specialty types. HSAG also recommends reviewing member-to-provider ratios within access requirements to determine if there are enough in-network providers available to allow for timely appointment scheduling. The Illinois Medicaid and All Kids programs could also consider conducting a focus study to determine why parents/caregivers of child members may not feel they are getting needed information. Upon identification of potential barriers to member experience, interventions or education can take place, such as adding providers to the network to distribute patient-to-provider ratios, educating providers, or soliciting provider feedback to identify areas for improvement.
	Opportunity: Experience survey results were below the 50th percentile for every measure except *Coordination of Care for Children with Chronic Conditions*, indicating that parents/caretakers of child members may perceive a lack of access to and timeliness of care for their child, as well as an overall lack of quality of care and services from providers and the programs. **Why the Opportunity Exists:** Lower ratings for the measures may indicate that parents/caretakers of child members have difficulty obtaining access to the care or treatments their child needs, as well as difficulty scheduling needed care with a provider or at a facility in a timely manner. When child members receive care, providers may not be spending an adequate amount of time with the child to provide the quality of care the parent/caretaker of the child member anticipates or expects to meet the child's healthcare needs. These experiences can be especially important to those parents/caregivers of child members due to the high level of stress families may feel while caring for a child with a chronic condition. Member experiences related to quality of care could be related to

frustrations with parents/caretakers' perception of a lack of access and availability of needed care or an overall need for quality of care improvements. Additionally, lower experience scores with customer service and the overall programs are likely related to member materials, interactions with program staff, and the level of assistance that was provided when parents/caretakers of child members were in need.

Recommendation: HSAG recommends that the Illinois Medicaid and All Kids programs conduct root cause analyses or focus studies to determine why parents/caretakers of child members are perceiving a lack of access to care, timeliness of needed care, and overall quality of care. Once a root cause or probable reasons for lower ratings are identified, the Illinois Medicaid and All Kids programs can determine appropriate interventions, education, and actions to improve performance.

7. Additional EQR Activities

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

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Quality Rating System

Overview

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

In SFY 2021, HSAG was tasked with developing a report card to evaluate the performance of health plans serving HealthChoice Illinois beneficiaries.

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

Reporting Measures and Categories

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

- **Doctors' Communication**: Includes adult and child CAHPS composites and items on consumer perceptions about how well their doctors communicate and overall ratings of personal doctors. In addition, this category includes a CAHPS measure related to medical assistance with smoking and tobacco use cessation.
- **Access to Care**: Includes adult and child CAHPS composites on consumer perceptions regarding the ease of obtaining needed care and how quickly they received that care. This category includes HEDIS measures that assess adults' access to care and children's and adolescents' access to dentists.
- **Women's Health**: Includes HEDIS measures that assess how often women-specific services are provided (e.g., breast cancer, cervical cancer, and chlamydia screenings, as well as prenatal and postpartum care).

[7-1] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

- **Living With Illness**: Includes HEDIS measures that assess how well MCOs take care of people who have chronic conditions, such as diabetes and hypertension.
- **Behavioral Health**: Includes HEDIS measures that assess whether members with behavioral health conditions received appropriate follow-up after hospitalization, emergency department (ED) visit, or high intensity care, as well as measures that assess pharmacotherapy for opioid use disorder and the initiation and engagement of alcohol and other drug (AOD) 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. Fifty-three measures were chosen: 11 CAHPS and 42 HEDIS, and 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 2021 Quality Compass national Medicaid benchmarks. In addition, HSAG provided 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 health plan's average rating in each category improved, declined, or stayed the same from 2020 to 2021 based on comparisons to national Medicaid benchmarks. HSAG computed six reporting category summary scores for each health plan. HSAG compared each measure to national benchmarks and assigned star ratings for each measure.

Responding to Illinois Legislation

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

Evaluation of Quality Strategy

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 Special Needs Children 1915(b) waiver (SNC) populations in HealthChoice Illinois and the statewide expansion of the Managed Long Term Services and Supports 1915(b) waiver (MLTSS), HFS worked throughout SFY 2020 to revise its Quality Strategy. HFS' new *Comprehensive Medical Programs Quality Strategy (Quality Strategy)* was published in March 2021 at: https://www2.illinois.gov/hfs/info/reports/Pages/default.aspx.

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. *Medicaid and Children's Health Insurance Program (CHIP) Managed Care Quality Strategy Toolkit for States*. Available at: https://www.medicaid.gov/medicaid/downloads/managed-care-quality-strategy-toolkit.pdf. Accessed on: Jan 21, 2022.

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 first biannual review of 2021 included an assessment of internal health plan staff members as well as any delegated entities performing case management services.

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

HSAG analyzed 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. Health plans were also required to provide remediation responses related to findings from the CY 2020 biannual staffing and training reviews.

The first biannual review of 2021 included health plan data for staff members with hire dates on or before March 1, 2021. HSAG noted that training is completed each calendar year; 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, 2021.

Findings

The health plans and their delegates had not completed required general or waiver-specific trainings for all case managers by March 2021. As the health plans can complete training throughout the calendar year, HSAG will reassess training completion rates during the second biannual review.

HealthChoice Illinois

HSAG analyzed health plan compliance with 17 contractually required elements of case management staffing and training in the HealthChoice Illinois contract. YouthCare Specialty Plan's compliance with eight contractually required elements of case management staffing was analyzed; training will be evaluated during the second biannual analysis. The health plan-specific strengths, opportunities for improvement, and recommendations are described below.

Strengths

- Four health plans (Aetna, BCBSIL, CountyCare, and Molina) met all contract requirements related to caseloads.
- All of BCBSIL's case managers met qualification/education requirements except for one Persons who are Elderly (ELD) waiver case manager.
- CountyCare's and its delegate's case managers met all qualification/education requirements except two Persons with Disabilities (PD) waiver case managers and two Persons with Brain Injuries (BI) waiver case managers.
- All of Molina's case managers met qualification/education requirements except for one BI waiver case manager and two PD waiver case managers.
- YouthCare demonstrated 97 percent compliance or higher for all caseload requirements.

Opportunities for Improvement

Opportunity: Meridian was the lowest-performing health plan.

- 43 percent (199/465) of case managers did not meet weighted caseload limits, and 32 percent (148/456) did not meet high risk caseload limits.
- Findings were identified for case managers managing all four waiver types due to not meeting either qualification/education requirements, required experience, or caseload limits.

Why the Opportunity Exists: The health plan is not effectively monitoring caseload limits and ensuring distribution of cases to meet caseload requirements across all case managers. The health plan may not have a consistent monitoring process to review staff qualifications/education prior to waiver caseload assignment and ensure that only staff that meet waiver-specific requirements are assigned waiver caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/education that may show compliance with the contract requirements.

Recommendation: The health plan should identify a plan to reassign caseloads to those case managers not meeting weighted, high-risk, moderate-risk, or waiver caseload limits. The health plan should review the qualification/education requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. The health plan should review the required related experience for the Persons with HIV [human immunodeficiency virus] or AIDS [acquired immunodeficiency

syndrome] (HIV) waiver to ensure that only staff with experience in all five required areas are assigned HIV waiver caseloads and should develop a plan to ensure that experience is reviewed prior to waiver caseload assignment. Those staff without the appropriate qualifications/education should have those waiver cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/education that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.
Opportunity: Of Aetna's 298 internal case managers, eight BI waiver case managers, six HIV waiver case managers, and six PD waiver case managers did not meet qualification/education requirements. Aetna's delegate had three case managers assigned to waivers who did not meet qualification/education requirements. **Why the Opportunity Exists:** The health plan may not have a consistent monitoring process to review staff qualifications/education prior to waiver caseload assignment and ensure that only staff who meet waiver-specific requirements are assigned waiver caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/education that may show compliance with the contract requirements. **Recommendation:** The health plan should review the qualification/education requirements for the BI and PD waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. The health plan should review the required related experience for the HIV waiver to ensure that only staff with experience in all five required areas are assigned HIV waiver caseloads and should develop a plan to ensure that experience is reviewed prior to waiver caseload assignment. Those staff without the appropriate qualifications/education should have those waiver cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/education that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.
Opportunity: 14 percent (15/105) of YouthCare's case managers did not have required qualifications, and 7 percent (7/105) did not have required credentials. **Why the Opportunity Exists:** The health plan may not have a consistent monitoring process to review staff qualifications/credentials prior to caseload assignment and ensure that only staff who meet requirements are assigned caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/credentials that may show compliance with the contract requirements. **Recommendation:** The health plan should review the qualification/credential requirements and develop a plan to ensure that only staff meeting requirements

are assigned caseloads. Those staff without the appropriate qualifications/credentials should have cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/credentials that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.

MMAI

HSAG analyzed Medicare-Medicaid Plan (MMP) compliance with 17 contractually required elements of case management staffing and training in the MMAI contract. The health plan-specific strengths, opportunities for improvement, and recommendations are described below.

Strengths	• Three MMPs (Aetna, BCBSIL, and Meridian) met all contract requirements related to caseloads. • All of Aetna's case managers met qualification/education requirements except one ELD waiver case manager and one PD waiver case manager. • All of BCBSIL's case managers met qualification/education requirements except one ELD waiver case manager. • All but one of Molina's case managers met weighted caseload maximum requirements, and only one BI waiver case manager did not meet qualification/education requirements.
Opportunities for Improvement	**Opportunity:** Humana had nine PD waiver case managers who did not meet qualification/education requirements. **Why the Opportunity Exists:** The health plan may not have a consistent monitoring process to review staff qualifications/education/experience prior to waiver caseload assignment and ensure that only staff who meet waiver-specific requirements are assigned waiver caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/education/experience that may show compliance with the contract requirements. **Recommendation:** The health plan should review the qualification/education/experience requirements for the PD waiver and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. Those staff without the appropriate qualifications should have those waiver cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/education/experience that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.

Opportunity: Meridian had one ELD waiver case manager and two PD waiver case managers who did not meet qualification/education requirements, and three HIV waiver case managers did not have the required related experience.

Why the Opportunity Exists: The health plan may not have a consistent monitoring process to review staff qualifications/education/experience prior to waiver caseload assignment and ensure that only staff who meet waiver-specific requirements are assigned waiver caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/education/experience that may show compliance with the contract requirements.

Recommendation: The health plan should review the qualification/education/experience requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. Those staff without the appropriate qualifications should have those waiver cases reassigned to qualified staff. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/education/experience that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.

Remediation

Health plans were required to provide remediation responses related to findings from the CY 2020 biannual staffing and training reviews. Detailed descriptions of findings were provided in the 2021 first biannual review health plan-specific reports, which are available upon request. Health plans are required to remediate all findings and report remediation progress in the 2021 second biannual review.

Recommendations for HFS

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

- HFS 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.

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 conducted quarterly record reviews and system effectiveness assessments to determine health plan compliance with the HealthChoice Illinois and MMAI contract measures and MLTSS waiver requirements. Six health plans were included in the FY 2021 review. A detailed description of the sampling methodology and data collection processes is provided in Appendix G1. File review elements were scored as either *Met* or *Not Met*. Health plans were required to follow up on any required actions associated with *Not Met* elements to ensure compliance.

HSAG reviewed information provided by the health plans to assess system effectiveness. HSAG assessed the following elements:

- CI intake and process
- CI data reporting
- CI reporting to investigating authorities
- Communication with investigating authorities
- Internal processes and oversight to resolve CIs
- Remediation of recommendations from quarterly reviews
- Categorization of falls within internal CI systems
- Internal documentation, including CI forms and case note documentation
- Processes including care plan/service plan updates, investigating authority reports and responses, and closure/resolution of incidents
- Provision of abuse, neglect, and exploitation (ANE) education to enrollees

System Effectiveness and File Review Findings

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

Strengths	• All six health plans demonstrated 90 percent or higher performance in reporting CIs to the appropriate investigating authority. • All six health plans demonstrated 90 percent or higher performance in assuring the health, safety, and welfare (HSW) of the enrollee after the CI was identified. • All six health plans demonstrated system effectiveness in the ability to identify, address, and seek to prevent instances of ANE and unexplained death. • All six health plans demonstrated appropriate revision of P&Ps to address updated guidance from investigating authorities.
Opportunities for Improvement	**Opportunity:** All six health plans have an opportunity for improvement in contacting enrollees' authorized representatives, when applicable, to assess an enrollee's HSW for CIs that originated in a nursing home or supportive living program (SLP) in the absence of being able to directly reach the enrollee. **Why the Opportunity Exists:** Due to COVID-19 visitation restrictions, health plans were unable to conduct face-to-face visits with enrollees who reside in a nursing home or SLP. This barrier has adversely impacted the health plans' ability to contact enrollees, as most enrollees do not have a direct line and the nursing staff are unable to field the volume of incoming calls. **Recommendation:** The health plans should consider developing procedures for contacting authorized representatives and/or other care team members and consistent documentation of barriers to reach enrollees who reside in the nursing home or SLP.
	Opportunity: The six health plans do not uniformly report internal CIs, which impacts the aggregate analysis of the health plans' performance. **Why the Opportunity Exists:** All six health plans demonstrated utilization of CI categorizations that were inconsistent with the *HFS Critical Incident Guide.* **Recommendation:** The health plans would benefit from receiving direction from HFS regarding the utilization of categories specified in the *HFS Critical Incident Guide*. HFS should consider having the health plans submit their CI categorization for approval.
	Opportunity: Aetna and Meridian demonstrated inconsistent processes and procedures for handling CIs in the HealthChoice and MMAI lines of business. **Why the Opportunity Exists:** Upon acquisition of additional populations (Centene/IlliniCare HealthChoice to Aetna; Centene/IlliniCare MMAI to Meridian), Aetna and Meridian did not integrate the CI processes of the two

lines of businesses, resulting in separate internal processes for reporting, monitoring, tracking, and resolving CIs. **Recommendation:** Aetna and Meridian should consider merging internal CI processes to ensure consistent process application, valid data capture and categorization of CIs, and identification and utilization of best practices between lines of business. The health plans should consider conducting a strengths, weaknesses, opportunities, and threats (SWOT) analysis.
Opportunity: BCBSIL, County Care, Molina, and Humana demonstrated an opportunity for improvement with following their process for communication with the investigating authority after the initial CI report. **Why the Opportunity Exists:** The health plans do not consistently apply their internal procedures to contact the investigating authority for an update on the status of the CI report prior to closure of the internal CI. **Recommendation:** The health plans should consider revising their processes for communication with the investigating authority to align with the external entity's communication requirements. The health plans should provide training to staff members on their process for conducting follow-up with the investigating authority after an initial CI report has been made.
Opportunity: Humana's self-reported CI data revealed that the majority of its CIs were identified through emergency department or inpatient utilization and categorized as "falls with injury" and "significant medical event." The health plan demonstrated a lack of identification of CIs related to abuse, neglect, and exploitation or other incidents reported directly by enrollees, authorized representatives, and providers. **Why the Opportunity Exists:** The health plan's utilization management processes may directly identify CIs based on coding or file review; however, other CIs would be reported to health plan staff directly from enrollees, authorized representatives, or providers. Due to COVID-19 visitation restrictions, direct enrollee contact by health plan staff members, including care coordinators, was limited, which may have impeded detection of some potential CIs. **Recommendation:** Humana should identify potential barriers that impact staff, enrollees, and providers in identifying and reporting instances of abuse, neglect, or exploitation. The health plan should reeducate staff, enrollees, and providers on identification of abuse, neglect, and exploitation and the health plan's reporting requirements.

Health Plan-Specific Results

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

CMS HCBS Waiver Performance Measures Record Reviews

Overview

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

This summary of findings for the SFY 2021 HCBS Waivers CMS Performance Measures Record provides an evaluation of the health plans' compliance with CMS waiver performance measures requirements. The report includes findings for HealthChoice Illinois, including the MLTSS 1915(b) waiver program and the MMAI managed care population. Details about the methodology and detailed results are included in Appendix G1.

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

HealthChoice Illinois Record Reviews

Table 7-1 displays the five HealthChoice Illinois health plans reviewed in SFY 2021.

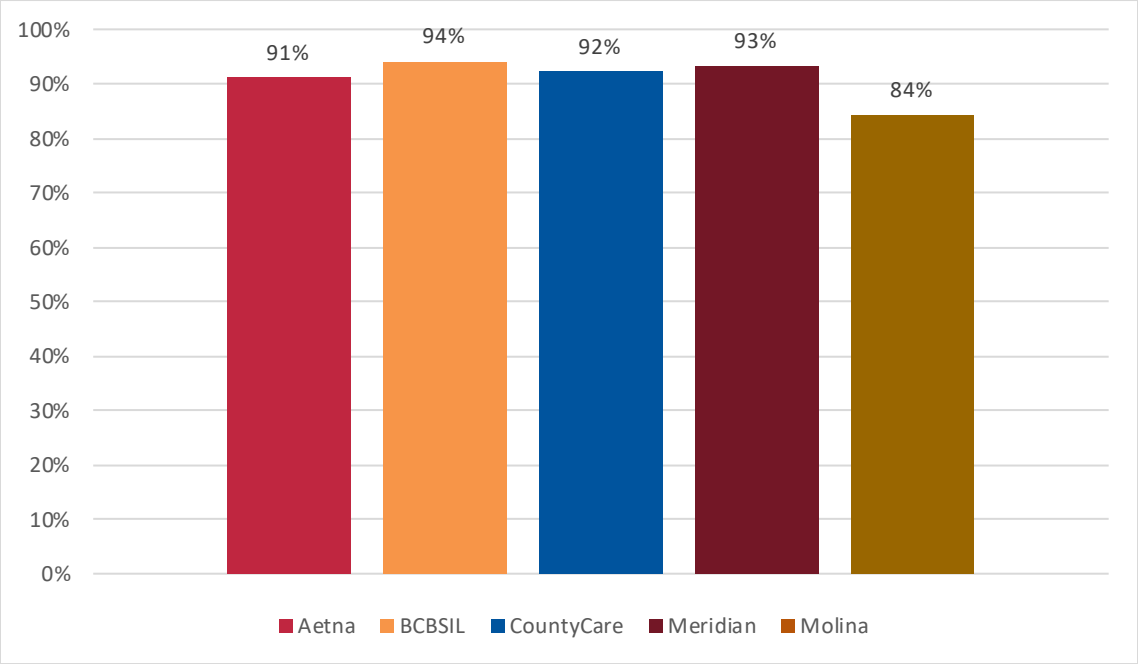
Table 7-1—HealthChoice Illinois Plans Reviewed in SFY 2021

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (Serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

During SFY 2021, 1,457 HealthChoice records were reviewed using HSAG's web-based data collection tool, which identified 1,272 HealthChoice findings of noncompliance.

Figure 7-1 displays a computed average of the total performance achieved by each health plan on all 18 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 18 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. Four of the five health plans averaged greater than 90 percent compliance in SFY 2021. There was a difference of 10 percentage points (84 percent to 94 percent) among health plans.

Figure 7-1—Overall HealthChoice Compliance



SFY 2021 represented the fourth year of review for the HealthChoice population, and several successes were identified as well as opportunities for improvement.

Strengths

- Twelve of the 18 CMS performance measures averaged 90 percent or greater compliance.
- Five of the 18 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2021 when compared to SFY 2020.
- Four of the five health plans averaged greater than 90 percent compliance.
- Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for five measures in SFY 2021.
- Compared to SFY 2020, CountyCare realized a statistically significant increase in performance for seven measures in SFY 2021.
- Compared to SFY 2020, Meridian realized a statistically significant increase in performance for four measures in SFY 2021.

- Compared to SFY 2020, the BI waiver realized a statistically significant increase in performance for two measures in SFY 2021.
- Compared to SFY 2020, the ELD waiver realized a statistically significant increase in performance for three measures in SFY 2021.
- Compared to SFY 2020, the HIV waiver realized a statistically significant increase in performance for three measures in SFY 2021.
- Compared to SFY 2020, the PD waiver realized a statistically significant increase in performance for two measures in SFY 2021.

Opportunities for Improvement

Opportunity: Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 28 percent compliance. All five health plans performed at a rate of less than 50 percent.

Why the Opportunity Exists: Case management systems may not include appropriate alerts to assist case managers in completing waiver service plan renewals in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals.

Recommendation: Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans. Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.

Opportunity: Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, averaged 7 percent compliance in SFY 2021. All five health plans performed at a rate of less than 25 percent in SFY 2021.

Why the Opportunity Exists: Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue.

Recommendation: Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Opportunity: Measure 20C, *a PA evaluation was completed annually*, averaged 73 percent compliance in SFY 2021.

Why the Opportunity Exists: Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue.

Recommendation: Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Opportunity: Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 68 percent and 66 percent compliance for the BI and HIV waivers, respectively.

Why the Opportunity Exists: 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.

Recommendation: Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement. Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30. Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required. Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

MLTSS Record Reviews

Table 7-2 displays the five MLTSS health plans reviewed in SFY 2021.

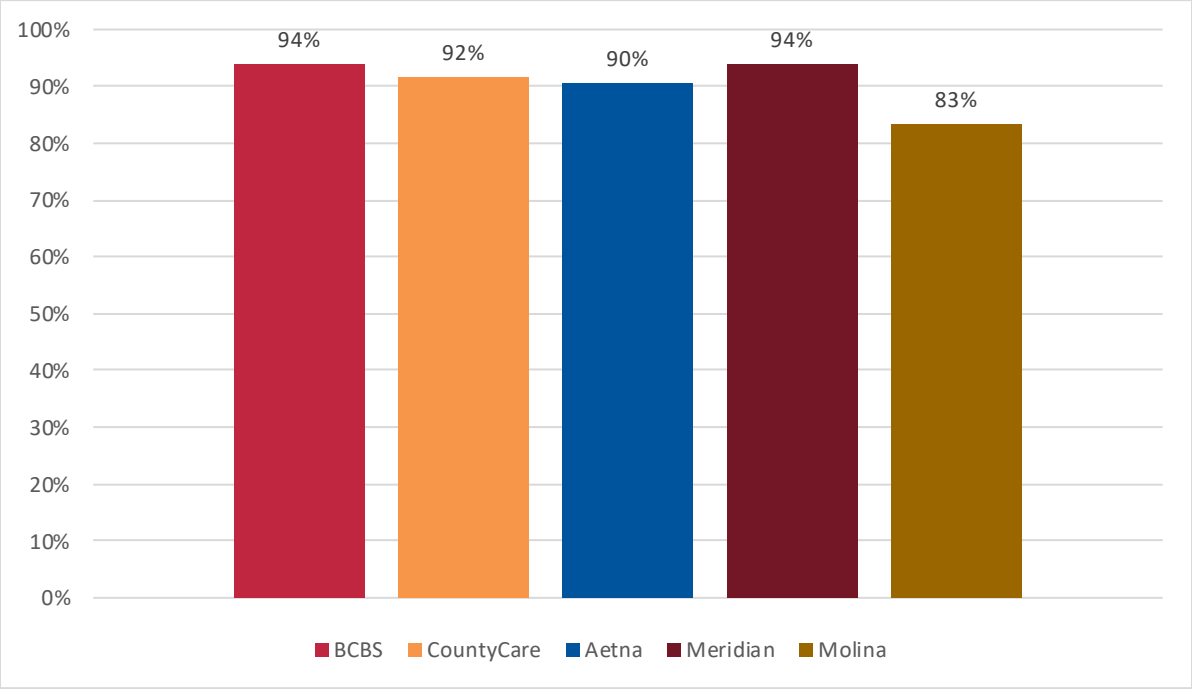
Table 7-2—MLTSS Health Plans Reviewed in SFY 2021

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan (Serves Cook County only)	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

During SFY 2021, 1,507 MLTSS records were reviewed using HSAG's web-based data collection tool, which identified 1,391 MLTSS findings of noncompliance.

Figure 7-2 displays a computed average of the total performance achieved by each health plan on all 18 CMS waiver performance measures reviewed by HSAG. Displaying each health plan's overall average on the 18 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. Four of the five health plans averaged greater than 90 percent compliance in SFY 2021. There was a difference of 11 percentage points (83 percent to 94 percent) among health plans.

Figure 7-2—Overall MLTSS Compliance



SFY 2021 represented the third year of review for the MLTSS population, and several successes were identified as well as opportunities for improvement.

Strengths	• Thirteen of the 18 CMS performance measures averaged 90 percent or greater compliance. • Seven of the 18 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2021 when compared to SFY 2020. • Four of the five health plans averaged greater than 90 percent compliance. • Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for four measures in SFY 2021. • Compared to SFY 2020, CountyCare realized a statistically significant increase in performance for four measures in SFY 2021. • Compared to SFY 2020, Meridian realized a statistically significant increase in performance for six measures in SFY 2021. • Compared to SFY 2020, Molina realized a statistically significant increase in performance for one measure in SFY 2021. • Compared to SFY 2020, the BI waiver realized a statistically significant increase in performance for two measures in SFY 2021. • Compared to SFY 2020, the ELD waiver realized a statistically significant increase in performance for one measure in SFY 2021. • Compared to SFY 2020, the HIV waiver realized a statistically significant increase in performance for three measures in SFY 2021. • Compared to SFY 2020, the PD waiver realized a statistically significant increase in performance for six measures in SFY 2021.
Opportunities for Improvement	**Opportunity:** Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 28 percent compliance. All five health plans performed at a rate of less than 50 percent. **Why the Opportunity Exists:** Case management systems may not include appropriate alerts to assist case managers in completing waiver service plan renewals in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals. **Recommendation:** Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to 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.

Opportunity: Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, averaged 6 percent compliance in SFY 2021. All five health plans performed at a rate of less than 50 percent in SFY 2021.

Why the Opportunity Exists: Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue.

Recommendation: Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Opportunity: Measure 20C, *a PA evaluation was completed annually*, averaged 70 percent compliance in SFY 2021.

Why the Opportunity Exists: Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue.

Recommendation: Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

Opportunity: Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 71 percent and 72 percent compliance for the BI and HIV waivers, respectively.

Why the Opportunity Exists: 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.

Recommendation: Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement. Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30. Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required. Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

MMAI Record Reviews

Table 7-3 displays the six MMAI health plans reviewed during SFY 2021.

Table 7-3—MMAI Health Plans Reviewed in SFY 2021

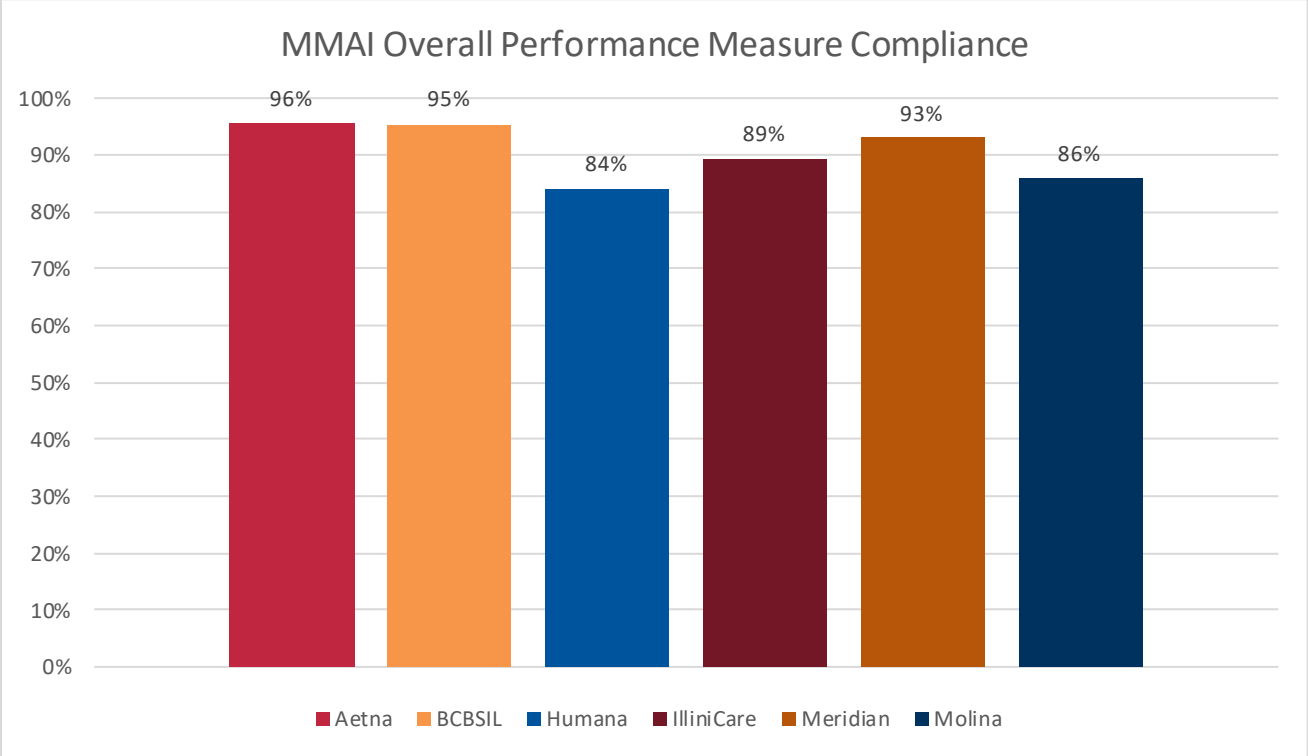
Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
Humana Health Plan, Inc.	Humana
MeridianComplete	Meridian
MeridianTotal (previously IlliniCare Health Plan)	MeridianTotal/IlliniCare
Molina Healthcare of Illinois	Molina

During SFY 2021, 1,258 MMAI records were reviewed using HSAG's web-based data collection tool, which identified 1,118 findings of noncompliance.

Figure 7-3 displays a computed average of the total performance achieved by each health plan on all 18 CMS waiver performance measures reviewed by HSAG during SFY 2021. Each health plan's overall average on the 18 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 overall compliance in SFY 2021. There was a difference of 12 percentage points (84 percent to 96 percent) among health plans.

Figure 7-3—Overall MMAI Compliance



SFY 2021 represented the seventh year of review for the MMAI population, and several successes were identified as well as opportunities for improvement.

Strengths

- Twelve of the 18 CMS performance measures had rates exceeding 90 percent in SFY 2021.
- 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*, realized a statistically significant increase in performance in SFY 2021 when compared to SFY 2020.
- Three of the six health plans averaged greater than 90 percent compliance in SFY 2021.
- Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for four measures in SFY 2021.
- Compared to SFY 2020, Molina realized a statistically significant increase in performance for one measure in SFY 2021.
- Meridian maintained stable performance in SFY 2021 when compared to SFY 2020; performance reflected merging of IlliniCare and MeridianComplete data and enrollees.
- Compared to SFY 2020, the ELD and PD waivers realized a statistically significant increase in one measure in SFY 2021.

Opportunities for Improvement	**Opportunity:** Measure 4A, *overdue service plan was completed within 30 days of expected renewal*, averaged 32 percent compliance in SFY 2021. All six health plans performed at a rate of less than 50 percent in SFY 2021. **Why the Opportunity Exists:** Case management systems may not include appropriate alerts to assist case managers in completing waiver service plan renewals in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that activities include assessment of compliance with timely waiver service renewals. **Recommendation:** Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to update waiver service plans. Educate the care manager/care coordination staff about the expectation to complete overdue service plans no later than 30 days after the date of expected renewal.
	Opportunity: Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, averaged 11 percent compliance in SFY 2021. All six health plans performed at a rate of less than 50 percent in SFY 2021. **Why the Opportunity Exists:** Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue. **Recommendation:** Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate the care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
	Opportunity: Measure 20C, *a PA evaluation was completed annually*, averaged 75 percent compliance in SFY 2021. **Why the Opportunity Exists:** Case management systems may not include appropriate alerts to assist case managers in completing annual PA evaluations in a timely manner. Health plans may not have adequate oversight and monitoring procedures to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue. **Recommendation:** Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to complete PA evaluations. Educate the care manager/care

coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.
Opportunity: Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 74 percent and 77 percent compliance for the BI and HIV waivers, respectively, in SFY 2021. **Why the Opportunity Exists:** 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. **Recommendation:** Health plans should conduct a root cause analysis on their HIV and BI cases to determine opportunities to effect change in this measure. Form targeted teams of case managers/care coordinators who manage HIV and BI waiver caseloads to discuss barriers to effective contact and brainstorm ideas for improvement. Analyze staffing ratios to ensure case managers/care coordinators who manage HIV and BI waiver caseloads do not have caseloads greater than 30. Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required. Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement. Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.

Remediation, Health Plan Interventions, and Process Improvements

Remediation

As a result of the on-site reviews, HSAG identified noncompliant performance measures. The health plans received their individualized report of findings subsequent to each on-site record review and were required to remediate the noncompliant findings and implement performance improvement strategies to improve the quality of care management/care coordination activities for waiver enrollees. Remediation actions were defined in the contract and were specific to each CMS waiver performance measure. The time frame for remediation of findings was 60 days, except for two measures, 42G and 49G, that fall under the CMS Health and Welfare Waiver Assurance and require remediation within 30 days. HSAG monitored compliance with timely remediation of these findings by reviewing completion of remediation actions within 30 and 60 days as required by CMS and HFS. During SFY 2021, all health plans demonstrated full compliance with completion of remediation action documentation for all noncompliant performance measures within 30 and 60 days, as required.

HFS was committed to ensuring that remediation actions were completed and that enrollee HSW was maintained. HSAG completed remediation validation semiannually to determine if remediation actions were completed appropriately by the health plans.

Overall remediation validation among the five HealthChoice health plans cases averaged 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. BCBSIL did not demonstrate 100 percent compliance; noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. 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 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. Molina did not demonstrate 100 percent compliance; noncompliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Overall remediation validation among the six MMAI health plans averaged 99 percent. Five of the six health plans demonstrated 100 percent compliance with remediation validation. Humana's noncompliant remediation validation case demonstrated that training materials did not include topics to address the remediation action required for all performance measures. HSAG provided technical assistance regarding expectations for staff training.

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 2020 reviews, efforts to incorporate technical assistance received during onsite reviews, and efforts to integrate HFS guidance into internal processes.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY 2021. 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 completion of annual reassessments, care plan and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.

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 2021 Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) annual report.

Methodology

Annually, HFS provides the health plans with a QA/UR/PR report outline, which describes the expectations for the annual report. HSAG reviewed the report outline and the annual QA/UR/PR report requirements in the HealthChoice Illinois and MMAI contracts to develop an assessment tool.

For contractually required elements, the HSAG review team assessed the QA/UR/PR reports for evidence of compliance. HSAG used a two-point scoring methodology. Each requirement was scored as *Met* (the report included the element required) or *Not Met* (the report did not include the element required). HSAG also used a designation of *N/A* if the requirement was not applicable to the health plan; *N/A* findings were not included in the two-point scoring methodology.

HSAG calculated an overall percentage-of-compliance score for each of the annual report elements. HSAG calculated the score by adding the score from each element, indicating either a score of *Met* (value: 1 point) or *Not Met* (value: 0 points), and dividing the summed scores by the total number of applicable cases.

HSAG also assessed general requirements for the annual report, as identified in HFS' report outline. General requirements were scored *Met* or *Not Met* but were not included in overall scoring. Elements scored as *Not Met* were included in recommendations to inform health plans and HFS of opportunities for improved compliance to HFS' report outline requirements.

HSAG also assessed the overall quality and effectiveness of the health plan's annual report. This qualitative assessment was scored as *Beginning, Effective,* or *Mature* but was not included in overall scoring. Scores of *Beginning* or *Effective* were included in recommendations to inform the health plans and HFS of opportunities for improvement to the health plan's overall processes.

General Requirements

HSAG assessed each health plan's FY 2021 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 10 pages?
- Is the entire report (excluding appendices) no more than 70 pages?
- Does the report cover the correct time period (FY 2021, HEDIS calendar year 2020)?
- Does the report include discussion of the impact of COVID-19 on operations and quality results, including implementation of any community or enrollee initiatives related to COVID-19?
- Does the report include discussion of analysis, initiatives, and opportunities to address health equity, including analysis of geography, disproportionately impacted areas, etc.

Contract Requirements

As shown in Table 7-4, HSAG's assessment of annual QA/UR/PR report contract requirements included 23 elements across HealthChoice and MMAI; some elements were applicable to only one contract.

Table 7-4—QA/UR/PR Contract Requirements

Standard
1. Does the report include an Executive Summary that provides a high-level discussion/analysis of each area of the Annual Report of findings, accomplishments, barriers and continued need for quality improvement? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7; MMAI Three-Way 1/1/18, 2.13.5.1.2*
2. Does the report include a detailed analysis of the QA/UR/PR Plan with overview of goal areas? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.1; MMAI Three-Way 1/1/18, 2.13.5.1.2.1*
3. Does the report include a detailed analysis of the major initiatives to comply with the State Quality Strategy, including all pillars? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.2; MMAI Three-Way 1/1/18, 2.13.5.1.2.2*
4. Does the report include a detailed analysis of the quality improvement structure and program, including the adequacy of QI program resources, QI Committee structure, practitioner participation and leadership involvement in the QI program, and any needs for restructuring/changes to the QI program for the subsequent year? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.10, 1.1.4-1.1.6; MMAI Three-Way 1/1/18, 2.13.1, 2.13.5.1.2.10*
5. Does the report include a detailed analysis of quality improvement and work plan monitoring? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.3; MMAI Three-Way 1/1/18, 2.13.5.1.2.3*
6. Does the report include a detailed analysis of network access and availability and service improvements, including access and utilization of dental services? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.4*
7. Does the report include a detailed analysis of network access and availability and service improvements, including access, utilization of dental services, and provider satisfaction? *MMAI Three-Way 1/1/18, 2.13.5.1.2.4*
8. Does the report include a detailed analysis of cultural competency? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.5; MMAI Three-Way 1/1/18, 2.13.5.1.2.5*

Standard
9. Does the report include a detailed population profile including demographics and geography-based statistics (disproportionately impacted areas, urban/rural, etc.)? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.7; MMAI Three-Way 1/1/18, 2.13.5.1.2.7*
10. Does the report include a detailed analysis of improvements in Care Coordination/Care Management and Clinical Services/Programs? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.8; MMAI Three-Way 1/1/18, 2.13.5.1.2.8*
11. Does the report include a detailed analysis of the effectiveness of the Care Coordination Model of Care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.9*
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*
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*
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*
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*
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*
17. Does the report include a detailed analysis of dental care? *HealthChoice 2018-24-001, Attachment XI, Section 1.1.3.7.15*
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*
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*
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*
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*
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*
23. Does the report include a detailed analysis of Americans with Disabilities Act compliance/monitoring? *MMAI Three-Way 1/1/18, 2.13.5.1.2.19*

Findings and Recommendations

General Requirements

Review of the health plans' annual reports identified that five of six health plans demonstrated full compliance with the general requirements. Aetna failed to include a detailed analysis or summary for its HealthChoice population. The health plan should realign the overall quality process to demonstrate that the health plan has a robust process inclusive of all populations/programs served.

Contract Requirements

Table 7-5 summarizes the findings related to contract requirements for all health plans.

Table 7-5—Summary Scoring Table for Contract Requirements

Scoring Summary—Contract Elements				
Health Plan	**Number Met**	**Number Not Met**	**Number N/A**	**Performance Score**
Aetna	17	6	0	74% (17/23)
BCBSIL	19	4	0	83% (19/23)
CountyCare	18	2	3	90% (18/20)
Humana	16	3	4	84% (16/19)
Meridian	20	3	0	87% (20/23)
Molina	21	2	0	91% (21/23)

HSAG offered the following overall recommendations to HFS:

1. All six health plans received recommendations to include a detailed analysis of access and utilization of dental services. HFS should consider providing additional detail to the health plans of expectations for reporting on access and utilization of dental services.
2. Four of the six health plans received recommendations to include a detailed analysis of cultural competency. HFS should require the health plans to provide their culturally and linguistically appropriate services (CLAS) analyses and/or substantial analysis of the inclusion of cultural competency plans and programs. HFS may consider use of the CMS document, "*A Practical Guide*

to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities"[7-3] as a resource for health plans.

3. To demonstrate achievement in the qualitative analysis section, all health plans may benefit from additional direction from HFS regarding expectations for analysis and reporting. Health plans should be encouraged to consider use of the report outline narrative example, which may provide alternatives to the report structure that may allow for more intuitive analysis.
4. HFS' health plan account managers should follow up with the health plans to provide guidance on findings and expectations to ensure a successful report submission in FY 2022.

Remediation

As directed by HFS, remediation of findings will be expected to be addressed in the health plans' FY 2022 reports.

[7-3] National Committee for Quality Assurance. A Practical Guide to Implementing the National CLAS Standards: For Racial, Ethnic and Linguistic Minorities, People with Disabilities and Sexual and Gender Minorities, December 2016. Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/CLAS-Toolkit-12-7-16.pdf. Accessed on: Jan 18, 2022.

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 2021.

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 health 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.

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://www2.illinois.gov/hfs/info/reports/Pages/default.aspx.

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

Freedom of Information Act (FOIA) Requests

The FOIA pertains to a person's right of access to federal agency records, except those protected from disclosure by a set of exemptions and special law enforcement exclusions. When a FOIA request is received, HFS often requests HSAG's assistance to provide the necessary information to fulfill the request as required.

Development of Program-Specific Performance Measures

Historically, HSAG has provided key support to assist HFS in developing performance measures that meet the unique demands of Illinois Medicaid programs. HSAG works collaboratively with HFS to identify and develop performance measures specific to each of the programs and the populations they currently serve as part of the care coordination expansion. In SFY 2021, HSAG provided TA in the development and selection of performance measures, including those for the YouthCare Specialty Plan.

HFS, Health Plan, and Stakeholder Training

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

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

Report and Data Collection Templates

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

HFS understands that a key to achieving Medicaid delivery system reform is data analytic capacity. HFS seeks to offer support and solutions to health plans in building and strengthening their data analytic capacity and 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 health plans participate. HFS used the map to inform stakeholders and legislators of expansion progress, and it was displayed publicly on the HFS website. Throughout SFY 2021, 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://www2.illinois.gov/hfs/SiteCollectionDocuments/StatewideHealthChoiceIllinoisPlansAugust12021MMAIUpdate.pdf.

Appendix A1. 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 opportunities for improvement 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).

Table A1-1 lists the required and recommended elements for the EQR Annual Technical Report, in accordance with 42 CFR §438.364 and recent CMS technical report feedback received by states. The table identifies the page number where the corresponding information that addresses each element is located in the Illinois EQR Annual Technical Report.

Table A1-1—Technical Report Elements

	Required Elements	Page Number
1	The state submitted its EQR Annual Technical Report by April 30.	NA
2	All eligible Medicaid and CHIP plans are included in the report.	3-4

	Required Elements	Page Number
3a	Required elements are included in the report: Describe the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were **aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the managed care organization (MCO), prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.**	7
3b	Required elements are included in the report: An assessment of the **strengths and opportunities for improvement of each MCO, PIHP, PAHP, and PCCM entity** with respect to (a) quality, (b) timeliness, and (c) access to the health care services furnished by each MCO, PIHP, PAHP, or PCCM entity (described in 42 CFR §438.310[c][2]) furnished to Medicaid and/or CHIP beneficiaries. Contain specific recommendations for improvement of identified opportunities.	Appendix A3
3c	Required elements are included in the report: Describe how the state can **target goals and objectives in the quality strategy**, under 42 CFR §438.340, to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid or CHIP enrollees.	14-16
3d	Recommend improvements to the quality of health care services furnished by each MCP.	Appendix A3
3e	Provides state-level recommendations for performance improvement.	14-16, 27, 30, 32-33, 36, 45-46, 60, 85
3f	Ensure methodologically appropriate, comparative information about all MCPs.	Throughout
3f	Assess the degree to which each MCP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	Appendix A2
4	Validation of PIPs: A description of **PIP interventions** associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	Section 4
4a	PIPs: **Interventions**	82-84
4b	PIPs: **Objectives**	76
4c	PIPs: **Technical methods of data collection and analysis**	77, 82-84
4d	PIPs: **Description of data obtained**	82-84
4e	PIPs: **Conclusions drawn from the data**	85-92, Appendix A3
5	Validation of performance measures (PMV): A description of **objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.**	Section 2
5a	PMV: **Objectives**	18-19

	Required Elements	Page Number
5b	PMV: **Technical methods of data collection and analysis**	Appendix B1
5c	PMV: **Description of data obtained**	Appendix B1
5d	PMV: **Conclusions drawn from the data**	30, 32-33, 36, 45-46, Appendix A3
6	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report including information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330.	Section 3
6a	Review for compliance: **Objectives**	Appendix C
6b	Review for compliance: **Technical methods of data collection and analysis**	Appendix C
6c	Review for compliance: **Description of data obtained**	Appendix C
6d	Review for compliance: **Conclusions drawn from the data**	53-56, 60, 66-67, 72, Appendix A3
7	**Each remaining activity** included in the technical report must include a **description of the activity** and the following information: • Optional activities: **Objectives** • Optional activities: **Technical methods of data collection and analysis** • Optional activities: **Description of data obtained** • Optional activities: **Conclusions drawn from the data**	Section 5, 6, 7

Scope of Report

Mandatory activities for SFY 2021 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 2021 included:

- Administration or validation of consumer or provider surveys of quality of care.
- 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.[A1-1]
- CMS Home- and Community-Based Services (HCBS) Waiver Performance Measures Record Reviews—To monitor the quality of services and supports provided to the HCBS waiver program enrollees, HSAG continued quarterly record reviews for health plans to monitor performance on the HCBS waiver performance measures.
- Critical Incident Monitoring Reviews—To assess the health plans' compliance to health, safety, and welfare and CI monitoring and reporting, as required by State and federal statutes and regulations, or otherwise a condition for HCBS waivers. HSAG conducted quarterly record reviews for health plans to monitor system effectiveness of CI programs.
- Care Coordination Staffing and Training Reviews—To assess the health plans' compliance with contract requirements related to staffing and training of case management staff members. HSAG conducted biannual reviews to determine health plan performance on multiple staffing and training elements.
- 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.

Medicaid Managed Care Programs and Populations

HealthChoice Illinois

HealthChoice Illinois health plans provide the full spectrum of Medicaid-covered services to the general Medicaid population through an integrated care delivery system. Populations/services covered include:

[A1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 13, 2022.

- Families and children eligible for Medicaid through Title XIX or Title XXI (Children's Health Insurance Program).
- Affordable Care Act expansion Medicaid-eligible adults.
- Medicaid-eligible adults with disabilities who are not eligible for Medicare.
- Medicaid-eligible older adults who are not eligible for Medicare.
- Managed Long-Term Services and Supports (MLTSS 1915(b) waiver) provides dual-eligible beneficiaries institutional or community-based long-term services and supports (including HCBS waivers), transportation, and behavioral health services.
- Special needs children (SNC 1915[b] waiver), defined as individuals under the age of 21 who meet any of the following criteria:
  - Are eligible for Supplemental Security Income (SSI) under Title XVI;
  - Receive Title V care coordination services through the Division of Specialized Care for Children (DSCC) (also known as the CORE Program);
  - Qualify as disabled;
  - Are under the legal custody or guardianship of the Illinois Department of Children and Family Services (DCFS); or
  - Formerly were under the legal care of DCFS and are receiving assistance through Title IV-E.

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. The MMAI program expanded statewide effective July 1, 2021.

Illinois Health Plan Enrollment

Table A1-2 identifies the HealthChoice Illinois health plans, their counties of operation, and the enrollment for each health plan.

Table A1-2—HealthChoice Illinois Health Plans and Enrollment

Health Plan Name	Counties	June 2021 Enrollment
Aetna	All Counties	395,630
BCBSIL	All Counties	619,437
CountyCare	Cook County	393,680
Meridian	All Counties	862,904
Molina	All Counties	306,657

Health Plan Name	Counties	June 2021 Enrollment
	Total	**2,578,308**

Table A1-3 identifies the MMAI health plans, their counties of operation, and the enrollment for each health plan.

Table A1-3—MMAI Health Plans and Enrollment

Health Plan Name	Regions	June 2021 Enrollment
Aetna	All Counties	9,421
BCBSIL	Serving all counties except: Champaign, Ingham, and Massac	20,028
Humana	Serving all counties except: Jo Daviess, Macon, Massac, and Rock Island	9,674
Meridian	Serving all counties except: Alexander, Franklin, Jackson, Macon, Massac, Pulaski, Wabash, and Williamson	13,713
Molina	Serving all counties except: Kankakee, Lake, Massac, and Wabash	8,822
	Total	**61,658**

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.[A1-2]

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

[A1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations.* Title 42, Volume 81, May 6, 2016.

on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).[A1-3]

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."[A1-4] 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.

[A1-3] Ibid.

[A1-4] National Committee for Quality Assurance. 2013 Standards and Guidelines for Managed Behavioral Health Organizations (MBHOs) and MCOs.

Performance Measure Domains

Table A1-4 shows HSAG's assignment of the HEDIS measurement year (MY) 2020 performance measures HFS prioritized for improvement into the domains of quality, timeliness, and access.

Table A1-4—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Ambulatory Care—Per 1,000 Member Months—ED Visits—Total and *Outpatient Visits—Total*	NA	NA	NA
Child Health			
Annual Dental Visit—Total			✓
Child and Adolescent Well-Care Visits—Total	✓		✓
Childhood Immunization Status—Combination 3 and *Combination 10*	✓		
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and *Combination 2 (Meningococcal, Tdap, HPV)*	✓		
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Body Mass Index (BMI) Percentile Documentation—Total, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*	✓		
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Visits and *Well-Child Visits for Age 15 Months–30 Months—Two or More Visits*	✓		✓
Women's Health			
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women—Total	✓		
Maternal Health			
Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*	✓	✓	✓
Living With Illness			
Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Control (<8.0%), HbA1c Poor Control (>9.0%), HbA1c Testing, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*	✓		
Controlling High Blood Pressure	✓		

Performance Measure	Quality	Timeliness	Access
Statin Therapy for People With Diabetes—Received Statin Therapy and *Statin Adherence 80%*	✓		
Adult Behavioral Health			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Ages 18+ and *30-Day Follow-Up—Ages 18+*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64, and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 18–64. 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64, and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18–64, 7-Day Follow-Up—Ages 65+, 30-Day Follow-Up—Ages 18–64 and *30-Day Follow-Up—Ages 65+*	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 18+ and *Engagement of AOD Treatment—Ages 18+*	✓	✓	✓
Mental Health Utilization—Any Service—Ages 18-64, Any Service—Ages 65+, Inpatient—Ages 18–64, Inpatient—Ages 65+, Intensive Outpatient or Partial Hospitalization—Ages 18–64, Intensive Outpatient or Partial Hospitalization—Ages 65+, Outpatient—Ages 18-64, Outpatient—Ages 65+, ED—Ages 18–64, ED—Ages 65+, Telehealth—Ages 18–64, and *Telehealth—Ages 65+*	NA	NA	NA
Pharmacotherapy for Opioid Use Disorder—Ages 18–64, Ages 65+, and *Total (Ages 16+)*	✓	✓	✓
Child Behavioral Health			
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Ages 13–17 and *30-Day Follow-Up—Ages 13–17*	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6–17 and *30-Day Follow-Up—Ages 6–17*	✓	✓	✓
Follow-Up After High Intensity Care for Substance Use Disorder—7-Day Follow-Up—Ages 13–17 and *30-Day Follow-Up—Ages 13–17*	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6–17 and *30-Day Follow-Up—Ages 6–17*	✓	✓	✓
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Ages 13–17 and *Engagement of AOD Treatment—Ages 13–17*	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Mental Health Utilization—Any Service—Ages 0–12, Any Service—Ages 13–17, Inpatient—Ages 0–12, Inpatient—Ages 13–17, Intensive Outpatient or Partial Hospitalization—Ages 0–12, Intensive Outpatient or Partial Hospitalization—Ages 13–17, Outpatient—Ages 0–12, Outpatient—Ages 13–17, Telehealth—Ages 0–12, and *Telehealth—Ages 13–17*	NA	NA	NA
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total, Cholesterol Testing—Total, and *Blood Glucose and Cholesterol Testing—Total*	✓		

NA indicates this measure is a utilization measure and is not assigned to a domain.

Appendix A2. Follow-Up on Prior Year EQR Recommendations

Section Contents

Prior Recommendations A2-2

Health Plan Follow-Up A2-7

Prior Recommendations

The tables in this section identify recommendations for quality improvement made in the SFY 2020 EQR Technical Report and an assessment of the degree to which each health plan has addressed the recommendations effectively.

Table A2-1—Recommendations from Prior EQR Report

Care Coordination/Care Management (CC/CM) Processes
• Enhance timely communication with primary care provider (PCP), including the sharing of care plans and coordination of services to meet enrollees' needs.
• Monitor case activity and provide regular feedback to care managers to ensure timely completion of assessments/reassessments, care plans, and PCP communication.
• Implement organization-wide strategies to identify difficult-to-locate beneficiaries with complex needs and connect them with care managers.
• Continue improvements to the children's behavioral health (BH) CC/CM program to implement effective strategies for locating members, completing screenings, and creating crisis safety plans; enhance communication with PCPs; and ensure timely follow-up.
• Continue oversight and monitoring of caseload requirements for high- and moderate-risk enrollees.
• Continue to 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.
• 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 BI waiver enrollees at least one time per month.
• Improve documentation of valid contact with HIV waiver enrollees once per month, with a face-to-face contact bimonthly.
• 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 curricula 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.

Behavioral Health
• The statewide average and measure rates for all six health plans ranked at or 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 ED settings, discharge planning, and handoffs to community settings for members with BH needs.
Prevention and Screenings
• 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 at or below the 50th percentile.
• 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 at or 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.
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.

Provider Network Adequacy
• 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 center (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.
• Work with obstetrics/gynecology (OB/GYN) providers to ensure that (1) providers are aware of the different appointment availability standards based on a woman's trimester and (2) barriers to scheduling appointments are identified and corrected.
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.
• 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.

Compliance Monitoring—CI Reporting
• 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 the initial CI report.

Health Plan Follow-Up

Table A2-2—Follow-Up From Health Plans on Recommendations From Prior EQR Report

Focused Areas of Improvement	Health Plan Follow-Up
BCBSIL	
CC/CM Processes	Established multiple initiatives to improve care coordination including software enhancements to increase efficiency with member documentation, enhanced communication with State agencies, implementation of virtual provider meet and greets, and implementation of monthly provider in-service meetings between staff and waiver service providers to review provider programs with our teams to provide education and offer services to members. MMAI care coordination established partnerships with Advocate Healthcare facilities to incorporate a transition of care plan, perform additional outreach pre- and post-discharge to PCPs, and gain access to two of the plan's largest provider electronic medical record systems. MMAI decreased readmissions to Advocate Healthcare facilities by 5 percent. Expanded the "frequent ER program" in which care coordinators call the members with four or more emergency room (ER) visits within a one-month span. A pilot program was initiated by care coordination which involves daily collaboration with the utilization management department to follow up with high-risk members from admission through discharge.
Behavioral Health	To further enhance relationships with acute care facilities, BCBSIL behavioral health established a facility liaison role with over 21 high-volume facilities to provide one point of contact to assist with discharge planning and promote continuity of care after member discharge. The Family Leadership Council migrated to a virtual platform to facilitate opportunities to engage families directly regarding issues in children's behavioral health resulting in a 175 percent increase in attendance compared to SFY 2020 and expanded eligible member participation through the State of Illinois. To increase access to behavioral health and substance use services, BCBSIL assisted in expanding the telemedicine infrastructure and capabilities of BCBSIL's contracted CMHC substance use recovery providers by funding of $2M for 58 providers' covered services and technology equipment and software. Established clinical liaisons at multiple facilities to facilitate communication and strengthen partnerships with participating providers.

Focused Areas of Improvement	Health Plan Follow-Up
BCBSIL	
Prevention and Screenings	Special Beginnings launched YoMingo, an online database platform to increase engagement with pregnant members and provide them with instant access to pregnancy-based tools and education in multiple languages. YoMingo's online platform will assist in increasing outreach and participation with more diverse members providing quantifiable data to assist in future initiatives to target vulnerable members and improve outcomes for the prenatal and postpartum population. Dental Days was established, a partnership with a Medicaid dental provider (nine sites) which hosted Dental Days to improve access and availability for dental visits. To increase access to vaccines and childhood immunizations, BCBSIL used mobile Care Vans and partnerships with FQHCs and local community organizations. BCBSIL identified an opportunity to address the racial disparities among its Hispanic and African-American member population for breast cancer and cervical cancer screening. BCBSIL is partnering with two FQHCs to host Care Van events to help increase member education on breast cancer and cervical cancer.
Customer Service/Beneficiary and Provider Satisfaction With Services	To remediate missed performance metrics for the member services line, attendance incentives were put in place, additional staff were hired, and 10 customer service representatives were cross-trained to support the MMAI member services call center.
Provider Network Adequacy	Offered initiatives such as incentives for appointment block scheduling, increasing the payment of quality incentives on a quarterly basis, and onboarding to the Inovalon tool which is used to monitor open care gaps.
Compliance Monitoring—Oversight of Delegated Vendors	No initiatives identified.
Compliance Monitoring—CI Reporting	BCBSIL demonstrated an improvement in identification and reporting of member safety issues, with a 24 percent increase in reported CIs compared to SFY 2020.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
CC/CM Processes	Implemented the final phase of the transition of 115,000 CountyCare members and 35 care management staff to the internal health plan care management team. A team of Cook County Health transition of care (TOC) staff transitioned to CountyCare, boosting centralized transitional care support services. This team merged with CountyCare's TOC team under a new shared services model which uses a single CM platform that integrates real-time alerts, UM authorizations, and dispatch protocols to support the shared service team in providing maximum outreach to members. Community Based Services and Supports Workgroup established a dedicated LTC transition team of care coordinators to develop key relationships with community partners to support transition care plans created within 90 days of identifying a transition candidate. CountyCare's Flexible Housing Pool team also partnered with this workgroup to expand options for members whose greatest barrier is securing housing.
Behavioral Health	Launched a telepsychiatry and telecounseling program in partnership with Aunt Martha's Health & Wellness to provide increased access via shorter wait times for appointments. This significantly expanded direct access to and options for behavioral health services to members; 491 unique members had 729 encounters with this program. CountyCare reinvested nearly $15 million in community behavioral health resources with partners that promote health equity and reduce health disparities. Established an Adult and Child Behavioral Health Workgroup which produced detailed BH TOC protocols for staff, made changes to improve HEDIS measure data capture and coding, incentivized members who receive a follow-up appointment, standardized audit feedback to drive application of lessons learned, and trained care coordinators on mental illness.
Prevention and Screenings	Launched HEDIS vendor Vital Data Technology's ProviderLink platform, which supports provider access to member-level detail specific to individual providers so they can monitor their patients' care gaps directly and close them using more timely, actionable data. Developed a racial disparities dashboard that leverages race and ethnicity data to compare population-based data on risk scores, PMPM [per member per month] cost, inpatient admissions, lengths of stay, and engagement in care management to pinpoint areas for intervention and quantitatively evaluate effectiveness of equity initiatives. Contracted with mPulse Mobile for messaging services to shift to high-volume, high-impact text message contact with membership and upgraded the text messaging platform to a conversational AI [artificial intelligence] technology designed to communicate with a broad range of demographics and multicultural populations.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
CountyCare	
Customer Service/Beneficiary and Provider Satisfaction With Services	Provider Pipeline initiative aimed to reconcile all CountyCare provider contracts, develop a provider data source of truth on a new platform, reseed the claims system with clean provider data, and improve provider profile data. Completed a successful implementation and transition with transmission of over 110,000 provider records to the pipeline. Continued to partner with Canary Telehealth on its self-management and home screening programs, with a 69 percent increase in enrollment, and 77 percent of members reporting the service was "very valuable" and 83 percent reporting a positive change in their health habits.
Provider Network Adequacy	CountyCare built capacity among its provider-based care management entities (CMEs). Advanced value-based reimbursement program with additional agreements; new value-based agreements with 10 FQHCs.
Compliance Monitoring—Oversight of Delegated Vendors	Reduced and reprocured vendor relationships to further consolidate LTSS care management under the health plan. Demonstrated stringent oversight through seven annual audits involving 956 elements, ensuring resolution of 155 requiring improvement.
Compliance Monitoring—CI Reporting	Provided additional CI training to the CMEs. Hold standing interdisciplinary HSW incident case conferences that include leadership from a variety of roles to lend their experience toward individualized case resolutions.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Aetna	
CC/CM Processes	The Complete Care Management Program is a comprehensive program focused on health inequities and reducing unwarranted utilization, by "finding" high-risk members in the community and wrapping them in comprehensive services using a person-centered approach.
Behavioral Health	The Behavioral Health Micro Team is a team of six behavioral health specialists and social workers that support the UM Team. The team members act as liaisons between UM and CM, streamlining communication and follow-up. The team also helps to support key partnerships by being a single point of contact for six top-volume hospitals, meeting regularly with hospital partners to solve issues for members who are difficult to place post discharge, for members who have high utilization history, or for members with unique needs. Granted funding to 12 top-volume MCR providers, representing 60 percent of the health plan's MCR calls, for infrastructure support and/or wraparound services. The health plan meets monthly with these providers.
Prevention and Screenings	Implemented several initiatives across all Medicaid populations with the goal of improving medication adherence. This included engagement of nonadherent members in care coordination, encouraging 90-day maintenance medication fills, as well as promoting unique dose pack solutions to simplify complex medication regimens. From baselines set at the end of SFY 20, the health plan was able to increase adherence levels in four out of five key maintenance medication classes.
Customer Service/Beneficiary and Provider Satisfaction With Services	Made enhancements to the areas of claims denials, provider training, and provider relations in an effort to improve provider relationships, including rollout of a new online tool to enhance our secure provider portal (Availity) with the goal of decreasing time and administrative burden on providers and providing enhanced capabilities to manage claims.
Provider Network Adequacy	Conduced face-to-face provider and virtual education via Webex and telephone regarding updated access and availability standards by condition and provider type and annual reeducation of providers regarding access and availability standards through newsletters, webinars, fax blasts, and provider portal.
Compliance Monitoring—Oversight of Delegated Vendors	Implemented the Provider Network Assistance Form to address inconsistencies in directory data provided to members.
Compliance Monitoring—CI Reporting	Daily CI huddles are held with case management staff to discuss referrals and drive cases to safe resolution. A team was established to move all CI documentation into the Dynamo system to further streamline efforts for optimizing referrals, simplify both documentation and case closure efforts, and improve reporting capabilities.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
CC/CM Processes	None identified.
Behavioral Health	YouthCare implemented a crisis team in January 2021 to exclusively track, coordinate, and facilitate the care of youth who received MCR services. The crisis team's main objectives are to decrease the time a youth spends in the ED and ensure implementation of follow-up services and supports. The Crisis Stabilization Multidisciplinary Team (CSMDT) launched in March 2021. CSMDT is designed to support the MCR providers as they work toward responding to the needs of Youth in Care who are experiencing a behavioral health crisis. The CSMDT brings together stakeholders from various specialties with diverse knowledge to respond to the Youth in Care's clinical treatment needs while also considering the Youth in Care's emotional, social, intellectual, and developmental needs.
Prevention and Screenings	Initiated a new partnership with a texting vendor, GoMo, to conduct outreach around maternal and child health to improve prenatal and postpartum mother and infant health; improve completion of office visits during pregnancy, postpartum, and the first eight years of life; and provide guidance on early childhood growth and developmental milestones. Partnered with Vheda Health, a remote health monitoring program that uses member engagement to decrease hospital inpatient admissions and ER visits, and improve overall health outcomes for specific chronic conditions and high-risk populations. Identified measures with the most significant racial disparities, identified regions where rates on those measures were particularly low, reviewed member materials and provider education efforts, and collaborated with community organizations in those areas to reduce barriers to care.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Meridian	
Customer Service/Beneficiary and Provider Satisfaction With Services	To continue improving the satisfaction of providers, Meridian is creating a publication of "Known Issues" on its website, available to all providers, in and out of network. This allows the providers to proactively report any issues they are experiencing and work collaboratively with their provider relations representative for resolution. The provider network team launched comprehensive provider meetings and educational campaigns targeted to providers in rural and new counties to address claims submission barriers. The Member and Provider Satisfaction Workgroup will develop an action plan to focus on improving members' overall satisfaction with behavioral health practitioners and medication education.
Provider Network Adequacy	None identified.
Compliance Monitoring—Oversight of Delegated Vendors	Conducting a complete provider data validation clean-up initiative that includes all lines of business. The project will include various validation activities being done simultaneously including the use of LexisNexis, roster reconciliations, and direct provider outreach.
Compliance Monitoring—CI Reporting	Implemented a new CI reporting definition and platform for YouthCare and Former Youth in Care, conducted quarterly staff training sessions across all lines of business that provide timely updates on CI process and reporting requirements, and conducted annual review of the health plan CI reporting form to ensure consistent alignment of all required reporting elements.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
CC/CM Processes	Molina's new Social Determinants of Health (SDOH) program uses SDOH specialists (community connectors) to connect members with SDOH needs to social resources near them. The community connectors also administer a community needs assessment to capture information on SDOH to address any deficits and to triage the member into full case management as needed. The SDOH Committee provides a framework for supporting and meeting Molina members' SDOH care gaps and ensuring adequate SDOH resources are available. Molina relaunched its Housing Program with a streamlined process for case management teams to submit referrals for members who are inadequately housed, at risk of homelessness, or currently homeless. Began a partnership with Carle Foundation Healthy Beginnings Program to help link high-risk pregnant members with Carle Clinical staff to provide additional case management services including intensive contact to provide members and families with clinical guidance in areas of chronic and acute condition management, healthy behaviors, education, prevention and safety, and housing resources. Molina enhanced and formalized an internal case management audit program that tests case manager performance against all HSAG standards; tracks performance by measure, team, and staff member; and links to individual or systemic retraining or remediation as needed. The formalized internal audit program led to measurable performance improvement: since January 2021, waiver case manager audit scores increased over 10 percent.
Behavioral Health	Molina's Behavioral Health Excellence Program allows behavioral health providers that met readmission and follow-up benchmark goals to receive preferred provider status and potentially reduced authorization review. Molina observed improvement in scheduling specific follow-up appointments with members in place of general walk-in clinic referrals. Molina partnered with community substance use disorder (SUD) treatment providers to participate in monthly patient rounds to better equip Molina's SUD navigators to address barriers to care and reduce potential triggers for relapse. Reinvested a large proportion of withhold funding to provider and community support, including grants to Division of Substance Use Prevention and Recovery (SUPR) providers, the CMHC Telepsychiatry Program, and expanded counseling program.
Prevention and Screenings	Expanded disease-specific case management, focusing on specialized interventions for addressing high-risk chronic diagnoses: Diabetes, Asthma, COPD, Congestive Heart Failure, Sickle Cell Anemia, SUD, Chronic Kidney Disease, and HIV/AIDS.

Focused Populations/Processes Targeted for Improvement	Health Plan Follow-Up
Molina	
Customer Service/Beneficiary and Provider Satisfaction With Services	The appeals and grievances team moved to a new documentation application, Pega. The new application allows for enhanced reporting, better oversight of case inventory through an improved dashboard, and provides a streamlined documentation workflow.
Provider Network Adequacy	As part of Molina's effort to focus resources on network maintenance, launched several initiatives to improve communication with the provider community to better align provider expectations with plan processes and supply them [providers] with proper recourse for feedback, including provide education webinars, CMHC/SUPR town halls, and open forums.
Compliance Monitoring—Oversight of Delegated Vendors	Plans to increase the volume of roster audits, proactively focusing roster audit provider groups that have historically had loading issues. Developed an automated audit tool to reduce the amount of manual roster review needed which will allow an increase in proactive audit volume.
Compliance Monitoring—CI Reporting	Revised CI reporting P&P and trained on 7/1/2021.

Appendix A3. Health Plan-Specific Conclusions

Introduction

This section summarizes an assessment of each health plan's strengths and opportunities for improvement for the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries and recommendations for improving the quality of healthcare services furnished by each health plan, as required by 42 CFR §438.364.

Methodology

42 CFR §438.364 also requires a description of the manner in which the data from all activities conducted were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and accessibility of the care furnished by each health plan.

EQR activities typically measure program performance through quantitative data (i.e., data are numeric and consist of frequency counts, percentages, or other statistics) that provide evidence of outcomes and help assess a health plan's or a program's progress toward its stated goals. While data demonstrate what is occurring, these data do not necessarily indicate what caused the occurrence.

The EQRO is tasked with drawing conclusions from the data for an overall assessment that distinguishes successful efforts from ineffective activities and services and to provide recommendations for improving results. HSAG analyzes the quantitative results obtained from each EQR activity for each health plan to identify strengths and opportunities for improvement for providing healthcare timeliness, access, and quality across activities. HSAG then identifies whether common themes or patterns exist across the data and conducts a qualitative analysis to draw conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each health plan independently and the overall statewide Medicaid managed care program.

Health Plan-Specific Conclusions

Aetna Better Health—formerly IlliniCare Health Plan (IlliniCare)

Strengths

Related to Quality

- Demonstrated strong performance in the standards reviewed to demonstrate compliance with the federal and State requirements contained in its HealthChoice and MMAI contracts (99 percent and 96 percent, respectively).
- Fully compliant with all HEDIS Information System (IS) standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the performance measure audit received a *Reportable* designation.
- Ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020.
- Performed at or above 90 percent with demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.
- Performance on SMART Aim goals for both PIPs improved over baseline.
- The health plan demonstrated compliance with case management staffing and training requirements.
- The health plan demonstrated compliance with scored elements assessing the effectiveness of its critical incident (CI) processes, including the ability to identify, address, and seek to prevent instances of abuse, neglect, and exploitation (ANE) and unexplained death.

Related to Access

- Contracted with a sufficient number of required provider types within each service region, met most time/distance requirements, achieved a rate of 91.2 percent in the provider directory validation (PDV) study, and P&Ps were generally compliant with contract requirements regarding access to care.

Related to Timeliness

- Performed at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day and 30-Day Follow-Up* measure indicators. This performance demonstrates a commitment to mental health services overall for the health plan's members and that the health plan is ensuring members seen in the ED with a mental health diagnosis are receiving follow-up visits for mental illness, resulting in fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.
- The health plan demonstrated full compliance with timeliness requirements for standard and expedited denials, as established during compliance file reviews.

Opportunities for Improvement	
	Opportunity: Adult and child members were not always **accessing timely services** to obtain the preventive and/or condition-specific care they needed to maintain optimal health as indicated through lower or declining HEDIS rates for access-related measures in the domains of Access to Care, Maternal Health, Dental, and Behavioral Health. **Why the Opportunity Exists:** Although adults and children appear to have access to PCPs for preventive and ambulatory services, these members were not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits. **Recommendation:** Conduct a root cause analysis or focus study to determine why its members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends working with members to increase the use of telehealth services, when appropriate.
	Opportunity: Related to **quality**, the health plan's provider agreements failed to include required language to educate providers on identifying and preventing ANE and CIs. The quarterly CI file review identified opportunities to improve CI reporting processes. **Why the Opportunity Exists:** Failure to include ANE/CI requirements in provider agreements represents a missed opportunity to ensure all providers are educated in identifying and reporting ANE/CIs. Upon acquisition of the Centene/IlliniCare HealthChoice population, Aetna did not integrate the CI processes of the two lines of businesses, resulting in separate internal processes for reporting, monitoring, tracking, and resolving CIs. **Recommendation:** Revise provider agreements and conduct provider training on identification and reporting of ANE/CIs. Consider merging of internal CI processes to ensure consistent process application, valid data capture and categorization of CIs, and identification and use of best practices between lines of business.
	Opportunity: Related to **quality**, there was a decrease in *Breast Cancer Screening* and *Cervical Cancer Screening* performance of more than 5 percentage points. **Why the Opportunity Exists:** Women are not receiving timely access to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.

Opportunity: Related to **quality**, the health plan ranked below the 25th percentile for the *HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators and the *Controlling High Blood Pressure* measure.

Why the Opportunity Exists: Members are not receiving services needed for proper diabetes management, and members with hypertension are not adequately controlling their blood pressure. Left unmanaged, both conditions can lead to serious complications, premature death, and higher healthcare costs.

Recommendation: Conduct a root cause analysis or focus study to determine why its members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.

Blue Cross Blue Shield of Illinois

Strengths

Related to Quality

- Demonstrated strong performance in the standards reviewed to demonstrate compliance with the federal and State requirements contained in its HealthChoice and MMAI contracts (94 percent for both contracts).
- Performed at or above the 75th percentile for one *Comprehensive Diabetes Care* measure rate and at or above the 90th percentile for the *Received Statin Therapy* measure rate, suggesting members are managing diabetes to avoid serious complications and premature death.
- Met or exceeded the 75th percentile for all three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators. This demonstrates that children and adolescent members with ongoing antipsychotic medication use are receiving regular metabolic testing to monitor and reduce the risk for developing serious metabolic complications associated with poor cardiometabolic outcomes in adulthood.
- Ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020.
- Fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the performance measure audit received a *Reportable* designation.
- Performed above 90 percent with demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.
- Performance on its SMART Aim goal for the *Follow-Up After Hospitalization for Mental Illness* PIP improved over baseline.
- The health plan demonstrated strong compliance with case management staffing and training requirements.
- The health plan demonstrated compliance with scored elements assessing the effectiveness of its CI processes, including the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Related to Access

- Contracted with a sufficient number of required provider types within each service region, met most time/distance requirements, and P&Ps were generally compliant with contract requirements regarding access to care.
- Performed at or above the 75th percentile for the *Ambulatory Care—Outpatient Visits—Total* measure rate, indicating the health plan's members have access to and utilization of primary and preventive care.

- Performed at or above the 90th percentile for *Annual Dental Visit*, indicating a majority of the health plan's members accessed at least one dental visit during the year.

Related to Timeliness

- Performed at or above the 75th percentile for the *Prenatal and Postpartum Care* measure, suggesting women are receiving timely and adequate access to prenatal and postpartum care which prevents pregnancy-related deaths and creates a foundation for the long-term health and wellbeing of new mothers and their infants.
- Performed at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day (Ages 6-17 and 18-64* and *30-Day Follow-Up (Ages 6–17)* measure indicators. This performance demonstrates a commitment to mental health services overall for the health plan's members and that the health plan is ensuring members seen in the ED with a mental health diagnosis are receiving follow-up visits for mental illness, resulting in fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.
- The health plan demonstrated full compliance with timeliness requirements for standard and expedited denials, as established during compliance file reviews.

Opportunities for Improvement

Opportunity: There was a decrease in *Breast Cancer Screening* and *Cervical Cancer Screening* rates.

Why the Opportunity Exists: Women are not receiving **timely access** to screenings for breast or cervical cancer. Early detection reduces the risk of dying from cancer and can lead to a greater range of treatment options and lower healthcare costs.

Recommendation: Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast and cervical cancer. Upon identification of a root cause, implement appropriate interventions to improve performance.

Opportunity: Related to **quality**, performance ranked below the 25th percentile for the *Controlling High Blood Pressure* measure.

Why the Opportunity Exists: This low performance suggests members with hypertension are not adequately controlling their blood pressure. Left unmanaged, high blood pressure can damage a person's heart and cause health problems, such as heart disease and stroke, if it stays high for a long period of time.

Recommendation: Conduct a root cause analysis or focus study to determine if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance related to this measure.

Opportunity: Demonstrated an opportunity for improvement with following its process for communication with the investigating authority after submitting an initial CI report.

Why the Opportunity Exists: The health plan does not consistently apply its internal procedures to contact the investigating authority for an update on the status of the CI report prior to closing the internal CI.

Recommendation: To ensure **quality**, the health plan should consider revising its processes for communication with the investigating authority to align with the external entity's communication requirements.

CountyCare Health Plan

Strengths

Related to Quality

- Demonstrated strong performance (96 percent) in the standards reviewed to demonstrate compliance with the federal and State requirements contained in its HealthChoice contract.
- Performed at or above the 50th percentile for three *Comprehensive Diabetes Care* measure rates and at or above the 75th percentile for the *Statin Therapy for Patients With Diabetes* measure, suggesting members are managing diabetes to avoid serious complications and premature death.
- Met or exceeded the 50th percentile for all three *Metabolic Monitoring for Children and Adolescents on Antipsychotics* measure indicators, demonstrating that children and adolescent members with ongoing antipsychotic medication use are receiving regular metabolic testing to monitor and reduce risk for developing serious metabolic complications.
- Ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)* measure indicator.
- Fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the performance measure audit received a *Reportable* designation.
- Performed above 90 percent with demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.
- Performance on its SMART Aim goal for the *Follow-Up After Hospitalization for Mental Illness* PIP improved over baseline.
- The health plan demonstrated strong compliance with case management staffing and training requirements.
- The health plan demonstrated compliance with scored elements assessing the effectiveness of its CI processes, including the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Related to Access

- CountyCare was compliant with access standards for all provider categories in Region 4.
- Contracted with a sufficient number of required provider types within each service region, met most time/distance requirements, and P&Ps were generally compliant with contract requirements regarding access to care.

Related to Timeliness

- Performed at or above the 90th percentile for the *Initiation of AOD Treatment—18+ Years* measure rate and at or above the 75th percentile for *Initiation of AOD Treatment—Ages 13–17*, indicating timely initiation of treatment after diagnosis which has been shown to reduce AOD-associated morbidity and mortality; improve health, productivity, and social outcomes; and reduce healthcare spending.

Opportunities for Improvement	
	Opportunity: Related to **access**, the health plan failed to provide evidence that it evaluates all required provider appointment standards annually, the annual PCP after-hours access survey failed to meet requirements, and the provider directory validation study located only 79.3 percent of sampled providers in the directory. **Why the Opportunity Exists:** The health plan has not implemented processes that meet requirements to evaluate enrollee appointment access, conduct after-hours access surveys, monitor PCP panel requirements, and ensure accurate provider directories. **Recommendation:** Implement a process to annually evaluate enrollee access to provider time-specific appointments, conduct an annual after-hours survey to evaluate provider compliance with after-hours access for enrollees, develop and implement a process to monitor provider compliance with PCP panel requirements, and implement a process to ensure accurate provider directory information.
	Opportunity: Related to **quality**, the provider agreement did not include the required language to educate providers on identifying and preventing ANE and CIs, and CI file review identified an opportunity for improvement with following the health plan's process for communication with the investigating authority. **Why the Opportunity Exists:** Failure to include ANE/CI requirements in provider agreements represents a missed opportunity to ensure all providers are educating in identifying and reporting CIs. The health plan does not consistently apply its internal procedures to contact the investigating authority for an update on the status of the CI report prior to closing the internal CI. **Recommendation:** Revise provider agreements and conduct provider training on identification and reporting of ANE/CIs. Consider revision of processes for communication with the investigating authority to align with the external entity's communication requirements..
	Opportunity: Related to **quality**, rates for *Breast Cancer Screening* decreased more than 10 percentage points and rates for *Chlamydia Screening in Women* decreased more than 5 percentage points. **Why the Opportunity Exists:** Women are not receiving timely access to screenings for breast cancer or chlamydia. Early detection reduces the risk of dying from cancer or serious and irreversible complications from chlamydia infections and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.

Opportunity: Related to **quality**, the health plan ranked below the 25th percentile for the *HbA1c Control (<8.0%)* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators and the *Controlling High Blood Pressure* measure.

Why the Opportunity Exists: Members are not receiving services needed for proper diabetes management, and members with hypertension are not adequately controlling their blood pressure. Left unmanaged, both conditions can lead to serious complications, premature death, and higher healthcare costs.

Recommendation: Conduct a root cause analysis or focus study to determine why its members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.

Humana Health Plan, Inc.

Strengths	**Related to Quality** • Demonstrated compliance (81 percent) with the federal and State requirements contained in its MMAI contract. • The health plan demonstrated compliance with case management staffing and training requirements. • The health plan demonstrated compliance with scored elements assessing the effectiveness of its CI processes, including the ability to identify, address, and seek to prevent instances of ANE and unexplained death. **Related to Access** • Contracted with a sufficient number of required provider types within each service region, and P&Ps were generally compliant with contract requirements regarding access to care. **Related to Timeliness** • The health plan demonstrated full compliance with timeliness requirements for standard and expedited denials, as established during compliance file reviews.
Opportunities for Improvement	**Opportunity:** Related to **quality**, the health plan had an opportunity to include a detailed analysis of access and utilization of dental services in its annual Quality Assurance/Utilization Review/Peer Review (QA/UR/PR) report. **Why the Opportunity Exists:** The health plan has not identified metrics to analyze access and utilization of dental services or has not received guidance from HFS on expectations for reporting. **Recommendation:** HFS should consider providing additional detail to the health plan of expectations for reporting on access and utilization of dental services. In lieu of guidance from HFS, the health plan should establish metrics for analysis of its members' utilization of dental services. **Opportunity:** Related to **access**, the health plan was noncompliant in including all requirements in its provider directory. **Why the Opportunity Exists:** The health plan's process to audit its provider directory was insufficient to identify gaps in required elements. **Recommendation:** Conduct biannual audits to improve the accuracy of the health plan's provider directory.

MeridianHealth

Strengths

Related to Quality

- Demonstrated strong performance in the standards reviewed to demonstrate compliance with the federal and State requirements contained in its HealthChoice and MMAI contracts (99 percent and 95 percent, respectively).
- Ranked at or above the 75th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020.
- Fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the performance measure audit received a *Reportable* designation.
- Performed above 90 percent with demonstrating compliance to CMS HCBS performance measures, as identified via the quarterly HCBS record reviews.
- Performance on SMART Aim goals for both PIPs improved over baseline.
- The health plan demonstrated compliance with scored elements assessing the effectiveness of its CI processes, including the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Related to Access

- Contracted with a sufficient number of required provider types within each service region, met most time/distance requirements, and P&Ps were generally compliant with contract requirements regarding access to care.

Related to Timeliness

- Performed at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day and 30-Day Follow-Up* measure indicators. This performance demonstrates a commitment to mental health services overall for the health plan's members and that the health plan is ensuring members seen in the ED with a mental health diagnosis are receiving follow-up visits for mental illness, resulting in fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.

Opportunities for Improvement

Opportunity: Related to **quality**, rates for *Breast Cancer Screening* decreased more than 5 percentage points, and rates for *Chlamydia Screening in Women* decreased more than 10 percentage points.

Why the Opportunity Exists: Women are not receiving timely access to screenings for breast cancer or chlamydia. Early detection reduces the risk of dying from cancer or serious and irreversible complications from chlamydia infections and can lead to a greater range of treatment options and lower healthcare costs.

Recommendation: Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.

Opportunity: Related to **quality**, the health plan ranked below the 25th percentile for the *HbA1c Control (<8.0%), HbA1c Poor Control (>9.0%),* and *Blood Pressure Control (<140/90 mm Hg)* measure indicators and the *Controlling High Blood Pressure* measure.

Why the Opportunity Exists: Members are not receiving services needed for proper diabetes management, and members with hypertension are not adequately controlling their blood pressure. Left unmanaged, both conditions can lead to serious complications, premature death, and higher healthcare costs.

Recommendation: Conduct a root cause analysis or focus study to determine why its members are not receiving timely screenings for diabetes and if any barriers to care exist for members with high blood pressure. Upon identification of a root cause, implement appropriate interventions to improve performance.

Opportunity: Related to **quality**, the provider agreement did not include the required language to educate providers on identifying and preventing ANE and CIs, and file review indicated opportunities to improve documentation prior to closure, reporting to and follow up with investigating authorities, and merging internal CI processes.

Why the Opportunity Exists: Failure to include ANE/CI requirements in provider agreements represents a missed opportunity to ensure all providers are educated in identifying and reporting CIs. Upon merger of the Centene and Meridian MMAI populations, Meridian did not integrate the CI processes of the two lines of businesses (HealthChoice and MMAI), resulting in separate internal processes for reporting, monitoring, tracking, and resolving CIs.

Recommendation: Revise provider agreements and conduct provider training on identification and reporting of CIs. Consider merging internal CI processes to ensure consistent process application, valid data capture and categorization of CIs, and identification and use of best practices between lines of business.

Opportunity: Related to **quality**, the health plan did not demonstrate compliance with case management caseload limits or waiver qualification/education and related experience requirements.

Why the Opportunity Exists: The health plan is not effectively monitoring caseload limits and ensuring distribution of cases to meet caseload requirements across all case managers. The health plan may not have a consistent monitoring process to review staff qualifications/education prior to waiver caseload assignment and to ensure that only staff who meet waiver-specific requirements are assigned waiver caseloads. The health plan may not be ensuring its staffing submission includes specificity regarding qualifications/education that may show compliance to the contract requirements.

Recommendation: The health plan should identify a plan to reassign caseloads to those case managers not meeting caseload limits. The health plan should review the qualifications/education and related experience requirements for the waivers and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads. The health plan should also review its staffing submission to ensure that specificity regarding qualifications/education that may show compliance with the contract requirements is included in its submissions. The health plan may also consider submitting exemption requests to HFS for consideration.

Molina Healthcare of Illinois

Strengths

Related to Quality

- Demonstrated consistent performance in the standards reviewed to demonstrate compliance with the federal and State requirements contained in its HealthChoice and MMAI contracts (84 percent and 81 percent, respectively).
- Ranked at or above the 90th percentile for the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicator for HEDIS MY 2020.
- Fully compliant with all HEDIS IS standards, all data supported the elements necessary for HEDIS reporting, all measure calculations resulted in rates that were not significantly biased, and all performance measures under the scope of the performance measure audit received a *Reportable* designation.
- Performance on SMART Aim goals for both PIPs improved over baseline.
- The health plan demonstrated strong compliance with case management staffing and training requirements.
- The health plan demonstrated compliance with scored elements assessing the effectiveness of its CI processes, including the ability to identify, address, and seek to prevent instances of ANE and unexplained death.

Related to Access

- Only health plan to achieve 100 percent compliance with provider agreement requirements during the compliance review.
- Contracted with a sufficient number of required provider types within each service region, met most time/distance requirements, and P&Ps were generally compliant with contract requirements regarding access to care.

Related to Timeliness

- Performed at or above the 75th percentile for the *Follow-Up After Emergency Department Visit for Mental Illness—7-Day and 30-Day Follow-Up* measure indicators. This performance demonstrates a commitment to mental health services overall for the health plan's members and that the health plan is ensuring members seen in the ED with a mental health diagnosis are receiving follow-up visits for mental illness, resulting in fewer repeat ED visits, improved physical and mental function, and increased compliance with follow-up instructions.
- The health plan demonstrated full compliance with timeliness requirements for expedited denials and pharmacy denials, as established during compliance file reviews.

Opportunities for Improvement	
	Opportunity: The requirements for monitoring enrollee **access** to providers was not demonstrated during the compliance review due to a lack of clear evidence of access-related reports used by the health plan. Policy failed to include 24/7 coverage requirements for primary care and specialty providers. **Why the Opportunity Exists:** The health plan failed to submit documentation of required monitoring of enrollee access, and health plan staff were unable to demonstrate monitoring procedures. **Recommendation:** Implement processes and develop/submit policies to demonstrate compliance with access and availability monitoring requirements, including time and distance standards, appointment availability and after-hours access, PCP panel capacity, and open and closed panels. Revise policy to include 24/7 coverage requirements for primary care and specialty providers.
	Opportunity: Molina performed below the 25th percentile for every reportable measure indicator in the **Access to Care** performance measure domain. **Why the Opportunity Exists:** Although adults appear to have access to PCPs for preventive and ambulatory services, these members were not consistently utilizing preventive and ambulatory services, which can significantly reduce nonurgent ED visits. **Recommendation:** Conduct a root cause analysis or focus study to determine why its members are not consistently accessing preventive and ambulatory services. Upon identification of a root cause, implement appropriate interventions to improve performance related to Access to Care measures. If COVID-19 was a factor, HSAG recommends working with its members to increase the use of telehealth services, when appropriate.
	Opportunity: Related to **quality**, rates decreased for *Breast Cancer Screening* and *Chlamydia Screening in Women*. **Why the Opportunity Exists:** Women are not receiving timely access to screenings for breast cancer or chlamydia. Early detection reduces the risk of dying from cancer or serious and irreversible complications from chlamydia infections and can lead to a greater range of treatment options and lower healthcare costs. **Recommendation:** Conduct a root cause analysis or focus study to determine why its female members are not receiving timely screenings for breast cancer and chlamydia. Upon identification of a root cause, implement appropriate interventions to improve performance related to these measures.
	Opportunity: Molina's providers were located in the provider directory in 72.8 percent of reviews. **Why the Opportunity Exists:** The health plan has not implemented processes that ensure accurate provider directories.

Recommendation: Conduct root cause analyses to determine the reason for the high number of discrepancies in provider specialty indicators and collaborate with provider offices to ensure the correct information is received from providers and updated within the provider directory and provider data file layout submissions.

Appendix B1. 2020–2021 PMV Methodology & Audit Results

NCQA HEDIS Compliance Audit

Objectives

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

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

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

Technical Methods of Data Collection and Analysis

HFS required that an NCQA-licensed audit organization conduct an independent audit of each health plan's MY 2020 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 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 health plan. All of HSAG's lead auditors were Certified HEDIS Compliance Auditors (CHCAs). The audit involved three phases: *Audit Validation Activities*, *Audit Review Activities*, and *Follow-Up and Reporting Activities*. The following provides a summary of HSAG's activities with the health plans, as applicable, within each of the validation phases:

Audit Validation Phase (October 2020 through May 2021)

- Forwarded HEDIS MY 2020 Record of Administration, Data Management, and Processes (Roadmap) to health plans upon release from NCQA.
- Conducted annual HEDIS updates webinar to review the audit timeline and discuss any changes to the measures, technical specifications, and processes.
- Scheduled virtual audit review dates.
- Conducted kick-off calls to introduce the audit team, discuss the audit review agenda, provide guidance on HEDIS audit processes, and ensure that health plans were aware of important deadlines.
- Reviewed completed HEDIS Roadmaps to assess compliance with the audit standards and provided the 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 with HEDIS Certified Measures[SM].[B1-1]
- 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.

Audit Review Phase (January 2021 through April 2021)

- Conducted virtual audit reviews to assess health plans' capabilities to collect and integrate data from internal and external sources and produce reliable performance measure results.
- Provided preliminary audit findings.

Follow-Up and Reporting Phase (May 2021 through July 2021)

- 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 MY 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.

[B1-1] HEDIS Certified Measures[SM] is a service mark of the National Committee for Quality Assurance (NCQA).

Description of Data Obtained

Through the methodology, HSAG obtained a number of different information sources to conduct the performance measure validation according to NCQA's established HEDIS deadlines. These included:

- HEDIS Roadmap.
- Source code, computer programming, and query language (if applicable) used to calculate the selected performance measure rates.
- 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 by HFS 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 HSAG's Validation

HEDIS MY 2020 Performance Measures Selected by HFS			
	Performance Measure Name	**Acronym**	**Methodology**
1	*Adults' Access to Preventive/Ambulatory Health Services*	*AAP*	Admin
2	*Annual Dental Visit*	*ADV*	Admin
3	*Child and Adolescent Well-Care Visits*	*WCV*	Admin
4	*Childhood Immunization Status*	*CIS*	Admin, Hybrid
5	*Follow-Up After Hospitalization for Mental Illness*	*FUH*	Admin
6	*Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment*	*IET*	Admin
7	*Prenatal and Postpartum Care*	*PPC*	Admin, Hybrid
8	*Well-Child Visits in the First 30 Months of Life*	*W30*	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 MY 2020 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS Measurement Year 2020, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, and updated information communicated by NCQA to the audit team directly.
- Virtual audit meetings with the health plans, which included staff interviews, live system and procedure demonstrations, documentation review and requests for additional information, primary source verification (PSV) for a selection of measures, programming logic review and inspection of dated job logs (if applicable), 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 applicable.
- If the hybrid method was used, an abstraction of a sample of medical records selected by the auditors was compared to the results of the health plan's review determinations for the same records.
- If nonstandard supplemental data were used, PSV was conducted on a sample of records, which involved review of proof-of-service (POS) documentation for each selected case.
- Requests for corrective actions and modifications to the health plan's HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates submitted by the health plans.
- A variety of interviews with individuals whose department or responsibilities played a role in the production of HEDIS data. Typically, such individuals included the HEDIS manager, the IS director, the quality management director, the enrollment and provider data manager, medical records staff, claims processing staff, programmers, analysts, and others involved in the HEDIS preparation process. Representatives of vendors that calculated HEDIS MY 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.

Rate/Result	Definition
*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 when permitted by NCQA.

* NA (Not Applicable) is not an audit designation, it is a status. Measure rates that result in an NA are considered *Reportable* (R); however, the denominator is too small to report.

** Benefits are assessed at the global level, not the service level.

*** NQ (Not Required) is not an option for required Medicare, Exchange, or Accreditation measures.

For measures reported as percentages, NCQA has defined significant bias as 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., *Childhood Immunization Status* and *Prenatal and Postpartum Care*). It is possible that the health plan prepared some of the rates required by the measure appropriately but had significant bias in others. According to NCQA guidelines, the health plan would receive a *Reportable (R)* result for the measure as a whole, but significantly biased rates within the measure would receive a *Biased Rate (BR)* result, where appropriate.

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

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

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

HSAG completed the MRRV process and over-read sample records across the appropriate measure groups and compared the results to each health plan's findings for the same medical records. This process provided an assessment of actual reviewer accuracy. HSAG randomly selected 16 cases from the MRR numerator positives as identified by each health plan. If fewer than 16 medical records were found to meet numerator compliance, all records were reviewed or additional records from another measure within the same group were added to equal 16 cases. If an abstraction discrepancy was noted,

only critical errors were considered errors. A critical error is defined as an abstraction error that affected the final outcome of the numerator event (i.e., changed a positive event to a negative one or vice versa). If one critical error was noted, HSAG was required to retest a second sample of 16 records that did not include the original sampled records. If the second sample was free of errors, the measure and measure group passed. If one or more errors were detected, the measure and measure group did not pass validation and could not be reported until all errors were corrected and reviewed by the auditor. If there was not enough time to correct all errors, the health plan was not allowed to report the measure via the hybrid methodology.

In addition to validating numerator positive cases, HSAG also validated the accuracy of exclusion cases. This task was accomplished by sampling exclusions across all measures to determine the appropriateness of the exclusion. If HSAG deemed that an exclusion was not in alignment with NCQA's specifications, the health plan was required to keep the case in the denominator.

HSAG completed the MRRV component of the audit and provided an assessment of each health plan's medical record abstraction accuracy.

Health Plan-Specific Findings for HealthChoice Illinois Health Plans

NCQA HEDIS Compliance Audit Results for Aetna

HSAG conducted a MY 2020 NCQA HEDIS Compliance Audit of Aetna's data collection and reporting processes for its HealthChoice Illinois population. HSAG determined Aetna was fully compliant with all HEDIS Information System (IS) standards and all data supported the elements necessary for HEDIS reporting. Further, all measure calculations resulted in rates that were not significantly biased and all performance measures under the scope of the audit received an *R* designation.

Table B1-3—Aetna MY 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 determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

Aetna acquired IlliniCare Health Plan, Inc. (IlliniCare) from Centene Corporation (Centene) on December 1, 2020. Centene processed IlliniCare's claims using the AMISYS Advance (AMISYS) system for claims with dates of service from January 1, 2020, through November 30, 2020. Claims with dates of service after November 30, 2020, were processed by Aetna in the QNXT claims processing system. Centene provided Aetna with the claims data files processed for IlliniCare between January 1, 2020, through November 30, 2020.

Aetna performed extensive testing to ensure it was ready to process the Aetna claims by December 1, 2020. This included parallel testing by processing the same claims in AMISYS and QNXT. The configuration team also worked to ensure state-specific claim edits were implemented. There were no significant issues with processing claims in QNXT after the go-live date.

Aetna claims processing vendors included March Vision, DentaQuest, and CVS. March Vision and DentaQuest also served as vendors for IlliniCare. All historical vendor data for IlliniCare were provided by Centene to Aetna. Aetna monitored vendor performance during MY 2020, and no CAPs were necessary.

Aetna was fully compliant with IS Standard 1.0.

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

Aetna received 837 enrollment files from the State, processed them through the Enrollment Central application, and then loaded the files to QNXT. When files completed processing, an automated email was generated indicating the time and total records processed, as well as error and exception messages that needed to be reviewed by enrollment staff and updated manually. There were no issues or delays receiving the State files during MY 2020.

Aetna inherited IlliniCare's membership as of December 1, 2020. The State audit file received in November was the first enrollment file processed in QNXT. This process was tested prior to going live, and there were no issues processing the November file. Also, no problems were encountered in processing the December daily files from the State.

QNXT included an attribute in the Attributes/Share of Cost section that provides the eligibility history for former IlliniCare members. These members had a termination date of December 25, 2020, for the IlliniCare health plan and an effective date of December 1, 2020, for the Aetna health plan.

Aetna/IlliniCare membership increased by approximately 60,000 members during 2020. Aetna confirmed the increase was due to State redeterminations enabling members to maintain eligibility, and an increase in eligible members due to COVID-19 pandemic-related unemployment.

Aetna was fully compliant with IS Standard 2.0.

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

Aetna housed provider data in the QNXT system for claims processing. The IlliniCare provider information was successfully transferred from AMISYS to QNXT. Testing was completed to ensure accuracy and completeness. In addition, QNXT was configured to ensure accurate claims payment. No issues were identified with Aetna's provider data processes.

Aetna was fully compliant with IS Standard 3.0.

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

Aetna's national team and local health plan staff were responsible for MRR. The national team conducted the training and initial interrater reliability (IRR) testing. The IRR testing was completed following training with 95 percent accuracy required, and all attendees passed. The national team also monitors progress and provides reports to the health plan. A weekly report was created for tracking all of Aetna's health plans and identified which health plans met the completion goals for the week.

Aetna maintained the same team at the health plan level to work on the MY 2020 MRR project. The team included five permanent staff and five temporary staff. All had previous HEDIS experience, and three had clinical experience.

Aetna had 12 providers that allowed remote electronic medical record access. The remainder of the charts were requested via fax. Aetna did not attempt to conduct any MRRs on-site.

Over-reads were performed at the health plan level. One hundred percent of charts were overread, including both compliant and noncompliant chases. The national team performed a mock audit when the health plan achieved 50 percent overread completion. The audit included eight compliant charts from each measure and sub-measure.

The auditor required a convenience sample for the *Prenatal and Postpartum Care (PPC)* and *Childhood Immunization Status (CIS)* measures due to the change in MRR processes. Aetna failed two of the *CIS—Combination 10* cases as the members were not compliant for all 10 antigens. The auditor selected all nine of the final *CIS—Combination 10* hybrid compliant cases for the final MRRV. Aetna passed all nine cases. In addition, the auditor selected the *CIS—Combo 9*, *PPC—Postpartum Care*, and *PPC—Timeliness of Prenatal Care* measures for MRRV. No errors were identified.

Aetna was fully compliant with IS Standard 4.0.

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

Aetna developed supplemental databases from Athena Continuity of Care Document (CCD) files, Crusader, OSF HealthCare, Quest and LabCorp laboratory (lab) results, and State immunizations and historical claims. Aetna had processes in place to validate all supplemental data files. Prior to loading any data, each data source undergoes scrutiny by Aetna's Data Governance Committee. As part of this process, the file layout is examined, and a sample file is tested.

The lab results and State data have been used in prior years and were considered by the auditor to be standard supplemental data.

Aetna contracted with Athena to share CCD files from providers who have provided consent to share these data. The Athena system provides real-time data to Aetna when the electronic health record (EHR) from the provider office is updated. This arrangement has been in place since 2016. Files are sent to Aetna in HL7 format via secure file transfer, and the file is automatically transferred to Aetna data storage. Aetna contracted with HealthBI to parse the data files and deliver a flat file template. Aetna validates the files during the load process to the data warehouse. The provider location information is available in the CCDs. Since the Athena data originate from CCD files, the auditor determined this data source as nonstandard. The auditor conducted PSV according to NCQA's supplemental data guidelines, and the data source was approved to use for MY 2020 reporting.

Centene provided all historical supplemental data from IlliniCare to Aetna, and the data were included in Aetna's HEDIS reporting for MY 2020. All standard and nonstandard data sources were approved to use for HEDIS MY 2020 reporting.

Aetna was fully compliant with IS Standard 5.0.

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

Aetna used Inovalon's Quality Spectrum Insight-XL (QSI-XL) HEDIS software for generating the HEDIS performance measure rates required for MY 2020 reporting. The software was vendor hosted.

Aetna provided the Data Load Refresh Calendar in the Roadmap. The initial load was in January, and additional loads were completed in February, March, and April.

Aetna ensured that all data were transferred to the vendor and were properly formatted by verifying the data loaded into QSI-XL completely. This task was performed by analyzing the data that were placed on the secure file transfer protocol (SFTP) site to the landing zone in QSI-XL and checking the total rows with the exported files document that was updated each month.

Aetna provided the Quality Assurance testing plan for Aetna's Medicaid analytical and reporting data warehouse, ASDB, in addition to the reconciliation documents.

Aetna provided the HEDIS Data Load Documents for the December 2020 load. No significant issues for Illinois Medicaid were identified; however, Aetna manually updated the Days Supply field to one where Days Supply was zero for the Illinois Care Coordinator Claims Data (CCCD) due to an Inovalon configuration change.

Aetna also provided the HEDIS Load Documents for the January 2021 data load. All identified issues were corrected.

Aetna provided the Provider Specialty Mapping document in the Roadmap. The auditor reviewed the mapping and did not identify any issues.

Aetna 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 administrative rates during the virtual audit for all measures under the scope of the audit, and no issues were identified. The administrative rates for all measures that were reported in the prior year were within 5 percent of the administrative rates reported for MY 2020.

The auditor completed three of the four queries during the virtual audit. For the first query, the auditor selected five compliant cases each from QSI-XL for the *WCV*, *ADV*, and *PPC—Postpartum Care* measures. For all cases, Aetna demonstrated the proof of service in either QNXT or the data warehouse.

For the second query, Aetna provided the pharmacy claim counts by month for MY 2020. The auditor reviewed the data with Aetna during the virtual audit and noted the pharmacy claim counts were consistent.

For the third query, Aetna provided the count of lab, dental, and vision claims by month for MY 2020. All showed significant decreases in April, May, and June due to the COVID-19 pandemic. Volumes started to increase toward the end of the year to more normal levels.

The membership data provided for the virtual audit were not the data the auditor requested. Aetna provided the count of total membership for each month during MY 2020 as a follow-up to the virtual audit. The auditor reviewed the report and did not identify any issues.

The auditor did not identify any measures at risk at the time of the virtual audit. The auditor reviewed and signed off on the Interactive Data Submission System (IDSS) Tier 2 Warnings for Aetna's submission. The auditor confirmed by reviewing the IDSS warnings that the certified version of the HEDIS reporting software was used to produce each measure rate.

The auditor reviewed and benchmarked all final rates and approved all rates for reporting.

Aetna was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for BCBSIL

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

Table B1-4—BCBSIL MY 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 determining full compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

BCBSIL continued to use Cognizant as a third-party administrator to process medical services data. Cognizant used Facets to process claims. Cognizant received approximately 90 percent of claims in a standard 837 format with the remaining 10 percent being received on paper. Cognizant converted paper claims to an 837 format using scanning and optical character recognition (OCR) technology. All 837 files received through the clearinghouse and via Cognizant's scanning process were loaded into Facets through the applications translator. Standard validations and business rules were applied. Cognizant only accepted standard claims forms, diagnosis codes, and procedure codes, so no custom code mapping was required.

For MY 2020, approximately 99.5 percent of clean claims were adjudicated within 30 days, and approximately 99.9 percent were adjudicated in 30 to 60 days, exceeding the established goal of 90

percent in 30 days and the goal of 99.5 percent in the 30 to 60 day time frame. Cognizant's Quality Team conducted audits on a random sample of claims to monitor processor proficiency and accuracy. As part of its oversight process, BCBSIL met with Cognizant weekly to discuss operations and targeted audit results. In addition, BCBSIL conducted annual delegation audits of Cognizant. The audits assessed timeliness, compliance with State processing requirements, potential fraud and abuse, technical accuracy, and financial accuracy. Cognizant had no corrective actions related to medical services data processing during 2020. BCBSIL reimbursed providers on a fee-for-service (FFS) basis with no capitation agreements in place, for all services, which was confirmed during the virtual audit review.

During the virtual audit review, Cognizant provided a system walkthrough to demonstrate the ability of the Facets system to capture data elements required to support HEDIS reporting. The live walkthrough confirmed that Facets had built-in 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 as its pharmacy benefits manager (PBM). BCBSIL's PBM oversight included weekly and biweekly meetings between BCBSIL and Prime Therapeutics. Reports and dashboards presenting performance on key performance indicators of operational and quality metrics were reviewed during the meetings. No corrective actions were requested of Prime Therapeutics related to its data in 2020. BCBSIL contracted with DentaQuest for dental services. BCBSIL released a dental request for proposal (RFP) and re-selected DentaQuest, which resulted in the opportunity for BCBSIL to add additional quality interventions to its new DentaQuest contract. BCBSIL held monthly Joint Operational Committee meetings with DentaQuest wherein claims delegation was monitored and vendor performance was discussed. DentaQuest had no corrective actions related to its data in 2020. BCBSIL vendor contracts contained performance guarantees. BCBSIL demonstrated examples of its reports live during the virtual audit review.

BCBSIL was fully compliant with IS Standard 1.0 for medical services data.

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

BCBSIL membership increased from 2019 to 2020. This was attributed to the State's redetermination freeze and also likely due to additional individuals becoming eligible for Medicaid during the COVID-19 pandemic (e.g., employment and income changes). Monthly membership counts also increased throughout MY 2020, with the highest membership of the year occurring in December 2020. BCBSIL continued to use Cognizant to process enrollment data.

Cognizant continued to use 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, were reconciled to the information received in the daily files, and then loaded into Facets via its enrollment processing system application. Even with the MY 2020 increases in membership, Cognizant did not experience any issues with meeting its internal timeliness standard to process enrollment files within 24 hours of receipt. Most records loaded from the State files without any issues, and Facets included checks and balances so that any records which were not able to be processed would automatically route to a queue for manual intervention. These were required to be worked within 24

hours, and manager review of the queues occurred within 24 to 72 hours to ensure timeliness was maintained.

The Cognizant Quality Team monitored the accuracy of the enrollment data, and Cognizant demonstrated Facets enrollment screens and the process for editing enrollment data live during the virtual audit review. All data elements required to support HEDIS and State reporting were present in the Facets system. Member eligibility history with applicable start and end dates was present, and long-term care identifiers were confirmed during the virtual audit review demonstration.

BCBSIL was fully compliant with IS Standard 2.0 for enrollment data.

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

BCBSIL maintained practitioner data in Premier Provider Web (PPW) and Facets. Credentialing and contracting data were maintained in the PPW system. Daily files were exported and transferred to Cognizant via a file transfer protocol (FTP) site. Weekly reports were produced within PPW and Facets and reviewed to ensure information between the two systems matched. The reports compared the full set of practitioner data in each system. During the virtual audit review, system demonstrations were conducted for both the PPW and Facets provider systems. A PCP and non-PCP record were demonstrated within both systems, and configuration of FQHC providers was discussed and demonstrated as well. The system allowed for the listing of individual practitioners affiliated with FQHCs according to the demonstrations. All data elements, including specialty and active contract segments, matched between the two systems.

HSAG reviewed and approved the provider specialty mapping with only minor clarifications requested, which did not result in any mapping updates.

BCBSIL was fully compliant with IS Standard 3.0 for practitioner data.

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

BCBSIL continued to conduct its own chart abstraction; however, it initiated a contract with a new vendor, Change Healthcare, for chart retrieval. Provider chase logic was reviewed and determined to be sound. Also new for MY 2020, BCBSIL contracted with Baltimore Health Analytics as an OCR vendor for converting scanned medical records to searchable data. BCBSIL continued to use internal staff to conduct quality assurance, and this process had not changed from prior years. Staff members were sufficiently qualified and trained on the HEDIS technical specifications and the use of Inovalon's Quality Spectrum Hybrid Reporter (QSHR) abstraction tool for the measures under review.

BCBSIL used the QSHR MRR dashboard to monitor completion rates, including a comparison of the current year's completion rates to the prior year's rates for the same time frame, as applicable. BCBSIL conducted appropriate post-training assessment of staff and required a 95 percent score for staff to begin working on the project. Ongoing over-reads of records were also conducted, with retraining taking place if an issue was identified. The BCBSIL staff members who conducted the abstraction were temporary staff members; however, BCBSIL used the same temporary staff each year for the project, while its experienced internal employees within the Quality Department continued to conduct the over-reads.

Although not required by the auditor, BCBSIL requested convenience sample validation for the hybrid measures within the scope of the HFS audit (i.e., PPC and CIS). BCBSIL passed the convenience sample review for all selected measures.

BCBSIL passed the MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics & Maternity—*PPC—Postpartum Care*
- Group D: Immunizations & Other Screenings—*CIS—Combo 10*
- Group F: All Medical Record Exclusions

BCBSIL was fully compliant with IS Standard 4.0 for MRR processes.

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

BCBSIL submitted documentation for three standard supplemental data sources for MY 2020 reporting, Quest Diagnostics (Quest), Boncura Lab Data (Boncura), and Lawndale (i.e., Lawndale Christian Health Center), as well as one nonstandard source, EPIC-Northshore.

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 which had been used by the provider group for many years and therefore has remained stable without changes. Boncura data required mapping of the lab test name to a standard code, which BCBSIL provided to HSAG. Lawndale data followed the same proprietary file layout structure as was followed by Boncura, as it also consisted of lab data, and had been used over multiple years for HEDIS reporting.

During the virtual audit review, BCBSIL discussed its process to add EPIC-Northshore as a new supplemental data source. This process included establishing a new file layout based on the HEDIS Value Sets, then working with Northshore to start transmitting the EPIC CCDs data in the established file layout. After extensive testing, error reports were transmitted from BCBSIL to alert EPIC-Northshore of any errors so they could be corrected immediately. An example of an error report was reviewed live during the virtual audit review, which showed how data problems (e.g., missing mandatory data, invalid values as defined by line number, data in the wrong format) were flagged. BCBSIL indicated its new file layout had more fields to accommodate prompt onboarding of new vendors/trading partners for supplemental data in the future, while ensuring a standard file layout can be used on an ongoing basis.

During the virtual audit review, BCBSIL provided a demonstration of the supplemental data in the EDW. The demonstration included data discussion about validations and visual inspection to confirm required data fields. A file review log was used to track all the reviewed files.

The three standard supplemental data sources, Quest, Boncura, and Lawndale, and the one nonstandard supplemental data source, EPIC-Northshore, were reviewed and approved by the auditor. PSV was completed on EPIC-Northshore, and no issues were identified.

BCBSIL was fully compliant with IS Standard 5.0 for supplemental data.

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

BCBSIL had a sound process for updating and monitoring the accuracy and completeness of the HEDIS data repository. Standard data sources including enrollment, provider, claims, pharmacy, and supplemental data were updated monthly. Routine data checks, including record counts and data integrity checks of both internal and vendor data, were performed and documented. BCBSIL's quality process also included monthly calculation and reporting of HEDIS measures to support internal quality improvement activities and to provide ongoing monitoring and comparison of the production of HEDIS performance measure calculations. The BCBSIL data quality review (DQR) process included a mechanism to identify any practitioner specialty data mapping issues requiring review. During the virtual audit review, BCBSIL provided a demonstration of the process for data extraction from the EDW to the Inovalon One QSI-XL load and validation process. The most recent DQR and the provider specialty mapping were also reviewed. No issues were identified during the walkthrough or DQR review.

BCBSIL was fully compliant with IS Standard 6.0 for data preproduction processing.

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

BCBSIL used Inovalon's One QSI-XL software to generate its performance measure rates. BCBSIL had a sound process for monitoring data integrity and the accuracy of calculations. BCBSIL conducted parallel calculation and reporting processes that provided monthly updated reporting and the annual production for HEDIS reporting. During the virtual audit review, PSV was conducted for five members for each of the following measures: *Well-Child Visits in the First 30 Months of Life (W30)* and *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET)*. For each member, enrollment, administrative, and practitioner data in the QSI-XL repository and source systems were reviewed to confirm compliance with measure specifications and system concordance. All five members for each of the selected measures were found to be compliant with the measure specification requirements. Additionally, five member records were demonstrated live in QSI-XL for the *Annual Dental Visit (ADV)* measure. All five members were found to be compliant with the measure specification requirements based on a review of the claims and enrollment information demonstrated in QSI-XL. BCBSIL demonstrated sufficient monitoring of vendor performance and included evaluation of vendor performance in its oversight processes.

BCBSIL was fully compliant with IS Standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for CountyCare

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

Table B1-5—CountyCare MY 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 determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

In MY 2020, CountyCare continued to delegate most health plan operations to Evolent, including claims processing. Evolent used Aldera as its claims transactional system. For MY 2020, approximately 97.5 percent of claims were received electronically in the standard 837 format. The remaining 2.5 percent of claims were received as paper claims, scanned, and converted to the standard 837 format for loading. In MY 2020, approximately 85 percent of CountyCare's claims auto-adjudicated, with the remaining 15 percent pended to a workflow queue to resolve an issue (e.g., authorization required but not present, coordination of benefits, member eligibility issue). Additionally, Evolent was able to manually move claims to a claims queue for manual processing based on certain remark codes that were added to the claim when an issue needed to be resolved (e.g., explanation of benefits required, out-of-network services). Evolent only accepted standard claims forms, diagnosis codes, and procedure codes. Electronic claims files were loaded into the Aldera system, and industry-standard edits were applied. Evolent had appropriate edits in place at the clearinghouse level for formatting as well as member validation, procedure code 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. During the virtual audit review, Evolent described a detailed internal audit process. A dedicated team at Evolent conducted claims audits of a random standard-sized sample of claims per each adjudicator. This team was separate from the claims processing team to avoid conflicts of interest. Any issues identified through the internal audit process were discussed with the claims

processor, and additional training was completed at an employee level, as well as at a team level if trends were identified. Results were documented and included in the employee's monthly and annual reviews. Evolent conducted both concurrent and retrospective audits and also conducted additional audits (e.g., configuration audits for end-to-end claim process, high-dollar claims, targeted provider claims, CountyCare-identified specific issues). The percentage of clean claims adjudicated within 30 days was determined to be about 98.3 percent on average, as identified as the rolling average within the 60 days prior to the virtual audit.

CountyCare reimbursed providers through a FFS delivery system, with a few exceptions for individual providers who 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. During the virtual audit review, Evolent provided a system demonstration during which original claims were compared with data in the Aldera system, and all HEDIS-related fields were demonstrated and traced through the Aldera system.

CountyCare contracted with MedImpact as a PBM through the entire MY 2020. 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 demonstrated examples of its reports live during the virtual audit review.

CountyCare was fully compliant with IS Standard 1.0 for medical services data.

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

CountyCare experienced an increase in membership from 2019 to 2020, which CountyCare attributed to the COVID-19 pandemic. The State had implemented freezes on membership disenrollments and redeterminations, plus more individuals gained Medicaid eligibility, which was determined to be likely due to the income impact of the COVID-19 pandemic.

CountyCare delegated enrollment processing to Evolent. Evolent received daily and weekly 834 files through an automated process and loaded these files into Aldera. Daily and weekly files contained member additions, member enrollment terminations, and member demographic or other enrollment-related changes. The 834 files provided by HFS were clean with a very low volume of rows that were rejected during the load process. Evolent indicated that the most common reason for eligibility file rows being rejected included overlapping segments, date of birth inconsistencies, and name inconsistencies. Evolent provided a demonstration of the Aldera enrollment system during the virtual audit review. All HEDIS-relevant data elements were observed in the system, including the capture of historical enrollment spans and long-term care flags.

CountyCare was fully compliant with IS Standard 2.0 for enrollment data.

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

Throughout MY 2020 provider credentialing was centralized with HFS and therefore did not occur at the CountyCare level. CountyCare submitted daily provider files to Evolent which were then loaded into

the Aldera system. In addition, Evolent routinely identified providers who submitted claims for CountyCare members but were not included in the files provided by CountyCare. These providers were researched through the State provider database and entered into the Aldera system; data elements included provider specialty. CountyCare demonstrated the process followed for verifying and processing its provider data prior to submission to Evolent, and Evolent provided a demonstration of the Aldera system. CountyCare validated provider specialties against the National Plan and Provider Enumeration System (NPPES) taxonomy codes. Unique provider identifiers were assigned within Aldera based on the provider's National Provider Identifier (NPI). CountyCare and Evolent also documented additional provider-specific identifiers such as state license numbers, Medicaid identifiers, and Medicare identifiers. No issues were identified with the provider data capture, transfer, and entry.

CountyCare was fully compliant with IS Standard 3.0 for practitioner data.

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

In MY 2020 CountyCare began contracting with a new medical record project vendor, KDJ Consultants (KDJ). This change in vendor was a result of CountyCare's change to Vital Data Technologies (VDT) as its HEDIS calculation vendor in 2020. HSAG reviewed the KDJ tools and participated in a live demonstration of the MRR application to determine compliance with HEDIS audit standards. The MRR system used for clinical documentation was Health and Recovery Plan (HARP). VDT's Affinitē system was used to capture nonclinical chart details.

KDJ did chart chases and input the data into VDT's system. CountyCare conducted close monitoring along with weekly oversight meetings to ensure complete and accurate data collection.

During the virtual audit review, HSAG reviewed a sample report from KDJ which was generated from HARP. Staff turnover for KDJ was discussed during the virtual audit, and KDJ confirmed its staff typically averages about seven years of experience for HEDIS MRR, with very little turnover. KDJ described its training process which included webinars for measure updates it offered to staff members prior to December. KDJ also had self-learning modules specific to clients, so KDJ had a module customized for the CountyCare HEDIS project. These learning modules were reviewed and updated annually to accommodate measure changes and any client-specific requests. Annually, CountyCare delegates over-reads of specific measures to Evolent. For MY 2020, Evolent conducted over-reads of two measures in the scope of the HFS audit: *PPC* and *CIS*. Evolent did a portion of over-reads and documented its findings in the VDT system, Affinitē. For oversight, CountyCare conducted over-reads of a sample of 20 percent of noncompliant records for all measures, for the records reviewed by both Evolent and KDJ. CountyCare met weekly with Evolent and KDJ to discuss over-read results as well as errors. This weekly meeting was also used to discuss and resolve any over-reads wherein a disagreement was identified by either CountyCare or Evolent, with the KDJ abstractions. For real-time issue resolution, CountyCare had access to a secure messaging function to notify KDJ about the errors, and KDJ provided a weekly report of any errors plus resolution that occurred for that measure's errors and included it in the discussion at the weekly meeting. If a nurse was continuously identified for making errors, KDJ followed its policy for training or assignment of that nurse to another measure. Evolent and CountyCare staff conducting over-reads were enrolled in KDJ's training and learning platform for consistency; therefore, all staff assigned had the same training as the KDJ staff members. CountyCare's

internal staff also underwent the health plan's own MRR training. CountyCare staff members conducting over-reads were full-time employees of CountyCare. Evolent brought in contracted staff to assist with over-reads and strove for consistency with these individuals, as Evolent has worked with the same temporary staff for three years. Throughout the MRR process, CountyCare held accountability and was responsible for documenting final approval in Affinitē, the VDT system.

Convenience sample validation was conducted for the hybrid measures within the scope of the HFS audit (i.e., *PPC* and *CIS*). All convenience sample records passed the validation process.

CountyCare passed the MRRV process for the following measures and corresponding measure groups:

- Group A: Biometrics & Maternity—*PPC—Postpartum Care*
- Group D: Immunizations & Other Screenings—*CIS—HepB*

CountyCare was fully compliant with IS Standard 4.0 for MRR processes.

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

HSAG reviewed CountyCare's supplemental data sources during the virtual audit review. HFS provided State supplemental data sources directly to CountyCare once the State recorded the member as enrolled in CountyCare. HFS sent State IMMS (i.e., immunizations) data and care coordination historical claims data monthly throughout MY 2020. Data were procured from the labs based on the CountyCare contracts completed with the applicable labs. EHR data were procured directly from the applicable providers. VDT conducted its own quality checks in batch form so that whenever data were submitted, the VDT data quality checks were run. During the virtual audit review, CountyCare provided process overviews describing data procurement, warehousing, and validations. The following nine data sources were reviewed and determined to be standard supplemental data sources:

- Care Coordination Claims Data (CCCD)
- CCHP Medstar
- IMMS Registry
- LabCorp
- Lawndale Christian Health Center (LCHC) EMR
- Medical Home Network
- Mt. Sinai
- Quest Diagnostic
- Stroger

All supplemental data sources were approved for MY 2020 HEDIS reporting. CountyCare was fully compliant with IS Standard 5.0 for supplemental data.

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

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

During the virtual audit review, CountyCare demonstrated live the MedImpact and Guardian Avesis data oversight and sample reports it used in MY 2020 with comparisons of data to prior submissions to identify outliers or significant changes. CountyCare demonstrated how distinct values were compared for vendor data to identify issues. CountyCare did not identify any data quality or completeness issues with Guardian Avesis or MedImpact for MY 2020.

While no data quality or completeness issues were identified, CountyCare has put stopgaps in place to ensure timeliness of data. Monthly meetings occurred with all delegated entities to discuss data quality and completeness during the Joint Operations Committees' (JOCs') meetings, which reported to the quarterly Delegation Oversight Committee. The Delegation Oversight Committee included a cross-functional team from all areas of delegation, as well as the chief executive officer (CEO) and compliance representation. Predelegation audits, annual audits, data/performance outliers, and CAP oversight occurred in these committee meetings. The Delegation Oversight Committee was overseen by the Quality Committee, which reported to the Board. No corrective actions were in place for any delegated entities.

Claims delegates were all required to complete Sarbanes-Oxley Act (SOX) audits—MedImpact, Guardian Avesis, and Evolent; all three completed these annual SOX audits. While CountyCare met regularly with its delegated entities, Evolent had more frequent meetings because of the high volume of work it performed on behalf of CountyCare (e.g., biweekly or more often as needed, based on the specific workstream and scope with the subject matter experts at CountyCare). Evolent demonstrated inbound and outbound data quality reports and flat files from the data warehouse during the virtual audit review. Evolent demonstrated how it was able to track the data sources at the file level in its data quality reports.

CountyCare was fully compliant with IS Standard 6.0 for data preproduction processing.

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

CountyCare initiated a new vendor relationship with VDT for HEDIS MY 2020 performance measure production. All HEDIS measures within the scope of the audit were included in VDT's measure certification. The VDT Affinitē Quality tool was demonstrated live during the virtual audit review.

During the virtual audit review, PSV was conducted for five members in each of the following measures: *W30*, *IET*, and *ADV*. Enrollment, administrative, and practitioner data in the Affinitē VDT

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.

CountyCare was fully compliant with IS Standard 7.0 for data integration and reporting.

NCQA HEDIS Compliance Audit Results for Meridian

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

Table B1-6—Meridian MY 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 determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

Meridian continued to use the internally developed Managed Care System (MCS) for claims and encounter data processing. There were no major upgrades to the system since the previous year's review. MCS was able to capture primary and secondary coding with the appropriate specificity.

Meridian does not accept nonstandard claims, nor does it allow nonstandard claim forms. The auditor verified through virtual audit demonstrations that nonstandard codes and claim forms were rejected back to the submitter when received. Meridian conducted audits of its claims receipts during the MY, which resulted in 98.3 percent accuracy of all claims adjudicated.

Meridian maintained an auto-adjudication rate above 75 percent for HEDIS MY 2020. Claims that failed to auto-adjudicate were usually those with attached medical records. Meridian also maintained an average of two days to process all clean claims.

Meridian had no vendors, other than electronic claims clearinghouses, involved with its claims process. Clearinghouses were required to maintain Health Insurance Portability and Accountability Act (HIPAA)-compliant edit checks prior to supplying the electronic claims to Meridian. Ninety-five percent of all claims were processed electronically.

Meridian's MCS system met all requirements for capturing HEDIS-relevant information.

The auditor had no concerns with Meridian's claims processing.

Meridian was fully compliant with IS Standard 1.0.

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

Meridian experienced an increase in enrollment during HEDIS MY 2020, up from 763,199 the previous year to 832,288 in the MY. The increase in membership resulted from both new enrollments and the State's moratorium on the recertification/redetermination process due to the COVID-19 pandemic.

Meridian maintained that it had sufficient staff and no issues with processing the additional enrollments. The MCO did not require any manual processing of applicants because all enrollments were submitted via standard 834 format daily. There were no interruptions or backlogs with the electronic process during HEDIS MY 2020.

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. Each month, Meridian also verified enrollment using the State's full roster. The full roster provides Meridian with additions, changes, or deletions that were previously reported on the daily files. Meridian's MCS system 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 audit. The review identified when Harmony Health Plan of Illinois, Inc. (Harmony) members were acquired by Meridian. There were no concerns with the data review or with Meridian's enrollment data processes.

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 location of the provider data in the MCS system for MY 2020. However, Meridian began to merge its provider credentialing process with WellCare Health Plan following WellCare's acquisition of Meridian in 2019. The merger did not impact provider specialty mapping, but rather impacted the process for housing the credentialing of providers. HSAG verified that Meridian's MCS system was able to capture primary and secondary specialties and verified that provider specialties matched the education requirements to meet that certification.

During the virtual audit, HSAG found that Meridian mapped Pain Management as a mental health specialty. The auditor requested that this specialty be changed to "Other" as it did not meet the HEDIS definition for "mental health practitioner." Meridian staff agreed and made the update to remove the mental health flag in the certified measures software. HSAG also advised Meridian to count certified midwives as PCPs since an update to the HEDIS technical specifications indicated this was allowed.

The provider specialty mapping for FQHCs that were mapped to PCPs was approved by the auditor for HEDIS MY 2020 reporting. FQHCs were allowed to provide both primary care and mental health

services to Medicaid members in the State of Illinois. To meet the qualifications for being an FQHC, certain criteria must be met according to NCQA guidelines.

HSAG had no concerns with the MCS system's ability to capture provider taxonomy, NPI, drug enforcement agency (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. All specialties were fully documented. All provider specialties were reviewed and approved for use in HEDIS MY 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 4.0 Roadmap pertaining to the P&Ps for IS Standard 4.0. The Roadmap review found these P&Ps to be consistent with the IS 4.0 requirements. Meridian sampled according to HEDIS sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across hybrid measures.

Meridian contracted with Change Healthcare to conduct abstractions and chases for HEDIS MY 2020. In prior years, Meridian conducted medical record abstraction internally using its own proprietary hybrid abstraction tools. Because of this change, HSAG required Meridian to undergo convenience sample validation for the two hybrid measures under review this year. Meridian successfully passed the validation process for both hybrid measures.

Change Healthcare conducted IRR for all staff and maintained a 95 percent accuracy for all abstractors. HSAG requested IRR scores for both training and final results to be uploaded to HSAG's SFTP site for verification.

Change Healthcare overreads 100 percent of all abstracted records for the first two weeks of reviews and then 90 percent after that. Additionally, Change Healthcare overreads 100 percent of all noncompliant records throughout the entire MRR process.

HSAG reviewed Change Healthcare's hybrid abstraction tools to ensure all fields, edits, and drop-down boxes were accurate against NCQA's Measurement Year 2020 and Measurement Year 2021 *Volume 2, Technical Specifications for Health Plans*. HSAG reviewed and approved Change Healthcare's hybrid tools and instructions.

Meridian was required to conduct a convenience sample for *PPC—Timeliness of Prenatal Care* (two records) and *CIS—Hepatitis A* (one record). Both measures passed the convenience sample review without issue.

The same measures were selected during final MRR, and no issues were found. Meridian passed the final MRRV.

Meridian was fully compliant with IS Standard 4.0.

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

Meridian presented four supplemental databases in its Roadmap for consideration. Three supplemental data sources were determined to be standard and one, MHP Internal, was determined to be nonstandard.

For the MHP Internal database, HSAG selected a random sample from all records in the database according to NCQA's guidelines for nonstandard supplemental data. Meridian provided proof-of-service documentation for all case selections in the nonstandard supplemental data source. All 50 records passed validation without any issues.

For the standard supplemental databases, providers were required to submit electronic health record (EHR) data in Meridian's file layout and 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.

Lab results data were also considered standard. Lab data were captured in standard file layouts and received monthly.

All standard and nonstandard supplemental databases were approved for use in HEDIS MY 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 began using Inovalon's QSI XL HEDIS Certified Measures for HEDIS MY 2020 reporting. In prior years, Meridian generated source code in-house for calculating the HEDIS measures. Data loads are done semimonthly with the first data load on the 5th and the second data load on the 20th of the month.

Meridian uses an extract, transform, load (ETL) process to extract the data from the EDW. The data are staged in a SQL server and mapped to the Inovalon QSI XL file formats for ingestion into the certified measures software platform. Multiple validations occur for each data load and for each file to ensure record load attempts and record load acceptance are within reasonable limits. Record rejections are reviewed to ensure systemic issues are not present with the data. HSAG reviewed data quality processes and reviews to ensure no issues were prevalent.

Meridian provided medical claims, Electronic Clinical Data System (ECDS) data, and encounters for three and a half years, pharmacy claims for two and a half years, lab claims for two years, vision claims for two years, mental health claims for two years, and dental claims for one year to Inovalon.

For members with at least one day of enrollment in the current or prior MY, Meridian loaded at least three and a half years of enrollment data.

HSAG did not find any materially biased issues with Meridian's data transfers and record consolidations.

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 converted to Inovalon's QSI XL tool for measure production in HEDIS MY 2020. Inovalon maintained that there were no changes to its operational processes or technology used for data integration or reporting, and that its QSI XL software did not endure any significant changes. Inovalon QSI XL contains HEDIS Certified Measures and undergoes certification annually. Inovalon passed certification for all measures under the scope of the audit for HEDIS MY 2020.

Hospice events for members are being identified through claims using the Hospice Value Set or through MRR when applicable.

Meridian and Inovalon staff performed data quality checks and field-level profiling. The loaded input files were run through QSI XL's data module which verified the quality and reasonableness of the data submitted. Data quality reports were reviewed by Meridian staff to ensure data errors were corrected and final submissions were accurate. This profiling exercise occurs during each data load and ensures the reasonableness, format, and data consistency are accurate.

HSAG did not have any concerns with Inovalon's data integration and reporting process.

Meridian successfully loaded all measures into the IDSS without issue.

Final rate review was conducted, and no issues or concerns were found in the final review.

Meridian was fully compliant with IS Standard 7.0.

NCQA HEDIS Compliance Audit Results for Molina

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

Table B1-7—Molina MY 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 determining compliance with the HEDIS IS standards was based on the findings summarized below. The review focused on the health plan's ability to comply with the standards and substantiate the submitted performance measure results. Any deviations from the standards that could bias the final results were identified. Recommendations for improving health plan processes were also identified.

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

There were no changes to Molina's claims and encounter process for HEDIS MY 2020. Molina continued to use QNXT, an industry-standard claims adjudication system, to process FFS claims during MY 2020. The QNXT system captured standard procedure and diagnosis codes appropriately and was able to capture primary and secondary codes billed on a claim. Molina did not have any nonstandard coding related to the measures under review.

HSAG verified that QNXT had appropriate claim edits to reject claims using invalid procedure and diagnosis codes. Additional edits were in place to reject claims if they were missing critical information, such as patient and provider identifiers, dates of service, and missing or null fields.

Encounter data were submitted from several vendors and capitated providers for MY 2020. HSAG and Molina confirmed that there was a significant dip in claims and encounter submissions for March and April 2020 dates of service, mainly due to the effects of COVID-19 pandemic office closures. HSAG has noted this in the event that some routine service measures show a decrease year over year.

All encounter data were directly fed into the corporate operational data store 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 continued to use Change Healthcare for both paper and electronic claims submission. Paper claims were scanned in-house by Molina's claims mailroom. Staff are responsible for date stamping, batching, and scanning claims in batches of 100. The claims are then scanned and electronically sent to the Utah location where the OCR process is completed. The images are returned within two business days of the receipt date via an SFTP site and are uploaded daily by Molina Healthcare's Information Technology (IT) Department. All other claims, which are not initially directed to the centralized Claims Post Office Box, are delivered to Molina's Claims Department's Mailroom where they are immediately batched and sent to Change Healthcare daily for scanning/imaging. In addition, any claims received from other departments within Molina are routed to the claims mailroom daily where they are prepped and submitted to Change Healthcare for OCR processing.

Molina denied having any issues with the claims process during the MY and did not experience any issues related to COVID-19 other than a decrease in overall submission in March and April 2020.

Molina was fully compliant with IS Standard 1.0.

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

Molina continued to use the daily and monthly files provided by the State's 834 transactions. The electronic files were captured in QNXT. There were no changes to this process from the previous year. Preprocessing of eligibility files was performed in the Molina Eligibility Gateway (MEG) module. All records excluding newborn records were loaded into QNXT.

All enrollment data were processed 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 so that families could be linked together. Molina received daily files from the State and reconciled those records with the final monthly file. The amount of time to process enrollment files was less than three days. There were no concerns with the enrollment process following HSAG's review.

Molina experienced an increase in enrollment due mainly to the State freezing the eligibility re-determinations. Members were not actively required to re-apply for eligibility due to COVID-19.

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 data process for HEDIS MY 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 HEDIS MY 2020. HSAG reviewed the provider mapping documents included in the Roadmap and found no issues during the

virtual audit review. Molina advised that it had a proportionate number of PCPs added during the MY, mainly to accommodate a growing membership and to ensure network adequacy.

Molina expanded its PCP capture to include certified midwives, which could positively impact rates for measures requiring a PCP.

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 together records with multiple identification numbers. There were no issues encountered with this practice of maintaining multiple identifiers.

Monthly, Molina audited the provider data in QNXT to ensure completion of specialties, license type, and professional degree. This internal audit included review of provider locations and ZIP Codes. Molina used several delegated entities to process provider information. The delegated entities were monitored annually, and no significant issues were found. Delegated entities that were audited were within 95 percent accuracy thresholds for MY 2020.

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 prior to the virtual audit. Molina did not reduce any samples for hybrid measures and did not need approval from NCQA for any sample increases.

Molina staff conducted medical record pursuit and data collection using ClaimSphere Clinical+. ClaimSphere Clinical+ was the HEDIS software used for data entry, chart collection, data annotation, and chart storage. HSAG reviewed and approved the ClaimSphere hybrid tools. Provider chase logic was reviewed and determined to be appropriate across the hybrid measures. Reviewer qualifications, training, and oversight were appropriate. IRR for training and final abstraction was submitted to HSAG prior to final approval of the hybrid abstraction, and no concerns were identified.

A convenience sample was required since Molina changed its process from the previous year. HSAG selected the *PPC—Timeliness for Prenatal Care* and *CIS—Hep A* measures for a convenience sample. Molina passed both measures without issue.

Molina successfully passed the final MRRV without any issues.

Molina was fully compliant with IS Standard 4.0.

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

Molina submitted eight supplemental databases for consideration for HEDIS MY 2020. Two supplemental databases were determined to be nonstandard sources, Supplemental Data Collection Tool

(SDCT) and Pilot Medical Record Review (PMRR). PSV was conducted for the nonstandard databases on 50 records from each database. Proof-of-service documentation was provided and reviewed for all selected cases, and both nonstandard supplemental databases passed the PSV process.

Six standard data sources were approved for MY 2020 reporting, including lab results, EHR from Independent Practice Associations (IPAs), and historical claims and immunization records from the State.

HSAG reviewed and approved all standard and nonstandard data sources. The standard data source review did not reveal any concerns with data capture, file layouts, or code mapping.

All standard and nonstandard data sources were approved for HEDIS MY 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

Molina converted from Inovalon's QSI XL to ClaimSphere software for reporting in HEDIS MY 2020. ClaimSphere is a TriZetto product that uses HEDIS Certified Measures.

HSAG and Molina discussed the conversion process and mapping documents during the virtual audit review. Molina conducted dual processing on both ClaimSphere and QSI XL to ensure rates appeared reasonable from the previous year's reported rates. Molina and HSAG reviewed processes and determined that all file consolidations performed in the preprocess did not change, other than the specific mapping documents required for the new HEDIS software.

Data transfers and mappings were managed appropriately as demonstrated during the virtual audit. Molina monitored data transfers through matching data loads to its data extracts from ODS into Inovalon's system. Data that fall out are quickly identified to ensure critical errors are corrected. During the virtual audit, the examination of the data transfer and consolidation did not reveal any issues. HSAG conducted PSV and did not encounter any issues.

Molina ensured all paid, denied, and pended claims were included in the data loads to ensure complete claims capture for reporting.

HSAG reviewed all provider type and specialty mapping documents as part of the query process and had no concerns with PCP mapping or with the specialties required for HEDIS reporting. Molina followed NCQA guidelines for assigning PCP status to FQHCs and Rural Health Clinics (RHCs).

Molina monitored all data loads to ClaimSphere to ensure data were accepted. Any rejected data records were examined to determine if there were global issues. Molina reported that there were no concerns or global issues with data transfers.

HSAG did not have any concerns with preproduction processing. 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 converted to a new software platform during the MY, moving from Inovalon's QSI XL product to TriZetto's ClaimSphere. ClaimSphere is an NCQA Certified Measures software product and had completed all certification at the time of the virtual audit. Molina corporate staff were responsible for the management and conversion of the ClaimSphere product. Corporate processes were reviewed during the virtual audit and were found to be sufficient for HEDIS MY 2020 reporting. Molina's staff were proficient in data warehousing and demonstrated during the virtual audit that record counts and volumes were monitored.

Molina met with ClaimSphere team members regularly to discuss file loading and processing. Molina indicated that the change to the new platform resulted in a fresh perspective on data and resulted in streamlined processes.

Molina continued to monitor provider submissions and tracked the volume for each submission over time. Trending volumes were compared to expected per member per month (PMPM) counts to determine if data were missing.

Molina regularly checks the TriZetto ClaimSphere audit control reports to validate the number of records and file sizes to ensure they match the source system before processing the data load. The ETL process is designed with an audit table to gather all record counts for each file loaded. Queries are employed to perform reconciliation checks and balances for both post- and pre-load processes. Queries verified naming conventions, number of records read, number of records loaded, and number of records rejected.

Molina and ClaimSphere also performed data quality checks and field level profiling. The loaded input files were run through ClaimSphere's data profiling module to check the quality and reasonableness of the data submitted in each field in each file. The profiling tool checked the reasonableness, format, range, consistency, and null data fields to ensure there were no concerns.

HSAG had no concerns with Molina's data integration and reporting processes. Molina was fully compliant with IS Standard 7.0.

Appendix B2. 2020–2021 Encounter Data Completeness

Encounter Data Completeness

The tables below display the estimate of the administrative data completeness for the HEDIS MY 2020 performance measure rates calculated using the hybrid methodology for each health plan. Health plans were not required to report using the hybrid method; therefore, the measures displayed 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 presents the percentage of each HEDIS hybrid measure rate that was determined using administrative encounter data only.

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

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Child Health	
Childhood Immunization Status	
Combination 3	94.40%
Combination 10	91.51%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	96.69%
Combination 2 (Meningococcal, Tdap, HPV)	94.44%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	64.02%
Counseling for Nutrition—Total	36.54%
Counseling for Physical Activity—Total	31.25%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	95.19%
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.20%
Postpartum Care	92.56%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.82%
HbA1c Control (<8.0%)	24.30%
Eye Exam (Retinal) Performed	98.36%
Blood Pressure Control (<140/90 mm Hg)	24.28%

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
HbA1c Poor Control (>9.0%)	86.17%
Controlling High Blood Pressure	
Controlling High Blood Pressure	25.68%

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—BCBSIL

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Child Health	
Childhood Immunization Status	
Combination 3	54.79%
Combination 10	55.64%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	95.34%
Combination 2 (Meningococcal, Tdap, HPV)	88.61%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	55.51%
Counseling for Nutrition—Total	48.29%
Counseling for Physical Activity—Total	38.05%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	88.02%
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	96.52%
Postpartum Care	92.15%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.88%
Eye Exam (Retinal) Performed	92.56%

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Controlling High Blood Pressure	
Controlling High Blood Pressure	22.40%

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—CountyCare

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Child Health	
Childhood Immunization Status	
Combination 3	96.76%
Combination 10	95.71%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	99.14%
Combination 2 (Meningococcal, Tdap, HPV)	100.00%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	61.58%
Counseling for Nutrition—Total	47.09%
Counseling for Physical Activity—Total	39.89%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	92.86%
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	92.48%
Postpartum Care	91.25%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	98.84%
HbA1c Control (<8.0%)	61.54%
Eye Exam (Retinal) Performed	82.71%
Blood Pressure Control (<140/90 mm Hg)	30.56%
HbA1c Poor Control (>9.0%)	100.00%

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Controlling High Blood Pressure	
Controlling High Blood Pressure	27.22%

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

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Child Health	
Childhood Immunization Status	
Combination 3	94.87%
Combination 10	95.35%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	96.96%
Combination 2 (Meningococcal, Tdap, HPV)	96.83%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	56.20%
Counseling for Nutrition—Total	42.04%
Counseling for Physical Activity—Total	37.12%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	94.33%
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.55%
Postpartum Care	93.23%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	97.58%
HbA1c Control (<8.0%)	11.56%
Eye Exam (Retinal) Performed	91.89%
Blood Pressure Control (<140/90 mm Hg)	8.63%

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
HbA1c Poor Control (>9.0%)	83.40%
Controlling High Blood Pressure	
Controlling High Blood Pressure	14.44%

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

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
Child Health	
Childhood Immunization Status	
Combination 3	97.49%
Combination 10	98.18%
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	98.36%
Combination 2 (Meningococcal, Tdap, HPV)	97.39%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	57.46%
Counseling for Nutrition—Total	34.69%
Counseling for Physical Activity—Total	32.22%
Women's Health	
Cervical Cancer Screening	
Cervical Cancer Screening	94.24%
Maternal Health	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	97.42%
Postpartum Care	93.02%
Living With Illness	
Comprehensive Diabetes Care	
HbA1c Testing	96.47%
HbA1c Control (<8.0%)	44.17%
Eye Exam (Retinal) Performed	93.37%
Blood Pressure Control (<140/90 mm Hg)	49.37%

MY 2020 Performance Measure	Percentage of Numerator Positive Cases Determined by Administrative Data
HbA1c Poor Control (>9.0%)	85.65%
Controlling High Blood Pressure	
Controlling High Blood Pressure	54.29%

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 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

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. HFS has an annual monitoring process in place to ensure the CFR and The Balanced Budget Act of 1997, Public Law 105-33 (BBA) requirements are met over a three-year period.

Since June 2002, 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 (HCI). In SFY 2021, HSAG completed the HCI review by assessing the remaining standards. A full set of standards was also reviewed for the Medicare-Medicaid Alignment Initiative (MMAI) program.

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 used to complete the Compliance Review. HSAG followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019.[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. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Jan 13, 2022

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 of Services
Standard VI—Children’s Behavioral Health Services
Structure and Operations
Standard XI—Grievance and Appeal Systems
Standard XII—Organization and Governance
Standard XV—Subcontractual Relationships and Delegation
Measurement and Improvement
Standard XVIII—Quality Assessment and Performance Improvement Program (QAPI)</td><td>Access
Standard I—Availability of Services
Standard II—Assurances of Adequate Capacity and Services
Standard V—Credentialing and Recredentialing
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 Minimum Standards of Care
Standard XIII—Fraud, Waste, and Abuse</td></tr>
<tr><td colspan="3">For MMAI, all standards listed above were reviewed in SFY 2021 expect for Children’s Behavioral Health, which is not applicable to the MMAI population.</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

<table>
<tr><th>For this step,</th><th>HSAG…</th></tr>
<tr><td>Step 1:</td><td>Established early contact with the health plans.</td></tr>
<tr><td></td><td>HSAG coordinated with HFS and the health plans to set the schedule and identified members of the HSAG review team for each health plan.</td></tr>
<tr><td>Step 1a:</td><td>Prepared and submitted the pre-assessment form to the health plans.</td></tr>
<tr><td></td><td>The pre-assessment form is to identify gaps in information necessary to ensure a comprehensive EQR process and efficient and productive interactions with the health plan during the 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 virtual review, as well as a list of documents required for the virtual portion of the administrative compliance 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 virtual 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 for each of the file reviews listed below. Specifications were also supplied for the program description reviews listed below.
HCI
<table>
<tr><th>Standard #</th><th>Standard</th><th>File Reviews</th></tr>
<tr><td colspan="3">Access Standards</td></tr>
<tr><td>I</td><td>Availability of Services</td><td>Provider Agreement</td></tr>
</table></td></tr>
</table>

For this step,	HSAG…

II	Assurances of Adequate Capacity and Services	Provider Directory
III	Coordination and Continuity of Care	Care Management (CM); Care/Disease Management Program Description (PD)
IV	Coverage and Authorization of Services	Denials; Utilization Management PD; Peer Review PD
V	Credentialing and Recredentialing	None
VI	Children's Behavioral Health Services	Children's Behavioral Health Record Review
Structure and Operations Standards		
VIII	Enrollee Information/Enrollee Rights	Enrollee Handbook
IX	Confidentiality	None
X	Enrollment and Disenrollment	None
XI	Grievance and Appeal Systems	Appeals; Grievances; State Fair Hearing (SFH)/Independent Review Entity (IRE)
XII	Organization and Governance	None
XIII	Fraud, Waste, and Abuse	None
XIV	Health Information Systems	None
XV	Subcontractual Relationships and Delegation	Delegation Vendor File Review; Provider Complaints
Measurement and Improvement Standards		
XVI	Critical Incidents	None
XVII	Practice Guidelines and Required Minimum Standards of Care	None
XVIII	QAPI	Quality Assurance PD

MMAI

Standard #	Standard	File Reviews
Access Standards		
I	Availability of Services	Provider Agreement
II	Assurances of Adequate Capacity and Services	Provider Directory
III	Coordination and Continuity of Care	CM, CMPD
IV	Coverage and Authorization of Services	Denials, UM PD, and Peer Review PD

For this step,	HSAG…

V	Credentialing and Recredentialing	None
Structure and Operations Standards		
VIII	Enrollee Information/Enrollee Rights	Enrollee Handbook
IX	Confidentiality	None
X	Enrollment and Disenrollment	None
XI	Grievance and Appeal Systems	Grievances Appeals State Fair Hearing (SFH)/Independent Review Entity (IRE)
XII	Organization and Governance	None
XIII	Fraud, Waste, and Abuse	None
XIV	Health Information Systems	None
XV	Subcontractual Relationships and Delegation	Delegated Vendors File Review
Measurement and Improvement Standards		
XVI	Critical Incidents	None
XVII	Practice Guidelines and Required Minimum Standards of Care	None
XVIII	QAPI	Quality Assurance PD

Step 2: Perform a preliminary document review (desk review).

Received the health plans' documents for HSAG's desk review and evaluated the information before conducting the on-site/virtual review. HSAG reviewers used the documentation to gain insight into each health plan's processes for providing access to care for its members, structure and operations, and quality assessment and performance improvement program. HSAG also used the documentation to begin compiling preliminary findings before the on-site/virtual 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/virtual interviews.
- Identified information not found in the desk review documentation that HSAG would request during the on-site/virtual administrative review.

Activity Three: Conduct Site Visits

HSAG conducted site visits[C-2] 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 health 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 virtual review, assembling requested documentation, and addressing logistical issues. The agenda set the tone, expectations, the objectives, and time frames for the review.

[C-2] Due to the COVID-19 pandemic, site visits were conducted virtually.

For this step,	HSAG…
Step 4:	**Provided preparation instructions and guidance to the health plans.**
	HSAG representatives conducted a teleconference with the health plans and HFS to exchange information, confirm the dates for the desk and virtual review, and complete other planning activities to ensure that the Compliance Review was completed methodically and accurately. In addition, clear instructions and guidance were provided to each health plan prior to the 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.
Step 5:	**Conducted virtual document review.**
	During the virtual 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 virtual health plan interviews.**
	During the virtual review, HSAG: • Conducted interviews with health plan staff. HSAG used interviews to obtain a complete picture of compliance with contract requirements, to explore any issues not fully addressed in the documents, and to increase overall understanding of the health plan's performance. • Reviewed information, documentation, and systems demonstrations. Throughout the virtual review process, reviewers used the administrative review tool to identify relevant information sources and to document findings regarding compliance with the standards. This activity included a review of applicable policies and procedures, meeting minutes, quality studies, reports, records, and other documentation. • Received and reviewed files designated for the file reviews. Reviewers used standardized monitoring tools to review records and to document findings regarding compliance with contract requirements and the health plans' policies and procedures. • Summarized findings at the completion of the virtual review.
Step 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 virtual review. The purpose of the exit interview allowed HSAG to clarify its understanding of the information collected throughout the compliance review process and provided the health plans the opportunity to respond to initial compliance issues to ensure the findings were due to true 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 health plan 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 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 used CMS' publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity,* October 2019.[D-1] Additionally, HSAG's PIP process facilitates frequent communication with the health plans. HSAG provides written feedback after each module is validated and provides technical assistance for further guidance. HSAG conducts webinar trainings prior to each module submission and progress check-ins while health plans test interventions.

HFS requires its health plans to conduct two PIPs annually. The topics continued and completed in SFY 2021 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 timeliness of and access to care and services.

For each PIP topic, the health plans 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 health plans 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. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on Jan 13, 2022

Approach to PIP Validation

There are five modules with an accompanying reference guide for the health plans to use to document their PIPs. The five modules are defined as:

- **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.

In SFY 2021, the health plans submitted Module 4 and Module 5 according to the approved timeline. HSAG obtained the data needed to conduct the PIP validation from the Module 4 and Module 5 submissions, which provided detailed information about the interventions tested and the PIP results.

HSAG validated Module 1, Module 2, and Module 3 prior to SFY 2021. After the initial validation, the health plans received HSAG's feedback and resubmitted the modules until all validation criteria were achieved. This process ensures that the methodology is sound before the health plans progress to the next phase of the PIP process. For Module 4 and Module 5, HSAG assessed whether the SMART Aim goal was achieved and if there was demonstrated improvement in the SMART Aim measure results that could be linked with an intervention tested for the PIP.

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 health plan conducted during the PIP.

PIP Validation Scoring

During validation, HSAG determines if criteria for each module are *Achieved.* At the completion of Module 5, HSAG determines a level of confidence representing the validity and reliability of the PIP. Using a standardized scoring methodology, HSAG assigns a level of confidence 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 health plan accurately summarized the key findings.
- ***Confidence*** = The PIP was methodologically sound, the SMART Aim was achieved, and the health plan 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.

Network Adequacy Validation (NAV) Methodology

Network Data Submission Process

HSAG worked extensively with HFS to develop and standardize the Provider Layout File (PFL) template for submitting provider network data. HFS and HSAG also developed the Provider Network Data Submission Instruction Manual and Data Dictionary (HSAG PFL manual), which included guidance and detailed instructions to the health plans for completing and submitting the PFL template. For example, the HSAG PFL manual included a data directory for all provider types required for reporting and submission to ensure the accuracy and consistency of network provider data across the health plans. The HSAG PFL manual includes the sections below.

- Section 1—Introduction describes the purpose of this manual and its organization as well as an overview of the PFL.
- Section 2—Provider File Layout Instruction provides detailed guidance on properly completing the PFL, including the file naming conventions, provider type specifications and definitions, and a description of the data submission elements needed to complete each field of the PFL.
- Section 3—Submission Process describes the procedure MCOs will use to submit their PFL on a quarterly basis.
- Appendix A—Data Dictionary defines all provider types required for submission.
- Appendix B—Home and Community Based Services (HCBS) Waiver Definitions defines HCBS service types required for submission.
- Appendix C—Provider File Layout Excel workbook template.
- Appendix D—Frequently Asked Questions (FAQs)
- Appendix E—Manual Update History
- Appendix F—List of Community Mental Health Centers (CMHCs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
- Appendix G—Illinois Department of Public Health (IDPH) Hospital Directory

Health plans were required to upload their provider network data files to a secure HSAG file transfer protocol site. These files include PCPs, adult and pediatric providers, behavioral health (BH) providers, dental providers, hospitals, facilities, pharmacies, HCBS, MLTSS providers, FQHCs, CMHCs, RHCs, nursing facilities, supportive living facilities, exceptional care providers, and transportation providers within each managed care service area including out-of-state providers in contiguous counties.

HFS requires all health plans to follow the guidance and instructions within the HSAG PFL manual to ensure and maintain the integrity of the provider network data across all health plans. HSAG uses the provider network data submissions for network validation analysis and monitors health plan compliance with network adequacy requirements. Health plans are informed of HSAG's findings to respond and address any potential network findings identified during NAV review. Based on the ongoing feedback

between HSAG/HFS and the health plans, HFS has the capability to monitor health plan progress toward the remediation of network findings.

Data Validation Process

Following the receipt of the health plans' provider network data, HSAG conducted a validation process that included:

- Review of the accuracy and completeness of required data fields.
- Identification of duplicate data.
- Verification of provider contract status.
- Categorization of providers to the correct provider group.
- Verification of open and closed panel status.
- Comparison of the number of data records between the prior and current data submissions.
- Verification of provider types.

After completion of HSAG's validation checks, the health plan provider data was loaded to a secure MS Access database containing programmed queries that generated network reports. As an additional validation check, the data generated by the source programming code was validated against the health plan data files to verify the accuracy of the network reports.

HSAG produced health plan-specific and comparative network reports to identify the number of provider types within each county statewide. These reports also included contracted providers within specific out-of-state counties neighboring the service regions.

Reporting and Communication

During the provider network validation reviews in SFY 2021, HSAG maintained ongoing communication with the health plans and HFS regarding any findings and recommendations identified during HSAG's analysis of the health plans' provider networks. HSAG monitored and reported to HFS the health plans' compliance towards establishing an adequate provider network. Network gaps were communicated to HFS and health plans were required to respond to all identified network gaps in writing and, if necessary, develop a contingency plan to remediate those gaps.

Monitoring Network Adequacy for HealthChoice Illinois

HSAG collaborated with HFS to develop biannual provider network capacity reports to ensure compliance with HFS' specifications. The HCI provider network capacity reports included:

- Hospital Analysis Report—hospitals listed by name and region to show contracted hospitals across the health plans.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Quarterly MLTSS Summary—review of 16 MLTSS service categories across 102 Illinois counties to determine the overall percentage of counties with contracted MLTSS providers. Review also included detail by health plan, county, and provider category.
- Pediatric Time and Distance Study—review completed to measure compliance with time and distance requirements between providers and enrollees.
- Provider Network Validation Study—review completed to measure compliance with provider directory specifications and requirements.

Monitoring Network Adequacy for Medicare-Medicaid Alignment Initiative (MMAI)

HSAG collaborated with HFS to develop biannual provider network capacity reports to ensure compliance with HFS' specifications. The MMAI provider network capacity reports included:

- Hospital Analysis Report—hospitals listed by name and region to show contracted hospitals across the health plans.
- Region Specific Network Summaries—regional review and health plan-specific reports by provider type and county, including contiguous counties.
- Long Term Services and Supports (LTSS) Provider Summary—review of 16 LTSS service categories across 102 Illinois counties to determine the overall percentage of counties with contracted LTSS providers. Review also included detail by health plan, county, and provider category.
- Behavioral Health Network Review—detailed review of BH providers across 102 Illinois counties to determine the overall percentage of counties with contracted BH providers. Review also included detail by health plan and county.

Appendix E2. Network Adequacy Regional Comparison

IL2021 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 1 - Northwest Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment as of April 1, 2021	82,885	35,086	132,242	66,105	3,719

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,473	689	915	1,055	1,978
Primary Care Providers (Pediatric)	655	610	459	1,173	1,054
Mid-Level Practitioners (Adult)	1,341	566	876	1,091	47
Mid-Level Practitioners (Pediatric)	1,301	486	521	1,058	0*
Adult Specialty Providers	2,332	1,499	1,784	1,770	1,346
Pediatric Specialists	1,122	531	666	1,299	803
Gynecology, OB/GYN	204	114	175	211	172
Dentists (Adult)	412	335	236	274	451
Dentists (Pediatric)	391	315	246	268	438
Behavioral Health Providers (Adult)	604	490	459	615	529
Behavioral Health Providers (Pediatric)	459	74	129	277	368
Facilities (# of locations)*					
CMHC/FQHC/RHC	158	151	136	194	233
Skilled Nursing Facilities	100	117	148	112	122
Supportive Living Facilities	24	22	24	24	25
Pharmacies	206	202	421	269	254
Other Facilities	299	414	654	378	1,480

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	28	24	30	30	29

Health Plan Notes
*The pediatric mid-level specialties (nurse practitioner, physician assistant) reported by YouthCare were listed as "Yes" for the PCP column which are reflected in the overall pediatric PCP category.

Summary Notes
*Provider counts were based on a unique count of NPIs for practitioners and count of provider locations for Facilities & Hospitals. All providers included in the summary above were reported by the health plans as Medicaid Contracted. Providers reported as "Pending" for Medicaid Contracted were not included.

IL2021 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 2 - Central Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment as of April 1, 2021	61,402	41,695	110,484	64,075	3,835

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,702	676	1,017	1,325	1,842
Primary Care Providers (Pediatric)	889	581	528	1,427	1,227
Mid-Level Practitioners (Adult)	1,497	786	1,004	1,210	39
Mid-Level Practitioners (Pediatric)	1,450	677	671	1,178	0*
Adult Specialty Providers	2,787	1,905	1,825	1,973	1,490
Pediatric Specialists	1,429	612	711	1,332	946
Gynecology, OB/GYN	254	107	181	232	210
Dentists (Adult)	246	194	166	188	216
Dentists (Pediatric)	239	188	169	182	208
Behavioral Health Providers (Adult)	541	447	520	680	500
Behavioral Health Providers (Pediatric)	327	76	165	277	236
Facilities (# of locations)*					
CMHC/FQHC/RHC	206	231	229	289	308
Skilled Nursing Facilities	112	119	149	123	135
Supportive Living Facilities	27	33	25	31	26
Pharmacies	216	224	447	272	261
Other Facilities	226	516	640	462	1,429

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	34	29	31	34	30

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.

Mid-Level Practitioners
- Adult – Nurse Practitioner, Physician Assistant, Nurse Midwife
- Pediatric – Pediatric Nurse Practitioner, Pediatric Physician Assistant
- The count for the mid-level category above does not include Nurse Practitioners and Physician Assistants reported as "Yes" for the PCP (Y/N) column.

IL2021 HealthChoice IL (HCI) Provider Network - Contracted Providers
Provider Network for Region 3 - Southern Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Enrollment as of April 1, 2021	54,594	30,171	113,891	54,403	3,871

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	1,229	550	809	856	1,050
Primary Care Providers (Pediatric)	693	531	493	944	716
Mid-Level Practitioners (Adult)	697	517	526	656	25
Mid-Level Practitioners (Pediatric)	669	427	384	603	0*
Adult Specialty Providers	1,874	1,293	1,073	1,287	918
Pediatric Specialists	1,027	472	437	867	609
Gynecology, OB/GYN	153	81	114	142	117
Dentists (Adult)	156	131	87	87	97
Dentists (Pediatric)	152	111	89	88	83
Behavioral Health Providers (Adult)	292	217	236	336	277
Behavioral Health Providers (Pediatric)	217	51	61	137	164
Facilities (# of locations)*					
CMHC/FQHC/RHC	199	224	256	268	324
Skilled Nursing Facilities	89	99	132	81	109
Supportive Living Facilities	23	30	20	27	22
Pharmacies	203	203	385	239	220
Other Facilities	134	377	500	433	527

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	35	34	31	35	32

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

IL2021 HealthChoice IL (HCI) Provider Network - Contracted Providers
Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna Cook & Collars		BCBS Cook & Collars		Meridian Cook & Collars	
Enrollment as of April 1, 2021	116,602	75,521	313,297	191,767	307,912	196,944

Health Plan	Aetna Cook & Collars		BCBS Cook & Collars		Meridian Cook & Collars	
Practitioners (# of unique NPIs)*						
Primary Care Providers (Adult)	4,692	1,611	2,721	1,477	2,823	1,433
Primary Care Providers (Pediatric)	1,244	548	2,084	1,241	1,231	732
Mid-Level Practitioners (Adult)	2,822	1,181	3,233	1,605	2,753	1,685
Mid-Level Practitioners (Pediatric)	2,793	1,228	2,684	1,297	2,185	1,319
Adult Specialty Providers	7,476	2,419	8,058	4,193	6,712	3,800
Pediatric Specialists	4,433	1,463	3,852	1,930	3,577	1,942
Gynecology, OB/GYN	787	254	609	344	717	399
Dentists (Adult)	1,569	923	1,416	870	1,093	684
Dentists (Pediatric)	1,556	911	1,329	812	1,129	696
Behavioral Health Providers (Adult)	1,971	812	1,827	990	1,731	799
Behavioral Health Providers (Pediatric)	1,427	594	197	174	777	304
Facilities (# of locations)*						
CMHC/FQHC/RHC	492	238	504	258	453	178
Skilled Nursing Facilities	194	90	202	111	239	150
Supportive Living Facilities	35	25	30	22	41	29
Pharmacies	574	367	660	413	1,335	930
Other Facilities	842	371	845	410	1,762	1,276

Health Plan	Aetna		BCBS		Meridian	
Hospitals (# of locations)*						
Hospitals	56	16	58	26	55	25

IL2021 HealthChoice IL (HCI) Provider Network - Contracted Providers
Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on June 15, 2021

Molina		YouthCare		CountyCare	
Cook & Collars		Cook & Collars		Cook & Collars	
91,005	27,603	6,018	2,722	386,820	N/A

Molina		YouthCare		CountyCare	
Cook & Collars		Cook & Collars		Cook & Collars	
1,901	572	4,511	1,587	3,485	N/A
2,318	727	2,492	914	2,337	N/A
1,830	764	170	32	3,845	N/A
1,875	766	0*	0*	2,244	N/A
3,656	1,117	5,752	1,773	7,278	N/A
2,676	800	4,414	1,397	2,844	N/A
540	155	846	244	916	N/A
818	430	1,345	915	706	N/A
815	428	1,288	901	90	N/A
1,866	788	2,025	790	2,234	N/A
930	295	1,205	573	1,514	N/A
579	212	870	329	597	N/A
168	86	252	118	201	N/A
30	23	30	24	36	N/A
820	528	840	521	833	N/A
650	345	8,076	6,417	909	N/A

Molina		YouthCare		CountyCare	
45	8	58	18	55	N/A

Region 1 Contiguous Counties
Iowa and Wisconsin Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	387	82	260	198	438
Primary Care Providers (Pediatric)	224	71	130	235	217
Mid-Level Practitioners (Adult)	256	62	291	198	12
Mid-Level Practitioners (Pediatric)	248	53	259	194	0
Adult Specialty Providers	540	231	736	475	332
Pediatric Specialists	217	85	261	346	179
Gynecology, OB/GYN	34	17	47	40	46
Dentists (Adult)	51	37	29	13	19
Dentists (Pediatric)	46	38	31	14	18
Behavioral Health Providers (Adult)	73	27	108	64	82
Behavioral Health Providers (Pediatric)	75	3	46	44	46
Facilities (# of locations)*					
CMHC/FQHC/RHC	8	0	6	6	35
Skilled Nursing Facilities	0	0	2	0	1
Supportive Living Facilities	0	0	0	0	0
Pharmacies	53	25	204	85	84
Other Facilities	44	119	171	81	114

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	8	4	7	11	10

*Contiguous counties included: Lee-IA, Des Moines--IA, Louisa-IA, Muscatine-IA, Scott-IA, Clinton-IA, Jackson-IA, Dubuque-IA, Grant-WI, Lafayette-WI, Green-WI, Rock-WI, Walworth-WI.

Provider Network for Region 3 Contiguous Counties
Missouri, Kentucky, Indiana Counties
Contracted Providers

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	765	117	287	402	953
Primary Care Providers (Pediatric)	399	138	134	464	750
Mid-Level Practitioners (Adult)	1,161	369	793	811	6
Mid-Level Practitioners (Pediatric)	1,164	344	721	829	0
Adult Specialty Providers	2,593	642	2,206	2,069	2,052
Pediatric Specialists	1,820	311	1,283	1,630	1,609
Gynecology, OB/GYN	247	75	194	212	221
Dentists (Adult)	35	7	8	29	27
Dentists (Pediatric)	37	11	10	30	32
Behavioral Health Providers (Adult)	287	115	220	227	188
Behavioral Health Providers (Pediatric)	233	3	134	171	154
Facilities (# of locations)*					
CMHC/FQHC/RHC	1	0	1	3	13
Skilled Nursing Facilities	2	0	1	0	3
Supportive Living Facilities	0	0	0	0	1
Pharmacies	68	13	487	137	132
Other Facilities	131	68	175	149	855

Health Plan	Aetna	BCBSIL	Meridian	Molina	YouthCare
Hospitals (# of locations)*					
Hospitals	20	10	8	20	19

*Contiguous counties included: St. Charles-MO, St. Louis City-MO, St. Louis-MO, Jefferson-MO, Ste. Genevieve-MO, Perry-MO, Cape Girardeau-MO, Scott-MO, Union-KY, Crittenden-KY, Livingston-KY, McCracken-KY, Ballard-KY, Sullivan-IN, Knox-IN, Gibson-IN, Posey-IN.

Appendix E3. MLTSS Network Monitoring

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Statewide & Cook Only Health Plans
Provider Network Data submitted on 6/15/21

Health Plan	Number of Counties with one or more Contracted MLTSS Provider by Service Category and Health Plan															
	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
Aetna																
Counties with 2 or more Providers	92	91	84	79	82	102	101	102	102	102	98	102	102	96	97	95
Counties with 1 Provider	10	9	15	20	17	-	1	-	-	-	4	-	-	4	3	5
Counties with no provider	-	2	3	3	3	-	-	-	-	-	-	-	-	2	2	2
Number of Counties by Region Reported with no Contracted Providers																
Region 1-Northwest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	-	1	2	2	2	-	-	-	-	-	-	-	-	-	-	-
Region 3-Southern	-	1	1	1	1	-	-	-	-	-	-	-	-	2	2	2
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
BCBS																
Counties with 2 or more Providers	88	88	22	87	88	87	88	88	88	102	22	88	88	88	88	88
Counties with 1 Provider	13	13	78	14	13	14	13	13	13	-	78	13	13	13	13	13
Counties with no provider	1	1	2	1	1	1	1	1	1	-	2	1	1	1	1	1
Number of Counties by Region Reported with no Contracted Providers																
Region 1-Northwest	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	1	1	2	1	1	1	1	1	1	-	2	1	1	1	1	1
Region 3-Southern	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Meridian																
Counties with 2 or more Providers	94	56	94	102	102	97	102	82	88	102	12	93	37	73	99	97
Counties with 1 Provider	8	40	7	-	-	4	-	9	14	-	24	5	41	29	3	5
Counties with no provider	-	6	1	-	-	1	-	11	-	-	66	4	24	-	-	-
Number of Counties by Region Reported with no Contracted Providers																
Region 1-Northwest	-	-	-	-	-	1	-	1	-	-	14	-	1	-	-	-
Region 2-Central	-	-	-	-	-	-	-	2	-	-	23	-	7	-	-	-
Region 3-Southern	-	6	1	-	-	-	-	8	-	-	29	4	16	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Molina																
Counties with 2 or more Providers	37	38	28	102	58	102	95	101	102	102	102	102	102	102	102	102
Counties with 1 Provider	22	19	35	-	44	-	7	-	-	-	-	-	-	-	-	-
Counties with no provider	43	45	39	-	-	-	-	1	-	-	-	-	-	-	-	-
Number of Counties by Region Reported with no Contracted Providers																
Region 1-Northwest	3	2	6	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 2-Central	13	17	20	-	-	-	-	1	-	-	-	-	-	-	-	-
Region 3-Southern	25	25	12	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 4-Cook	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Region 5-Collars	2	1	1	-	-	-	-	-	-	-	-	-	-	-	-	-
CountyCare - Cook Only Health Plan*																
Counties with 2 or more Providers	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
Counties with 1 Provider	-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-
Counties with no provider	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

HSAG Notes:

- Table above summarizes the number of counties identified with 2 or more providers; number of counties with 1 Provider; and number of counties with no providers by region. Refer to the statewide health plan-specific tabs for a detailed summary by county and MLTSS provider category.
- Green shading indicates that the health plan reported at least one contracted provider for all service counties.

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Aetna Better Health (Aetna)
Provider Network Data submitted on 6/15/21

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Adams	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Alexander	*Rural*	3+	2	1	2	1	3+	3+	3+	2	3+	2	3+	3+	1	1	1
Bond	*Rural*	2	1	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Boone	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Brown	*Rural*	1	1	1	1	1	2	1	3+	3+	3+	1	3+	2	2	2	2
Bureau	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Calhoun	*Rural*	1	1	1	1	1	2	2	2	2	3+	1	3+	3+	1	1	1
Carroll	*Rural*	3+	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	1	2	1
Cass	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Champaign	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Christian	*Rural*	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clark	*Rural*	2	3+	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clay	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clinton	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Coles	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Cook	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Crawford	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Cumberland	*Rural*	2	2	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
De Witt	*Rural*	1	1	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Dekalb	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Douglas	*Rural*	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
DuPage	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edgar	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edwards	*Rural*	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Effingham	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Fayette	*Rural*	2	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Ford	*Rural*	1	2	2	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Franklin	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Fulton	*Rural*	3+	3+	2	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Gallatin	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	0	0
Greene	*Rural*	2	2	1	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Grundy	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Hamilton	*Rural*	2	2	2	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Hancock	*Rural*	2	2	3+	2	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Hardin	*Rural*	3+	2	2	2	2	3+	3+	3+	3+	3+	2	3+	3+	2	2	2
Henderson	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Henry	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Iroquois	*Rural*	1	2	2	1	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Jackson	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jasper	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jefferson	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jersey	*Rural*	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jo Daviess	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	1
Johnson	*Rural*	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Kane	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Kankakee	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Kendall	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Knox	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
La Salle	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lake	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lawrence	Rural	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Lee	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Livingston	Rural	1	1	1	1	1	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Logan	Rural	3+	3+	2	1	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Macon	Urban	2	2	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Macoupin	Rural	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Madison	Urban	3+	2	3+	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Marion	Rural	2	3+	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Marshall	Rural	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Mason	Rural	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Massac	Rural	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
McDonough	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
McHenry	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
McLean	Urban	3+	2	3+	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Menard	Rural	2	1	0	0	0	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Mercer	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Monroe	Rural	3+	2	2	2	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Montgomery	Rural	1	0	0	0	0	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Morgan	Rural	3+	3+	1	2	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Moultrie	Rural	1	1	1	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Ogle	Rural	3+	3+	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Peoria	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Perry	Rural	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Piatt	Rural	1	1	1	1	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+
Pike	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Pope	Rural	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	0	0
Pulaski	Rural	3+	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	1	1	1
Putnam	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Randolph	Rural	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Richland	Rural	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Rock Island	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Saint Clair	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Saline	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Sangamon	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Schuyler	Rural	2	2	2	1	2	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Scott	Rural	3+	2	2	2	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Shelby	Rural	1	1	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Stark	Rural	2	2	2	1	1	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Stephenson	Rural	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Tazewell	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Union	Rural	3+	2	1	2	1	3+	3+	3+	3+	3+	2	3+	3+	2	2	2
Vermilion	Urban	2	2	1	1	2	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Wabash	Rural	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Warren	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Washington	Rural	2	0	0	0	0	3+	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Wayne	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+

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White	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	2	2	2
Whiteside	*Rural*	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Will	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Williamson	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Winnebago	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Woodford	*Rural*	2	2	1	1	2	3+	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Counties with 2 or more Providers		92	91	84	79	82	102	101	102	102	102	98	102	102	96	97	95
Counties with 1 Provider		10	9	15	20	17	-	1	-	-	-	4	-	-	4	3	5
Counties with no provider		-	2	3	3	3	-	-	-	-	-	-	-	-	2	2	2

Notes:

• This report includes the number of unique providers by Tax ID that were reported by the health plan within each county. Note - counties 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. This analysis reflects providers that were listed in the health plan data as Medicaid Contracted for the identified county.

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted providers identified in the health plan provider data for Medicaid.

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Blue Cross Blue Shield of Illinois (BCBSIL)
Provider Network Data submitted on 6/15/21

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Adams	*Rural*	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	2	2	3+	3+	3+
Alexander	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Bond	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Boone	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Brown	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Bureau	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Calhoun	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Carroll	*Rural*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Cass	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Champaign	*Urban*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Christian	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Clark	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Clay	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Clinton	*Rural*	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Coles	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Cook	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Crawford	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Cumberland	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
De Witt	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Dekalb	*Urban*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Douglas	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
DuPage	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edgar	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Edwards	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Effingham	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Fayette	*Rural*	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Ford	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Franklin	*Rural*	2	2	1	1	2	1	2	2	2	3+	1	2	2	2	2	2
Fulton	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Gallatin	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Greene	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Grundy	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Hamilton	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Hancock	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Hardin	*Rural*	2	2	2	2	2	2	2	2	2	3+	2	2	2	2	2	2
Henderson	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Henry	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Iroquois	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Jackson	*Rural*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Jasper	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Jefferson	*Rural*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Jersey	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Jo Daviess	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Johnson	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Kane	*Urban*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Kankakee	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Kendall	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Knox	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
La Salle	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Lake	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lawrence	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Lee	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Livingston	*Rural*	1	1	0	1	1	1	1	1	1	3+	0	1	1	1	1	1
Logan	*Rural*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Macon	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Macoupin	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Madison	*Urban*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Marion	*Rural*	3+	3+	1	2	3+	2	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Marshall	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Mason	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Massac	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
McDonough	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
McHenry	*Urban*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	2	2	3+	3+	3+
McLean	*Urban*	0	0	0	0	0	0	0	0	0	3+	0	0	0	0	0	0
Menard	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Mercer	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Monroe	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Montgomery	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Morgan	*Rural*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	3+	2	3+	3+	3+
Moultrie	*Rural*	2	2	2	2	2	2	2	2	2	3+	2	2	2	2	2	2
Ogle	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Peoria	*Urban*	3+	3+	2	2	3+	2	3+	3+	3+	3+	2	2	2	3+	3+	3+
Perry	*Rural*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Piatt	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Pike	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Pope	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Pulaski	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Putnam	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Randolph	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Richland	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Rock Island	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Saint Clair	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Saline	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Sangamon	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Schuyler	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Scott	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Shelby	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Stark	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Stephenson	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Tazewell	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Union	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Vermilion	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Wabash	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Warren	*Rural*	1	1	1	1	1	1	1	1	1	3+	1	1	1	1	1	1
Washington	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Wayne	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
White	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Whiteside	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Will	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Williamson	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Winnebago	*Urban*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Woodford	*Rural*	2	2	1	2	2	2	2	2	2	3+	1	2	2	2	2	2
Counties with 2 or more Providers		88	88	22	87	88	87	88	88	88	102	22	88	88	88	88	88
Counties with 1 Provider		13	13	78	14	13	14	13	13	13	-	78	13	13	13	13	13
Counties with no provider		1	1	2	1	1	1	1	1	1	-	2	1	1	1	1	1

Notes:

• This report includes the number of unique providers by Tax ID that were reported by the health plan within each county. Note - counties 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. This analysis reflects providers that were listed in the health plan data as Medicaid Contracted for the identified county.

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted providers identified in the health plan provider data for Medicaid.

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
MeridianHealth (Meridian)
Provider Network Data submitted on 6/15/21

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Adams	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	2	3+	1	3+	1	2	3+	2
Alexander	*Rural*	1	0	1	3+	2	3+	2	0	1	3+	0	1	0	1	2	2
Bond	*Rural*	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	0	1	3+	3+
Boone	*Rural*	3+	2	2	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Brown	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	2	3+	1	3+	1	2	3+	3+
Bureau	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Calhoun	*Rural*	3+	1	3+	3+	3+	3+	3+	2	2	3+	0	3+	1	1	3+	2
Carroll	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+	2
Cass	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	3+	3+
Champaign	*Urban*	3+	3+	2	3+	3+	1	2	3+	3+	3+	1	3+	3+	3+	3+	3+
Christian	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Clark	*Rural*	2	1	3+	3+	2	3+	3+	0	2	3+	0	2	0	1	1	1
Clay	*Rural*	2	1	3+	3+	2	3+	3+	2	2	3+	0	2	1	2	2	2
Clinton	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	3+	3+
Coles	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	1	2	3+	3+
Cook	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Crawford	*Rural*	1	1	2	3+	2	3+	2	2	2	3+	0	0	0	2	2	1
Cumberland	*Rural*	3+	1	3+	3+	3+	3+	3+	1	2	3+	0	3+	1	1	1	1
De Witt	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Dekalb	*Urban*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Douglas	*Rural*	3+	2	3+	3+	3+	3+	3+	1	3+	3+	0	3+	0	2	2	2
DuPage	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edgar	*Rural*	3+	2	3+	3+	3+	3+	3+	1	3+	3+	0	3+	2	2	2	2
Edwards	*Rural*	2	1	3+	3+	2	3+	3+	2	3+	3+	0	2	0	1	2	2
Effingham	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	2	2
Fayette	*Rural*	3+	1	2	3+	3+	3+	3+	3+	3+	3+	0	3+	1	1	2	2
Ford	*Rural*	3+	3+	2	3+	3+	3+	3+	2	3+	3+	1	3+	1	3+	3+	3+
Franklin	*Rural*	3+	1	3+	3+	2	3+	3+	2	2	3+	0	3+	1	2	3+	3+
Fulton	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Gallatin	*Rural*	1	0	2	3+	2	3+	2	0	2	3+	0	0	0	1	2	2
Greene	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	1	3+	2
Grundy	*Rural*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Hamilton	*Rural*	1	1	3+	3+	2	3+	3+	0	1	3+	0	3+	0	1	2	2
Hancock	*Rural*	3+	2	3+	3+	3+	3+	3+	0	3+	3+	0	3+	0	2	2	2
Hardin	*Rural*	1	0	0	3+	3+	3+	2	0	1	3+	0	1	0	1	2	2
Henderson	*Rural*	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	2	2
Henry	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+	3+
Iroquois	*Rural*	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	1	3+	2	3+	3+	3+
Jackson	*Rural*	3+	1	3+	3+	2	3+	3+	2	2	3+	0	3+	1	2	3+	3+
Jasper	*Rural*	2	1	3+	3+	2	3+	3+	3+	2	3+	0	1	0	2	2	2
Jefferson	*Rural*	2	1	3+	3+	2	3+	3+	2	2	3+	1	3+	1	2	3+	3+
Jersey	*Rural*	3+	1	3+	3+	3+	3+	3+	3+	2	3+	0	3+	2	1	3+	3+
Jo Daviess	*Rural*	3+	2	2	3+	3+	3+	3+	1	3+	3+	0	3+	1	3+	3+	2
Johnson	*Rural*	3+	1	2	3+	2	3+	3+	2	2	3+	0	3+	1	1	2	2
Kane	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Kankakee	*Urban*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+

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Kendall	Rural	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Knox	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
La Salle	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Lake	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lawrence	Rural	2	1	2	3+	2	3+	2	2	3+	3+	0	1	0	1	1	1
Lee	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Livingston	Rural	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	1	3+	1	3+	3+	3+
Logan	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Macon	Urban	3+	2	2	3+	3+	1	2	3+	3+	3+	1	3+	3+	2	3+	3+
Macoupin	Rural	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	3+	3+
Madison	Urban	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	1	3+	2	1	3+	2
Marion	Rural	2	1	3+	3+	2	3+	3+	3+	3+	3+	0	3+	1	2	3+	3+
Marshall	Rural	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	1	3+	2	3+	3+	3+
Mason	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Massac	Rural	1	0	2	3+	2	3+	3+	0	1	3+	0	0	0	1	2	2
McDonough	Rural	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
McHenry	Urban	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
McLean	Urban	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Menard	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	0	3+	3+	3+
Mercer	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	2	2
Monroe	Rural	3+	3+	3+	3+	3+	3+	3+	2	2	3+	0	3+	1	2	3+	3+
Montgomery	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	0	1	3+	3+
Morgan	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	1	2	3+	3+
Moultrie	Rural	3+	1	3+	3+	3+	3+	3+	2	3+	3+	0	3+	1	2	3+	3+
Ogle	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Peoria	Urban	3+	1	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	3+
Perry	Rural	3+	1	3+	3+	2	3+	3+	1	1	3+	0	3+	1	2	3+	3+
Piatt	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	2	3+	3+	3+
Pike	Rural	3+	1	3+	3+	3+	3+	3+	3+	2	3+	0	3+	1	2	3+	3+
Pope	Rural	1	0	2	3+	2	3+	3+	0	1	3+	0	0	0	1	2	2
Pulaski	Rural	1	0	2	3+	2	3+	3+	0	1	3+	0	1	0	1	2	2
Putnam	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Randolph	Rural	3+	2	3+	3+	3+	3+	3+	1	1	3+	0	3+	0	2	3+	3+
Richland	Rural	2	2	3+	3+	2	3+	3+	2	2	3+	0	2	0	1	2	1
Rock Island	Urban	3+	2	1	3+	2	0	3+	0	1	3+	0	3+	0	2	2	2
Saint Clair	Urban	3+	3+	3+	3+	3+	3+	3+	3+	2	3+	1	3+	1	1	3+	2
Saline	Rural	3+	1	3+	3+	2	3+	3+	2	2	3+	0	3+	1	1	2	2
Sangamon	Urban	2	1	2	3+	2	1	3+	3+	2	3+	1	3+	0	1	2	2
Schuyler	Rural	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	0	3+	0	2	3+	3+
Scott	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	2	3+	3+
Shelby	Rural	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	1	2	2
Stark	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Stephenson	Rural	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	0	3+	3+	3+	3+	3+
Tazewell	Urban	3+	2	1	3+	3+	3+	3+	3+	2	3+	1	3+	3+	3+	3+	3+
Union	Rural	3+	1	2	3+	2	3+	3+	2	1	3+	0	3+	1	1	2	2
Vermilion	Urban	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	0	3+	1	3+	3+	3+
Wabash	Rural	2	2	3+	3+	2	3+	3+	2	3+	3+	1	2	0	1	2	2
Warren	Rural	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Washington	Rural	2	1	3+	3+	2	3+	3+	1	1	3+	0	3+	1	2	3+	3+
Wayne	Rural	3+	1	3+	3+	2	3+	3+	3+	2	3+	0	3+	1	1	2	2

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
White	*Rural*	2	1	3+	3+	2	3+	3+	0	1	3+	0	2	0	1	2	2
Whiteside	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	0	3+	1	3+	3+	3+
Will	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Williamson	*Rural*	2	1	1	3+	2	1	3+	2	1	3+	1	3+	1	1	2	2
Winnebago	*Urban*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	2	3+	3+	3+	3+	2
Woodford	*Rural*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	1	3+	3+	3+	3+	3+
Counties with 2 or more Providers		94	56	94	102	102	97	102	82	88	102	12	93	37	73	99	97
Counties with 1 Provider		8	40	7	-	-	4	-	9	14	-	24	5	41	29	3	5
Counties with no provider		-	6	1	-	-	1	-	11	-	-	66	4	24	-	-	-

Notes:

• This report includes the number of unique providers by Tax ID that were reported by the health plan within each county. Note - counties 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. This analysis reflects providers that were listed in the health plan data as Medicaid Contracted for the identified county.

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted providers identified in the health plan provider data for Medicaid.

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
Molina Healthcare of Illinois (Molina)
Provider Network Data submitted on 6/15/21

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Adams	*Rural*	0	0	1	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Alexander	*Rural*	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Bond	*Rural*	1	1	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Boone	*Rural*	2	2	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Brown	*Rural*	0	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Bureau	*Rural*	0	1	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Calhoun	*Rural*	0	0	0	3+	1	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Carroll	*Rural*	1	1	0	3+	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Cass	*Rural*	0	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Champaign	*Urban*	2	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Christian	*Rural*	1	1	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clark	*Rural*	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clay	*Rural*	0	0	0	3+	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Clinton	*Rural*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Coles	*Rural*	0	0	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Cook	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Crawford	*Rural*	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Cumberland	*Rural*	0	0	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
De Witt	*Rural*	2	3+	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Dekalb	*Urban*	2	2	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Douglas	*Rural*	1	2	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
DuPage	*Urban*	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edgar	*Rural*	1	2	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Edwards	*Rural*	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Effingham	*Rural*	0	0	2	3+	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Fayette	*Rural*	0	0	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Ford	*Rural*	2	3+	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Franklin	*Rural*	0	0	3+	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Fulton	*Rural*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Gallatin	*Rural*	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Greene	*Rural*	1	0	0	3+	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Grundy	*Rural*	0	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Hamilton	*Rural*	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Hancock	*Rural*	0	0	1	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Hardin	*Rural*	0	0	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Henderson	*Rural*	0	0	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Henry	*Rural*	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Iroquois	*Rural*	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jackson	*Rural*	1	1	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jasper	*Rural*	0	0	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jefferson	*Rural*	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jersey	*Rural*	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Jo Daviess	*Rural*	1	1	0	3+	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+
Johnson	*Rural*	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Kane	*Urban*	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Kankakee	*Urban*	0	2	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
Kendall	Rural	2	3+	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Knox	Rural	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
La Salle	Rural	1	1	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lake	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lawrence	Rural	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Lee	Rural	1	1	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Livingston	Rural	1	2	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Logan	Rural	3+	3+	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Macon	Urban	1	1	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Macoupin	Rural	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Madison	Urban	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Marion	Rural	0	0	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Marshall	Rural	3+	2	2	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Mason	Rural	1	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Massac	Rural	0	0	1	3+	1	3+	2	2	3+	3+	3+	3+	3+	3+	3+	3+
McDonough	Rural	1	1	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
McHenry	Urban	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
McLean	Urban	3+	3+	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Menard	Rural	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Mercer	Rural	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Monroe	Rural	2	2	1	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Montgomery	Rural	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Morgan	Rural	1	0	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Moultrie	Rural	1	1	0	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Ogle	Rural	2	2	0	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Peoria	Urban	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Perry	Rural	1	1	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Piatt	Rural	3+	3+	0	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Pike	Rural	0	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Pope	Rural	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Pulaski	Rural	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Putnam	Rural	0	0	1	3+	2	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Randolph	Rural	2	2	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Richland	Rural	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Rock Island	Urban	1	1	2	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Saint Clair	Urban	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Saline	Rural	0	0	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Sangamon	Urban	2	1	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Schuyler	Rural	0	0	1	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Scott	Rural	0	0	0	3+	1	3+	1	3+	3+	3+	3+	2	3+	3+	3+	3+
Shelby	Rural	1	1	1	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Stark	Rural	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Stephenson	Rural	2	2	0	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Tazewell	Urban	3+	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Union	Rural	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Vermilion	Urban	1	0	0	3+	2	3+	3+	0	3+	3+	3+	2	3+	3+	3+	3+
Wabash	Rural	0	0	1	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Warren	Rural	1	2	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Washington	Rural	2	2	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Wayne	Rural	0	0	0	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+

		Number of Counties with one or more Contracted MLTSS Provider by Service Category															
Illinois County	Urbanicity	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
White	*Rural*	0	0	0	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Whiteside	*Rural*	1	1	0	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Will	*Urban*	3+	3+	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Williamson	*Rural*	0	0	2	3+	1	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+
Winnebago	*Urban*	3+	3+	2	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Woodford	*Rural*	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Counties with 2 or more Providers		37	38	28	102	58	102	95	101	102	102	102	102	102	102	102	102
Counties with 1 Provider		22	19	35	-	44	-	7	-	-	-	-	-	-	-	-	-
Counties with no provider		43	45	39	-	-	-	-	1	-	-	-	-	-	-	-	-

Notes:

• This report includes the number of unique providers by Tax ID that were reported by the health plan within each county. Note - counties 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. This analysis reflects providers that were listed in the health plan data as Medicaid Contracted for the identified county.

• "3+" - three (3) or more contracted providers

• "2" - two (2) contracted providers

•"1" - one (1) contracted provider

•"0" - no contracted providers identified in the health plan provider data for Medicaid.

IL2021 Managed Long Term Services and Supports (MLTSS) - HealthChoice IL (HCI)
CountyCare Health Plan (CountyCare)
Provider Network Data submitted on 6/15/21

Illinois County	Urbanicity	Number of Counties with one or more Contracted MLTSS Provider by Service Category															
		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
Cook	*Urban*	3+	2	3+	3+	1	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+	3+
Counties with 2 or more Providers		1	1	1	1	0	1	1	1	1	1	1	1	1	1	1	1
Counties with 1 Provider		-	-	-	-	1	-	-	-	-	-	-	-	-	-	-	-
Counties with no provider		-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Notes:
• This report includes the number of unique providers by Tax ID that were reported by the health plan within each county. Note - counties 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. This analysis reflects providers that were listed in the health plan data as Medicaid Contracted for the identified county.
• "3+" - three (3) or more contracted providers
• "2" - two (2) contracted providers
•"1" - one (1) contracted provider
•"0" - no contracted providers identified in the health plan provider data for Medicaid.

Appendix E4. MMAI Network Monitoring

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 1 - Northwest Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of May 1, 2021	TBD	TBD	TBD	TBD	3,212

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	674	187	341	1,562	1,001
Mid-Level Practitioners (Adult)	190	134	564	39	1,079
Adult Specialty Providers	545	721	682	1,518	1,661
Gynecology, OB/GYN	146	35	52	220	197
Dentists (Adult)	763	305	331	438	296
Behavioral Health Providers (Adult)	108	370	260	510	636
Facilities (# of locations)*					
CMHC/FQHC/RHC	123	34	35	176	194
Skilled Nursing Facilities	46	18	120	132	119
Supportive Living Facilities	11	1	31	26	24
Pharmacies	260	201	256	266	271
Other Facilities	51	224	352	822	363

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	13	15	18	17	28

Summary Notes

*Provider counts were based on a unique count of NPIs for practitioners and count of provider locations for Facilities & Hospitals. All providers included in the summary above were reported by the health plans as "MMAI Contracted". Providers reported as "Pending" for "MMAI Contracted" are represented in the "Regional Summary (Pending)" tab.

PCP Specialties

- Adult – Family Practice, General Practice, Internal Medicine, Nurse Practitioner, Physician Assistant
- PCP provider specilaites were reported by the health plans as "Yes" for the PCP (Y/N) column.

Mid-Level Practitioners

- Adult – Nurse Practitioner, Physician Assistant, Nurse Midwife
- The overall count for the mid-level category above does not include Nurse Practitioners and Physician Assistants reported 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

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 2 - Central Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of May 1, 2021	TBD	TBD	TBD	TBD	5,649

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	267	84	318	1,649	1,173
Mid-Level Practitioners (Adult)	14	83	551	38	1,170
Adult Specialty Providers	169	230	631	1,768	1,957
Gynecology, OB/GYN	90	3	79	225	221
Dentists (Adult)	501	179	181	212	216
Behavioral Health Providers (Adult)	88	376	125	495	603
Facilities (# of locations)*					
CMHC/FQHC/RHC	156	95	16	222	264
Skilled Nursing Facilities	22	22	126	144	128
Supportive Living Facilities	4	2	47	25	32
Pharmacies	276	224	273	290	272
Other Facilities	38	356	299	623	449

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	18	14	16	16	30

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 3 - Southern Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Enrollment as of May 1, 2021	TBD	TBD	TBD	TBD	TBD

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	34	44	189	740	606
Mid-Level Practitioners (Adult)	14	57	136	21	563
Adult Specialty Providers	43	251	369	630	970
Gynecology, OB/GYN	1	5	28	104	108
Dentists (Adult)	286	93	105	98	93
Behavioral Health Providers (Adult)	39	179	26	170	300
Facilities (# of locations)*					
CMHC/FQHC/RHC	143	66	30	260	230
Skilled Nursing Facilities	14	21	84	121	84
Supportive Living Facilities	9	5	46	22	27
Pharmacies	245	203	236	255	239
Other Facilities	43	285	213	401	386

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	20	19	15	12	26

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars	
Enrollment as of May 1, 2021	7,459	1,953	13,931	6,012

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars	
Practitioners (# of unique NPIs)*				
Primary Care Providers (Adult)	6,238	2,479	2,962	1,512
Mid-Level Practitioners (Adult)	1,857	900	3,062	1,643
Adult Specialty Providers	5,427	2,380	8,513	5,061
Gynecology, OB/GYN	902	307	641	361
Dentists (Adult)	2,464	1,456	1,349	840
Behavioral Health Providers (Adult)	1,590	693	2,153	1,124
Facilities (# of locations)*				
CMHC/FQHC/RHC	904	359	286	99
Skilled Nursing Facilities	222	115	195	98
Supportive Living Facilities	34	23	34	20
Pharmacies	847	536	660	413
Other Facilities	581	271	1,384	819

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars	
Hospitals (# of locations)*				
Hospitals	55	18	52	26

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 4-Cook & Region 5-Collar Counties
Health Plan Provider Data Submitted on June 15, 2021

Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
6,512	3,223	10,770	3,042	0	0

Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
1,123	860	5,183	2,489	1,715	519
442	406	188	39	1,680	752
2,533	2,000	5,803	2,432	3,125	998
359	265	839	319	491	145
1,358	826	1,340	907	849	454
1,058	665	1,886	847	1,659	767
301	141	879	295	557	212
417	206	264	134	167	85
76	59	34	26	30	23
861	550	934	591	820	528
1,073	1,086	1,414	813	637	336

Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
51	17	59	21	42	6

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review Provider Network for Region 1 - Northwest Counties - Pending Providers Health Plan Provider Data Submitted on June 15, 2021					
Health Plan	**Aetna**	**BCBSIL**	**Humana**	**Meridian**	**Molina**
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	0	1,585	0	17	0
Mid-Level Practitioners (Adult)	0	373	0	0	0
Adult Specialty Providers	0	1,999	0	50	0
Gynecology, OB/GYN	0	109	0	8	0
Dentists (Adult)	0	3	0	0	0
Behavioral Health Providers (Adult)	0	334	0	0	0

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 2 - Central Counties - Pending Providers
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	0	1,447	0	31	0
Mid-Level Practitioners (Adult)	0	717	0	0	0
Adult Specialty Providers	0	2,519	0	45	0
Gynecology, OB/GYN	0	124	0	5	0
Dentists (Adult)	0	4	0	0	0
Behavioral Health Providers (Adult)	0	405	0	11	0

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review Provider Network for Region 3 - Southern Counties - Pending Providers Health Plan Provider Data Submitted on June 15, 2021					
Health Plan	**Aetna**	**BCBSIL**	**Humana**	**Meridian**	**Molina**
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	0	508	0	28	0
Mid-Level Practitioners (Adult)	0	291	0	0	0
Adult Specialty Providers	0	973	0	148	0
Gynecology, OB/GYN	0	27	0	9	0
Dentists (Adult)	0	0	0	0	0
Behavioral Health Providers (Adult)	0	135	0	5	0

IL2021 Medicare-Medicaid Alignment Initiative (MMAI) Bi-Annual Summary Review
Provider Network for Region 4-Cook & Region 5-Collar Counties - Pending Providers
Health Plan Provider Data Submitted on June 15, 2021

Health Plan	Aetna Cook & Collars		BCBSIL Cook & Collars		Humana Cook & Collars		Meridian Cook & Collars		Molina Cook & Collars	
Practitioners (# of unique NPIs)*										
Primary Care Providers (Adult)	0	0	3,112	1,866	0	0	1	1	0	0
Mid-Level Practitioners (Adult)	0	0	981	611	0	0	0	0	0	0
Adult Specialty Providers	0	0	4,506	2,908	0	0	24	7	0	0
Gynecology, OB/GYN	0	0	445	211	0	0	2	1	0	0
Dentists (Adult)	0	0	19	1	0	0	0	0	0	0
Behavioral Health Providers (Adult)	0	0	1,433	1,268	0	0	2	2	0	0

Region 1 Contiguous Counties
Iowa and Wisconsin Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	75	4	21	96	161
Mid-Level Practitioners (Adult)	50	1	29	3	127
Adult Specialty Providers	101	6	75	123	333
Gynecology, OB/GYN	13	0	7	14	29
Dentists (Adult)	67	36	37	17	14
Behavioral Health Providers (Adult)	17	1	11	13	53
Facilities (# of locations)*					
CMHC/FQHC/RHC	5	6	0	10	6
Skilled Nursing Facilities	0	0	0	0	0
Supportive Living Facilities	1	0	0	0	0
Pharmacies	122	25	0	460	85
Other Facilities	16	2	190	53	49

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	5	0	1	0	9

*Contiguous counties included: Lee-IA, Des Moines--IA, Louisa-IA, Muscatine-IA, Scott-IA, Clinton-IA, Jackson-IA, Dubuque-IA, Grant-WI, Lafayette-WI, Green-WI, Rock-WI, Walworth-WI.

Region 3 Contiguous Counties
Missouri, Kentucky, Indiana Counties
Contracted Provider Network

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Practitioners (# of unique NPIs)*					
Primary Care Providers (Adult)	11	2	6	182	28
Mid-Level Practitioners (Adult)	14	10	40	4	107
Adult Specialty Providers	54	50	81	500	258
Gynecology, OB/GYN	0	0	8	58	30
Dentists (Adult)	50	6	7	28	31
Behavioral Health Providers (Adult)	2	0	4	27	8
Facilities (# of locations)*					
CMHC/FQHC/RHC	0	2	0	8	3
Skilled Nursing Facilities	0	0	8	0	0
Supportive Living Facilities	0	0	0	1	0
Pharmacies	165	13	0	538	137
Other Facilities	1	2	132	105	28

Health Plan	Aetna	BCBSIL	Humana	Meridian	Molina
Hospitals (# of locations)*					
Hospitals	2	0	1	2	6

*Contiguous counties included: St. Charles-MO, St. Louis City-MO, St. Louis-MO, Jefferson-MO, Ste. Genevieve-MO, Perry-MO, Cape Girardeau-MO, Scott-MO, Union-KY, Crittenden-KY, Livingston-KY, McCracken-KY, Ballard-KY, Sullivan-IN, Knox-IN, Gibson-IN, Posey-IN.

Appendix E5. Provider Directory Validation Study

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

SFY 2020 Provider Directory Validation Report

January 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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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 that its external quality review organization (EQRO), Health Services Advisory Group, Inc. (HSAG), conduct a provider directory validation (PDV) of the health plans' online provider directories to ensure enrollees have appropriate access to provider information.

The goal of the State Fiscal Year (SFY) 2020 Provider Directory Validation was to determine if the information in the health plans' online provider directories found on the respective health plans' websites matched the data in the health plans' provider files submitted to HSAG as part of the regular reporting process. As part of the PDV, HSAG compared the key elements (i.e., study indicators) published in the online provider directory with the data in the provider file, and HSAG confirmed each health plan's website met the requirements found at Title 42 of the Code of Federal Regulations (CFR) §438.10(h)[1-1] and the Medicaid Model Contract—2018-24-001 requirements[1-2] (e.g., the website clearly states how the enrollee can obtain a paper copy of the directory).

The health plans assessed in this analysis included:

- Blue Cross Blue Shield of Illinois (BCBSIL)
- CountyCare [1-3]
- IlliniCare Health Plan (IlliniCare)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)
- YouthCare

[1-1] Government Publishing Office. Electronic Code of Federal Regulations. Available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=36300623aa362eae90c0a7d206c0140d&mc=true&node=pt42.4.438&rgn=div5#se42.4.438_110. Accessed on: Nov. 24, 2020.

[1-2] State of Illinois Contract between the Department of Healthcare and Family Services and [MODEL CONTRACT] for Furnishing Health Services by a Managed Care Organization. 2018-24-001. Available at: https://www.illinois.gov/hfs/SiteCollectionDocuments/2018MODELCONTRACTadministrationcopy.pdf. Accessed on: Nov 19, 2020.

[1-3] Available only in Cook County.

The PDV addressed four main objectives:

- **Health plan directory validation:** For each health plan, HSAG reviewed the health plan's online directory to assess the presence of specific federal and Medicaid health plan contract requirements in the online provider directories.
- **Identification of the providers in the online directory:** Information on whether the sampled provider and the sampled provider location were found in the online directory. The information did not have to be an exact match (e.g., small variations in address, provider name misspellings). If the sampled provider could not be located at the sampled survey location in the online directory, the PDV review could not continue. For example, a provider could be sampled for a location at "123 E Main Street." If the reviewer could locate the provider in the online directory but could not locate the specific location, then the validation could not continue.
- **Provider data accuracy:** For each health plan, HSAG assessed the degree to which the provider demographic information submitted by the health plans exactly matched the information found in the online provider directories.
- **Provider data availability:** For each health plan, HSAG assessed the degree to which the provider services information was available in the online provider directories.

Overall PDV Findings

Health plan directory validation: HSAG reviewed the provider directory websites for all six health plans to ensure compliance with federal requirements and Medicaid health plan contract requirements. Upon review of the health plan websites, HSAG found that several offered additional search criteria in addition to those reviewed specifically in this validation. The additional search options included telehealth services, after-hours appointment availability, patient ratings, and hospital affiliation. Also, all six websites conspicuously displayed a toll-free number and email address to which any individual may report an inaccuracy in the provider directory. The provider directory was available to enrollees and providers on all health plan websites via the Web portal. The reviewers located an option to request a paper form of provider directory on all websites except BCBSIL's website. Additionally, all health plans except CountyCare posted on their website the date the paper directory and website were last updated. The BCBSIL, Molina, and YouthCare websites were most recently updated during the current calendar year, 2020. Meridian's website indicated an update in 2019, and CountyCare indicating the most recent validation of the provider and hospital information occurred in 2019. More health plan-specific details about the health plan PDV are presented in Appendix A.

Identification of the providers in the online directory: HSAG conducted 2,326 PDV reviews among the six participating health plans. Table 1 illustrates the frequency of providers found, providers not found, and providers' sampled locations not found in their respective health plan's online directory. Among the sampled providers, Meridian's providers were located in the directory most frequently, in 97.5 percent of reviews. YouthCare had the lowest rate of providers located during the reviews at 45.3 percent.

Table 1—Summary of Providers Present in Directory by Health Plan

Health Plan	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
BCBSIL	387	331	85.5	38	9.8	18	4.7
CountyCare	381	302	79.3	45	11.8	34	8.9
IlliniCare	374	341	91.2	26	7.0	7	1.9
Meridian	393	383	97.5	8	2.0	2	0.5
Molina	389	283	72.8	53	13.6	53	13.6
YouthCare	402	182	45.3	129	32.1	91	22.6
All Health Plans	**2,326**	**1,822**	**78.3**	**299**	**12.9**	**205**	**8.8**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Table 2 displays a summary of the identification of providers in the online directories for all health plans, by dental providers, obstetricians/gynecologists (OB/GYNs), and primary care providers (PCPs). The OB/GYN providers had the lowest rate of providers located in the directory (75.5 percent), and the PCPs had the highest rate of providers located in the directory (80.2 percent). The individual health plan data are shown by provider category in Appendix A.

Table 2—Overall Summary of Providers Present in Directory by Provider Category

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
All Health Plans							
Dental	775	615	79.4	86	11.1	74	9.5
OB/GYN	775	585	75.5	109	14.1	81	10.5
PCPs	776	622	80.2	104	13.4	50	6.4

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Table 3 details the percentage of exact matches between the demographic information given by the providers to HSAG and information listed in the online provider directory. Reviewers validated each provider in the sample and assessed whether each of these indicators was present and matched the information in the submitted provider data. Overall, the demographic indicators had high match rates among all health plans. The lowest match rates were IlliniCare Provider Telephone Number and Molina Provider Specialty, at 63.9 percent and 71.7 percent, respectively. While Molina's Provider Specialty

exact match rate was 71.7 percent, another 25.4 percent of Molina's sampled providers had a provider specialty in the same provider category as reported in the online directory. For example, if "Midwifery" was listed in the provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in the provider data and "Neonatology" was listed in the directory, then HSAG would consider the provider specialties to be in the same provider category, but not an exact match between the submitted data and the online directory.

Table 3—Percentages of Provider Demographic Indicators Matching Online Provider Directory by Health Plan

	Percentage of Exact Matches						
Indicator	**BCBSIL**	**CountyCare**	**IlliniCare**	**Meridian**	**Molina**	**YouthCare**	**All Health Plans**
Provider First Name	100.0	99.3	100.0	99.0	99.6	100.0	**99.6**
Provider Last Name	99.7	100.0	100.0	99.7	99.6	100.0	**99.8**
Provider Address 1	98.5	97.0	98.5	99.0	96.8	97.3	**98.0**
Provider Address 2	98.2	93.7	97.7	99.2	95.8	97.8	**97.1**
Provider City	99.7	99.7	99.4	99.7	99.6	100.0	**99.7**
Provider State	100.0	100.0	100.0	100.0	100.0	100.0	**100.0**
Provider Zip Code	99.4	99.7	99.1	100.0	99.6	99.5	**99.6**
Provider Telephone Number	97.6	92.1	63.9	99.2	95.4	89.6	**89.6**
Provider Specialty	94.0	87.7	95.0	99.0	71.7*	90.1	**90.3**
Provider Accepting New Patients	88.8	95.0	97.1	96.9	96.1	97.3	**95.1**

* While Molina's Provider Specialty exact match rate was 71.7 percent, another 25.4 percent of sampled providers were in the same provider category.

Additionally, reviewers determined which information and service elements were present in the online provider directories for the providers found in the directory. Table 4 lists the seven elements that were reviewed and displays the percentages present for the providers initially found in the directory for each health plan and overall. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was listed as pending. Detailed results for each health plan are shown in Appendix A.

There was a great degree of variability with regard to presence of service indicators. Provider Gender, Provider Office Hours, and Provider Primary Language were the most consistently reported indicators. Conversely, Provider Completed Cultural Competency Training and Provider Uniform Resource Locator (URL) were most consistently not present among the service indicators. CountyCare and Molina did not list Provider Completed Cultural Competency Training for any of the sampled providers. Overall, Provider Completed Cultural Competency Training was present in 38.9 percent of all health

plan reviews. Provider URL was present at an overall rate of 0.4 percent among all health plan online provider directories.

Table 4—Percentages of Provider Service Indicators Present in Online Provider Directory by Health Plan

	Percentage Present						
Indicator	**BCBSIL**	**CountyCare**	**IlliniCare**	**Meridian**	**Molina**	**YouthCare**	**All Health Plans**
Non-English Language Speaking Provider	94.3	34.4	53.1	95.3	77.0	91.8	**73.9**
Provider Accommodates Physical Disabilities	52.0	35.1	48.1	67.9	96.8	20.3	**55.6**
Provider Completed Cultural Competency Training	73.4	0.0	22.6	96.9	0.0	9.9	**38.9**
Provider Gender	99.7	99.7	97.1	98.7	100.0	99.5	**99.0**
Provider Office Hours	85.8	98.7	100.0	99.2	100.0	100.0	**97.0**
Provider Primary Language	97.0	98.3	79.8	96.6	100.0	61.5	**90.8**
Provider URL	0.9	1.0	0.3	0.0	0.0	0.0	**0.4**

Recommendations

HSAG offers the following recommendations based on the findings of the PDV:

- In general, the PDV results show a high degree of agreement between the provider data submitted by the health plans and the plan-specific online provider directories. However, the rate of providers found in the provider directory ranged from 45.3 percent to 97.5 percent. Health plans should follow the contract requirements and internal processes to verify the accuracy of the online provider directory.
- Among the demographic indicators validated, Provider Telephone Number for IlliniCare and Provider Specialty for Molina had the lowest match rates of 63.9 and 71.7 percent, respectively. This means that for 36.1 percent of IlliniCare sampled providers and 28.3 percent of Molina sampled providers, the data submitted by the health plans for these indicators did not match the data found in the online provider directory. IlliniCare and Molina should conduct root cause analyses to determine the reason for the high number of discrepancies in these indicators and collaborate with the provider offices to ensure the correct information received from the providers and updated within the provider directory and provider data file layout submissions.
- As mentioned in the Study Limitations section in Appendix B, this PDV focused on whether the information in the submitted provider data and the online provider directory aligned. This PDV analysis cannot confirm whether the information is accurate and up to date for the providers. As a follow-up to this study, HSAG recommends conducting telephone surveys to validate the

information in the provider demographic data and online directories. These telephone surveys can be performed concurrently with appointment availability surveys.

- Regarding the presence of service indicators, there was a large degree of variability between health plans and between indicators. Provider Completed Cultural Competency Training and Provider URL were most consistently not present among the service indicators. Aside from Meridian and BCBSIL, which listed Cultural Competency Training in 96.9 and 73.4 percent of the reviews, respectively, all other health plans listed Cultural Competency Training in less than 25.0 percent of cases. Furthermore, among all health plans 1.0 percent was the highest percentage present for Provider URL listed in the online provider directories. HSAG recommends that the health plans conduct outreach to their providers to ensure they collect updated information on all service indicators. For all health plans, provider website addresses should be collected as available to ensure members have access to the provider websites in addition to the health plan provider directory. Provider office websites frequently have information not available in the health plan online directory, such as frequently asked questions, provider ratings, and/or new patient forms, which may be helpful to members.
- HSAG recommends that health plans correct deficiencies identified as a result of the PDV study.

Appendix A. Provider Directory Validation Findings

Provider Directory Validation

HSAG reviewed the provider directory websites for each health plan to ensure compliance with federal requirements and health plan contract requirements. This section presents the detailed PDV findings for each health plan.

Blue Cross Blue Shield of Illinois (BCBSIL)

MCO directory validation: HSAG reviewed the BCBSIL provider directory website and found the following information:

- HSAG reviewers could not locate an option to request a paper form of provider directory.
- The website conspicuously displayed an email address and toll-free number for users to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 5, 2020, and information on the website noted that the most recent update to the website was made on October 5, 2020.
- Provider search options included:
  - Provider First/Middle/Last Name, Street Address, City, State, Zip Code, County, Specialty, Acceptance of New Patients, Languages Spoken, Gender, Board Certification, Patient Ratings, Affiliated Hospitals, Affiliated Practices, Average Wait Times, Awards, Expertise, Hospital Safety Grades, and Qualities

Identification of the providers in the online directories: HSAG reviewers conducted 387 PDVs by comparing a sample of provider data submitted by BCBSIL against the online provider directory. As shown in Table A-1, the sample was composed of 129 dental providers, 129 OB/GYNs, and 129 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 85.5 percent (331 providers) of the reviews. The provider was not found in the online provider directory in 9.8 percent of the reviews, and for an additional 4.7 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-1—Summary of Providers Present in Directory by Provider Category—BCBSIL

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
BCBSIL							
Dental	129	119	92.2	5	3.9	5	3.9
OB/GYN	129	106	82.2	16	12.4	7	5.4
PCP	129	106	82.2	17	13.2	6	4.7
Total	**387**	**331**	**85.5**	**38**	**9.8**	**18**	**4.7**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 331 providers initially found in the online provider directory. Table A-2 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-2, information for nine of the 10 indicators had a match rate greater than 90 percent.

Table A-2—Percentages of Provider Demographic Indicators Matching Online Provider Directory—BCBSIL

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	331	331	100.0	0	0.0
Provider Last Name	331	330	99.7	1	0.3
Provider Address 1	331	326	98.5	5	1.5
Provider Address 2	331	325	98.2	6	1.8
Provider City	331	330	99.7	1	0.3
Provider State	331	331	100.0	0	0.0
Provider Zip Code	331	329	99.4	2	0.6
Provider Telephone Number	331	323	97.6	8	2.4
Provider Specialty	331	311	94.0	20	6.0
Provider Accepting New Patients	331	294	88.8	37	11.2

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 331 providers initially found in the directory. Table A-3 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-3, information for three of the seven indicators could be found in the online provider directory more than 90.0 percent of the time. For the Provider URL element, reviewers only found a provider URL for 0.9 percent of providers.

Table A-3—Percentages of Provider Service Indicators Present in Online Provider Directory—BCBSIL

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Non-English Language Speaking Provider	331	312	94.3	19	5.7	0	0.0
Provider Accommodates Physical Disabilities	331	172	52.0	159	48.0	0	0.0
Provider Completed Cultural Competency Training	331	243	73.4	88	26.6	0	0.0
Provider Gender	331	330	99.7	1	0.3	0	0.0
Provider Office Hours	331	284	85.8	47	14.2	0	0.0
Provider Primary Language	331	321	97.0	10	3.0	0	0.0
Provider URL	331	3	0.9	328	99.1	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

CountyCare

MCO directory validation: HSAG reviewed the CountyCare provider directory website and found the following information:

- HSAG reviewers located an option to request a paper form of provider directory.
- The website conspicuously displayed an email address and toll-free number that users can use to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 15, 2020 and did not locate information on the website noting the most recent update to the directory.
- Provider search options included:
  - Provider First/Middle/Last Name, Street Address, City, State, Zip Code, County, Specialty, Acceptance of New Patients, Languages Spoken, Gender, Board Certification, Organization

Name, Mile Radius, Hospital Affiliation, Accreditation Title, Ages Seen, and Medical Group Affiliation

Identification of the providers in the online directories: HSAG reviewers conducted 381 provider data reviews by comparing a sample of provider data submitted by CountyCare against the online provider directory. As shown in Table A-4, the sample was composed of 127 dental providers, 127 OB/GYNs, and 127 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 79.3 percent (302 providers) of the reviews. The provider was not found in the online provider directory in 11.8 percent of the reviews, and for an additional 8.9 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-4—Summary of Providers Present in Directory by Provider Category—CountyCare

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
CountyCare							
Dental	127	112	88.2	10	7.9	5	3.9
OB/GYN	127	83	65.4	22	17.3	22	17.3
PCP	127	107	84.3	13	10.2	7	5.5
Total	**381**	**302**	**79.3**	**45**	**11.8**	**34**	**8.9**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 302 providers initially found in the online provider directory. Table A-5 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-5, information for nine of the 10 indicators had a match rate greater than 90 percent.

Table A-5—Percentages of Provider Demographic Indicators Matching Online Provider Directory—CountyCare

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	302	300	99.3	2	0.7
Provider Last Name	302	302	100.0	0	0.0
Provider Address 1	302	293	97.0	9	3.0
Provider Address 2	302	283	93.7	19	6.3

		Exact Match		Unmatched*	
Indicator	**Total**	**N**	**Percentage**	**N**	**Percentage**
Provider City	302	301	99.7	1	0.3
Provider State	302	302	100.0	0	0.0
Provider Zip Code	302	301	99.7	1	0.3
Provider Telephone Number	302	278	92.1	24	7.9
Provider Specialty	302	265	87.7	37	12.3
Provider Accepting New Patients	302	287	95.0	15	5.0

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 302 providers initially found in the directory. Table A-6 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-6, information for three of the seven elements could be found in the online provider directory more than 90.0 percent of the time. For the Provider URL indicator, reviewers only found a provider URL for 1.0 percent of providers; the Provider Completed Cultural Competency Training indicator was not found in any of the reviews.

Table A-6—Percentages of Provider Service Indicators Present in Online Provider Directory—CountyCare

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	**Total**	**N**	**Percentage**	**N**	**Percentage**	**N**	**Percentage**
Non-English Language Speaking Provider	302	104	34.4	198	65.6	0	0.0
Provider Accommodates Physical Disabilities	302	106	35.1	196	64.9	0	0.0
Provider Completed Cultural Competency Training	302	0	0.0	302	100.0	0	0.0
Provider Gender	302	301	99.7	1	0.3	0	0.0
Provider Office Hours	302	298	98.7	4	1.3	0	0.0
Provider Primary Language	302	297	98.3	5	1.7	0	0.0
Provider URL	302	3	1.0	299	99.0	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

IlliniCare Health Plan (IlliniCare)

MCO directory validation: HSAG reviewed the IlliniCare provider directory website and found the following information:

- HSAG reviewers located an option to request a paper form of the provider directory.
- The website conspicuously displayed an email address and toll-free number that users can use to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 15, 2020, and information on the website noted that the most recent update to the website and paper directory was made on July 1, 2020.
- Provider search options included:
  - Provider First/Middle/Last Name, Street Address, City, State, Zip Code, County, Specialty, Acceptance of New Patients, After Hours Appointments, Languages Spoken, Gender, Parking Access, Exterior Building Access, Interior Building Access, Programmatic Access, Patient Centered Medical Home, Extended Day Supply, Vaccines Offered, Home & Community Based Services (HCBS), National Provider Identifier, Pharmacy Types, Group Affiliation, Hospital Affiliation, and Integrated Health Home

Identification of the providers in the online directories: HSAG reviewers conducted 374 provider data reviews by comparing a sample of provider data submitted by IlliniCare against the online provider directory. As shown in Table A-7, the sample was composed of 125 dental providers, 124 OB/GYNs, and 125 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 91.2 percent (341 providers) of the reviews. The provider was not found in the online provider directory in 7.0 percent of the reviews, and for an additional 1.9 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-7—Summary of Providers Present in Directory by Provider Category—IlliniCare

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
IlliniCare							
Dental	125	114	91.2	6	4.8	5	4.0
OB/GYN	124	110	88.7	13	10.5	1	0.8
PCP	125	117	93.6	7	5.6	1	0.8
Total	**374**	**341**	**91.2**	**26**	**7.0**	**7**	**1.9**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 341 providers initially found in the online provider directory. Table A-8 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-8, information for nine of the 10 indicators had a match rate greater than 90 percent.

Table A-8—Percentages of Provider Demographic Indicators Matching Online Provider Directory—IlliniCare

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	341	341	100.0	0	0.0
Provider Last Name	341	341	100.0	0	0.0
Provider Address 1	341	336	98.5	5	1.5
Provider Address 2	341	333	97.7	8	2.3
Provider City	341	339	99.4	2	0.6
Provider State	341	341	100.0	0	0.0
Provider Zip Code	341	338	99.1	3	0.9
Provider Telephone Number	341	218	63.9	123	36.1
Provider Specialty	341	324	95.0	17	5.0
Provider Accepting New Patients	341	331	97.1	10	2.9

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 341 providers initially found in the directory. Table A-9 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-9, information for two of the seven elements could be found in the online provider directory more than 90.0 percent of the time. For the Provider URL element, reviewers only found a provider URL for 0.3 percent of providers.

Table A-9—Percentages of Provider Service Indicators Present in Online Provider Directory—IlliniCare

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Non-English Language Speaking Provider	341	181	53.1	160	46.9	0	0.0

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Provider Accommodates Physical Disabilities	341	164	48.1	1	0.3	176	51.6
Provider Completed Cultural Competency Training	341	77	22.6	262	76.8	2	0.6
Provider Gender	341	331	97.1	10	2.9	0	0.0
Provider Office Hours	341	341	100.0	0	0.0	0	0.0
Provider Primary Language	341	272	79.8	69	20.2	0	0.0
Provider URL	341	1	0.3	340	99.7	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

Meridian Health (Meridian)

MCO directory validation: HSAG reviewed the Meridian provider directory website and found the following information:

- HSAG reviewers located an option to request a paper form of provider directory.
- The website conspicuously displayed an email address and toll-free number that users can use to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 15, 2020, and information on the website noted that the most recent update to the website was made on September 3, 2019.
- Provider search options included:
  - Provider First/Middle/Last Name, Zip Code, County, Specialty, Acceptance of New Patients, Languages Spoken, Gender, Results Within (Number of Miles), and PCP

Identification of the providers in the online directories: HSAG reviewers conducted 393 provider data reviews by comparing a sample of provider data submitted by Meridian against the online provider directory. As shown in Table A-10, the sample was composed of 131 dental providers, 131 OB/GYNs, and 131 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 97.5 percent (383 providers) of the reviews. The provider was not found in the online provider directory in 2.0 percent of the reviews, and for an additional 0.5 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-10—Summary of Providers Present in Directory by Provider Category—Meridian

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
Meridian							
Dental	131	125	95.4	5	3.8	1	0.8
OB/GYN	131	128	97.7	2	1.5	1	0.8
PCP	131	130	99.2	1	0.8	0	0.0
Total	**393**	**383**	**97.5**	**8**	**2.0**	**2**	**0.5**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 383 providers initially found in the online provider directory. Table A-11 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-11, information for all 10 indicators had a match rate greater than 90 percent.

Table A-11—Percentages of Provider Demographic Indicators Matching Online Provider Directory—Meridian

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	383	379	99.0	4	1.0
Provider Last Name	383	382	99.7	1	0.3
Provider Address 1	383	379	99.0	4	1.0
Provider Address 2	383	380	99.2	3	0.8
Provider City	383	382	99.7	1	0.3
Provider State	383	383	100.0	0	0.0
Provider Zip Code	383	383	100.0	0	0.0
Provider Telephone Number	383	380	99.2	3	0.8
Provider Specialty	383	379	99.0	4	1.0
Provider Accepting New Patients	383	371	96.9	12	3.1

*Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 383 providers initially found in the directory. Table A-12 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-12, information for five of the seven elements could be found in the online provider directory more than 90.0 percent of the time. HSAG reviewers did not locate the Provider URL element in any of the reviews.

Table A-12—Percentages of Provider Service Indicators Present in Online Provider Directory—Meridian

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Non-English Language Speaking Provider	383	365	95.3	18	4.7	0	0.0
Provider Accommodates Physical Disabilities	383	260	67.9	123	32.1	0	0.0
Provider Completed Cultural Competency Training	383	371	96.9	12	3.1	0	0.0
Provider Gender	383	378	98.7	5	1.3	0	0.0
Provider Office Hours	383	380	99.2	3	0.8	0	0.0
Provider Primary Language	383	370	96.6	13	3.4	0	0.0
Provider URL	383	0	0.0	383	100.0	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

Molina Healthcare of Illinois (Molina)

MCO directory validation: HSAG reviewed the Molina provider directory website and found the following information:

- HSAG reviewers located an option to request a paper form of provider directory.
- The website conspicuously displayed an email address and toll-free number that users can use to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 15, 2020, and information on the website noted that the most recent update to the website and paper directory was made on October 13, 2020.
- Provider search options included:
  - Provider Last Name, City, State, Zip Code, Specialty, Acceptance of New Patients, Languages Spoken, Gender, Program/Plan Name, Hospital/Facility, Medical Group, and Telehealth Services

Identification of the providers in the online directories: HSAG reviewers conducted 389 provider data reviews by comparing a sample of provider data submitted by Molina against the online provider directory. As shown in Table A-13, the sample was composed of 129 dental providers, 130 OB/GYNs, and 130 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 72.8 percent (283 providers) of the reviews. The provider was not found in the online provider directory in 13.6 percent of the reviews, and for an additional 13.6 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-13—Summary of Providers Present in Directory by Provider Category—Molina

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
Molina							
Dental	129	92	71.3	22	17.1	15	11.6
OB/GYN	130	93	71.5	17	13.1	20	15.4
PCP	130	98	75.4	14	10.8	18	13.8
Total	**389**	**283**	**72.8**	**53**	**13.6**	**53**	**13.6**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 283 providers initially found in the online provider directory. Table A-14 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-14, information for nine of the 10 indicators had a match rate greater than 90 percent. While Molina's Provider Specialty exact match rate was 71.7 percent, another 25.4 percent of Molina's sampled providers had a provider specialty in the same provider category as reported in the online directory. For example, if "Midwifery" was listed in the provider data and "Nurse Midwife" was listed in the directory, or "Neonatal-Perinatal Medicine" was listed in the provider data and "Neonatology" was listed in the directory, then HSAG would consider the provider specialties to be in the same provider category, but not an exact match, between the submitted data and the online directory.

Table A-14—Percentages of Provider Demographic Indicators Matching Online Provider Directory—Molina

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	283	282	99.6	1	0.4
Provider Last Name	283	282	99.6	1	0.4

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider Address 1	283	274	96.8	9	3.2
Provider Address 2	283	271	95.8	12	4.2
Provider City	283	282	99.6	1	0.4
Provider State	283	283	100.0	0	0.0
Provider Zip Code	283	282	99.6	1	0.4
Provider Telephone Number	283	270	95.4	13	4.6
Provider Specialty	283	203	71.7**	80	28.3
Provider Accepting New Patients	283	272	96.1	11	3.9

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

** While Molina's Provider Specialty exact match rate was 71.7 percent, another 25.4 percent of sampled providers were in the same provider category.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 283 providers initially found in the directory. Table A-15 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-15, information for four of the seven elements could be found in the online provider directory more than 90.0 percent of the time. HSAG reviewers did not find two elements, Provider URL and Provider Completed Cultural Competency Training, in any of the reviews.

Table A-15—Percentages of Provider Service Indicators Present in Online Provider Directory—Molina

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Non-English Language Speaking Provider	283	218	77.0	65	23.0	0	0.0
Provider Accommodates Physical Disabilities	283	274	96.8	9	3.2	0	0.0
Provider Completed Cultural Competency Training	283	0	0.0	283	100.0	0	0.0
Provider Gender	283	283	100.0	0	0.0	0	0.0
Provider Office Hours	283	283	100.0	0	0.0	0	0.0
Provider Primary Language	283	283	100.0	0	0.0	0	0.0

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Provider URL	283	0	0.0	283	100.0	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

YouthCare

MCO directory validation: HSAG reviewed the YouthCare provider directory website and found the following information:

- HSAG found that the online provider directory search tool worked when using Google Chrome but not when using Internet Explorer.
- HSAG reviewers located an option to request a paper form of provider directory.
- The website conspicuously displayed an email address and toll-free number that users can use to report errors in the information presented in the provider directory.
- HSAG reviewed the website on October 15, 2020 and information on the website noted that the most recent update to the website and paper directory was made on October 14, 2020.
- Provider search options included:
  - Provider First/Middle/Last Name, City, State, Zip Code, Specialty, Acceptance of New Patients, After Hours Appointments, Languages Spoken, Gender, Patient Centered Medical Home, Extended Day Supply, Vaccines Offered, Disability Access, National Provider Identifier, Pharmacy Types, Group Affiliation, and Integrated Health Home

Identification of the providers in the online directories: HSAG reviewers conducted 402 provider data reviews by comparing a sample of provider data submitted by YouthCare against the online provider directory. As shown in Table A-16, the sample was composed of 134 dental providers, 134 OB/GYNs, and 134 PCPs. Among this sample, the provider name and location found in the submitted provider data were found in the online provider directory for 45.3 percent (182 providers) of the reviews. The provider was not found in the online provider directory in 32.1 percent of the reviews, and for an additional 22.6 percent of the reviews, the provider could be found by name in the online directory, but the reviewers could not find the sampled location for the provider.

Table A-16—Summary of Providers Present in Directory by Provider Category—YouthCare

Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		N	%	N	%	N	%
YouthCare							
Dental	134	53	39.6	38	28.4	43	32.1
OB/GYN	134	65	48.5	39	29.1	30	22.4
PCP	134	64	47.8	52	38.8	18	13.4
Total	**402**	**182**	**45.3**	**129**	**32.1**	**91**	**22.6**

Note: Due to rounding, the sum of the percentages across each row may not equal 100 percent.

Provider data accuracy: Reviewers then compared 10 demographic elements from the submitted provider data against the information that could be retrieved from the online provider directory for the 182 providers initially found in the online provider directory. Table A-17 lists the 10 indicators that were reviewed. HSAG reviewers were looking for an exact match between the submitted data and the data found in the online provider directory. As seen in Table A-17, information for nine of the 10 indicators had a match rate greater than 90.0.

Table A-17—Percentages of Provider Demographic Indicators Matching Online Provider Directory—YouthCare

		Exact Match		Unmatched*	
Indicator	Total	N	Percentage	N	Percentage
Provider First Name	182	182	100.0	0	0.0
Provider Last Name	182	182	100.0	0	0.0
Provider Address 1	182	177	97.3	5	2.7
Provider Address 2	182	178	97.8	4	2.2
Provider City	182	182	100.0	0	0.0
Provider State	182	182	100.0	0	0.0
Provider Zip Code	182	181	99.5	1	0.5
Provider Telephone Number	182	163	89.6	19	10.4
Provider Specialty	182	164	90.1	18	9.9
Provider Accepting New Patients	182	177	97.3	5	2.7

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Provider data availability: In addition, reviewers determined which information and service elements were present in the online provider directories for the 182 providers initially found in the directory. Table A-18 lists the seven indicators that were reviewed. HSAG reviewers determined whether the information was present in the directory, not present in the directory, or if the information was pending. As seen in Table A-18, information for three of the seven elements could be found in the online provider directory more than 90.0 percent of the time. The Provider URL element was not found to be present in any of the reviews. Additionally, the Provider Accommodates Physical Disabilities was listed as "Information Pending" in 79.7 percent of the reviews.

Table A-18—Percentages of Provider Service Indicators Present in Online Provider Directory—YouthCare

		Present in Directory		Not Present in Directory		Information Pending*	
Indicator	Total	N	Percentage	N	Percentage	N	Percentage
Non-English Language Speaking Provider	182	167	91.8	15	8.2	0	0.0
Provider Accommodates Physical Disabilities	182	37	20.3	0	0.0	145	79.7
Provider Completed Cultural Competency Training	182	18	9.9	162	89.0	2	1.1
Provider Gender	182	181	99.5	1	0.5	0	0.0
Provider Office Hours	182	182	100.0	0	0.0	0	0.0
Provider Primary Language	182	112	61.5	70	38.5	0	0.0
Provider URL	182	0	0.0	182	100.0	0	0.0

* Information Pending refers to instances in the provider directory that are displayed as "Information Pending."

Methodology

HSAG conducted the PDV for a sample of PCPs, OB/GYNs, and dental providers. Table B-1 lists the provider categories included in each survey.

Table B-1—Provider Categories Included in the Provider Directory Validation

Provider Category	Provider Specialties
PCP Providers	• Family Practice • General Practice • Internal Medicine • Physician's Assistant • Nurse Practitioner • Pediatric Medicine • Pediatric Nurse Practitioner • Pediatric Physician Assistant
OB/GYN Providers	• Obstetrics • Gynecology • Nurse Midwife
Dental Providers	• Pediatric Dentist • Dentist • Oral Surgeon

Data Collection

HSAG used the provider file layout data extracts submitted to HSAG/HFS by the health plans in July/August 2020. The provider files included the following data fields:

- Demographics (e.g., Medicaid ID, Tax ID, name, address, phone number)
- Provider specialty type (e.g., cardiology)
- County location
- Contract status
- Appropriate inclusion in the provider directory
- Open and closed panels
- Providers located in counties contiguous to the service region, if applicable

Sampling Approach

The following two-stage random sampling approach was used to generate a list of provider locations (i.e., "cases") for inclusion in the PDV:

1. HSAG assembled the sample frame for each validation based on providers identified in the most recent provider data extracts submitted to HSAG/HFS by the health plans.
   a. Out-of-state providers from counties contiguous to Illinois were included in the sample frame and attributed to the nearest geographic region.
2. HSAG used the sample frame to determine a statistically valid number of unique providers based on a 95 percent confidence level and ±5 percent margin of error. To ensure geographic representation for each provider category, the total sample size for each health plan was divided evenly between provider categories (i.e., PCP, OB/GYN, and dental providers) and distributed proportionately by geographic region.
3. Using the sample size calculations from Item 2, HSAG randomly selected an appropriate number of unique providers for each health plan.
4. Using the unique providers identified in Item 3, HSAG identified all locations associated with each health plan for the sampled providers.
5. Using the list of provider locations from Item 4, HSAG randomly selected one location for each provider within the sampled region. If a provider had only one location for the specified health plan, that location was selected.

Provider Directory Validation

The goal of the PDV activity was to determine if the information in the health plans' automated provider directories found on the respective health plans' websites matched the data in the health plans' provider files.

HSAG reviewers used an internally developed tool that displayed provider data submitted by the health plans to capture the results of the validation. Reviewers validated each of the sampled providers by comparing the data displayed in the tool to the information found in each health plan's online provider directory. If the provider's identifying information and sampled location were not found in the online provider directory, the reviewer noted the information and stopped the review. If the provider's sampled identifying information and location were found in the online provider directory, the reviewer noted the information and continued with the review. The reviewers compared 11 provider demographic indicators found in the tool (Table B-2) against the information found in the online provider directories. Exact matches were noted, and other outcomes were classified accordingly. An additional five provider services indicators (Table B-2) were assessed as present or not present in the online provider directories. For example, for the Provider Completed Cultural Competency Training provider services indicator, HSAG reviewers determined whether the information was present, rather than determining if the provider had actually completed the training.

Table B-2—List of Indicators for the PDV

Provider Demographic Indicators	Provider Services Indicators
Provider First Name	Non-English Language Speaking Provider
Provider Last Name	Provider Accommodates Physical Disabilities
Provider Address 1	Provider Completed Cultural Competency Training
Provider Address 2	Provider Gender
Provider City	Provider Office Hours
Provider State	Provider Primary Language
Provider Zip Code	Provider URL
Provider Telephone Number	
Provider Specialty	
Provider Accepting New Patients	

HSAG reviewers also assessed information about the health plans' website, separate from the specific provider information. This information included the presence or absence of the date the website was last updated, the availability of a paper form of the directory, and the presence of various search features within the site. These results were entered into a separate validation tool.

Study Indicators and Analysis

PDV responses were used to compare information found in the provider data submitted by the health plans versus the information found in the health plans' provider directories. The indicators and analyses of the PDV addressed four main objectives:

- **MCO directory validation:** For each health plan, HSAG reviewed the health plan directory to assess the presence of specific federal and Medicaid contract requirements in the online provider directories.
- **Identification of the providers in the online directory:** Information on whether the sampled provider and the sampled provider location were found in the online directory. The information did not have to be an exact match (e.g., small variations in address, provider name misspellings). If the sampled provider and the sampled provider location could not be located in the survey, the PDV review could not continue.
- **Provider data accuracy:** For each health plan, HSAG assessed the degree to which the provider demographic information submitted by the health plan exactly matched the information found in the online provider directories.
- **Provider data availability:** For each health plan, HSAG assessed the degree to which the provider services information was available in the online provider directories.

Study Limitations

The PDV performed by HSAG had several important limitations:

- HSAG received the provider data from the health plans in July/August 2020 (the latest data were received on August 17, 2020) and completed the validation activities from September 16, 2020, through October 21, 2020. In this time period, it is possible that the information submitted by the health plans could have changed and subsequently been updated in the online provider directories. This limitation would most potentially affect the exact-match rates for the demographic indicators. For example, it is possible that a provider was accepting new patients when the provider data were submitted to HSAG but was no longer accepting new patients when the information was validated. This would result in a lower exact-match rate for this indicator.
- This PDV is comparing the data submitted by the health plans against the information in the provider directories. Even though an indicator for a provider might be a match between both sources, the validation is not assuring that the information for the provider is correct. For example, the address for a provider might be a match between both sources, but the provider may no longer be practicing at the given location.

Appendix E6. Pediatric Network Time/ Distance Analysis

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

SFY 2020 Pediatric Provider Network Time/Distance Analysis

November 2020

HSAG HEALTH SERVICES ADVISORY GROUP

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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), to conduct a time/distance analysis between pediatric enrollees (age less than 21 as of May 31, 2020) and providers serving pediatric enrollees in the health plans' networks. HSAG has been working with the health plans to validate the specific age groups seen by each of the pediatric specialty providers in the network to facilitate the assessment of the provider networks providing services to pediatric enrollees. Specifically, the purpose of the *State Fiscal Year (SFY) 2020 Pediatric Provider Network 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 (CountyCare)[1]
- IlliniCare Health Plan (IlliniCare)
- MeridianHealth (Meridian)
- Molina Healthcare of Illinois (Molina)

Overall Statewide Time/Distance Study Findings

Health Plan Compliance—Enrollees Residing Within Time/Distance Standards

HSAG validated the time/distance access standards for pediatric enrollees for 25 provider categories within each geographic region.

- CountyCare was compliant with access standards for all provider categories in Region 4.

[1] Available only in Cook County.

- IlliniCare and Meridian were compliant with access standards for 23 provider categories across all geographic regions.
- BCBSIL and Molina were compliant with access standards for 21 provider categories across all geographic regions.

Health plans non-compliance with access standards for all pediatric enrollees, regardless of urbanicity, are summarized in Table 1. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standards across all regions.

Table 1—Summary of Regions for Pediatric Enrollees Not Within Time/Distance Access Standards

Provider Categories	BCBSIL	IlliniCare	Meridian	Molina
Pharmacies	Regions 1, 2, 5	Region 2	Regions 2, 5	Regions 1, 2
Allergy and Immunology	Region 3	✓	✓	Region 2
Neurosurgery	Regions 1, 3	✓	✓	✓
Oral Surgery	Regions 1, 2, 3	Region 3	Regions 1, 2, 3	Region 3
Rehabilitation Medicine	✓	✓	✓	Region 2

Table 2 shows the health plans' statewide compliance with the time/distance standards as shown in Table B-1. Additionally, the table shows the number of enrollees in each health plan in each region. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standards across all regions. Numerical values in red indicate regions in which the health plan did not meet the time/distance access standard.

Table 2—Summary of Pediatric Enrollee Access to Providers Within Time/Distance Access Standards by Region*

Health Plan	BCBSIL	IlliniCare	Meridian	Molina	CountyCare
Enrollment					
Region 1	8,916	36,560	75,788	23,054	NA
Region 2	13,142	24,311	57,452	28,942	NA
Region 3	7,216	21,995	56,880	22,273	NA
Region 4	141,173	45,074	162,854	39,568	171,129
Region 5	91,453	38,100	111,628	7,900	NA
All Regions	**261,900**	**166,040**	**464,602**	**121,737**	**171,129**
Provider Categories	**Statewide**			**Region 4⁺**	
Pediatric Primary Care Providers (PCPs)	✓	✓	✓	✓	✓
Pediatric Behavioral Health Service Providers	✓	✓	✓	✓	✓
Obstetrics/Gynecology (OB/GYN) Providers	✓	✓	✓	✓	✓
Pediatric Dentists	✓	✓	✓	✓	✓

Health Plan	BCBSIL	IlliniCare	Meridian	Molina	CountyCare
Hospitals	✓	✓	✓	✓	✓
Pharmacies	1,2,5	2	2,5	1,2	✓
Pediatric Specialists					
Allergy and Immunology	3	✓	✓	2	✓
Cardiology	✓	✓	✓	✓	✓
Cardiothoracic Surgery	✓	✓	✓	✓	✓
Dermatology	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓
Ear, Nose, and Throat (ENT) /Otolaryngology	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓
Infectious Disease	✓	✓	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓
Neurology	✓	✓	✓	✓	✓
Neurosurgery	1,3	✓	✓	✓	✓
Oncology	✓	✓	✓	✓	✓
Ophthalmology	✓	✓	✓	✓	✓
Oral Surgery	1,2,3	3	1,2,3	3	✓
Orthopedic Surgery	✓	✓	✓	✓	✓
Pulmonology	✓	✓	✓	✓	✓
Rehabilitation Medicine	✓	✓	✓	2	✓
Rheumatology	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	✓

* The contract standards require that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standards, except for pharmacy providers, which requires that 100 percent of enrollees have access to providers within the access standard. A check mark (✓) indicates that the health plan met the time/distance-based access standards in all regions for the identified provider category. Numeric values in red font indicate the region number in which the health plan was non-compliant.

NA indicates not applicable because the health plan does not operate in the region.

\+ Region 4 encompasses only Cook County. CountyCare operates exclusively in this county.

While Table 2 focuses on the assessment of health plan compliance with the standards at a regional level, regardless of urbanicity, the remainder of the report focuses on access differences for enrollees residing in urban versus rural areas. Table 3 shows the percentage of enrollees statewide that resided within time/distance access standards by urbanicity and the difference between enrollees within time/distance standards for urban and rural counties. Provider categories with enrollees that were not within the time/distance standards are highlighted in red. Generally, enrollees statewide were within the time/distance standards to the measured provider categories with the exception of pharmacy providers in urban counties and oral surgeons in rural counties.

Table 3—Percentage of Pediatric Enrollees With Access to Providers Within Time/Distance Access Standards by Urbanicity*

Statewide	Urban	Rural	Difference+
Provider Categories	**Percent (%)**	**Percent (%)**	**Percent (%)**
Pediatric PCPs	100	100	0.00
Pediatric Behavioral Health Service Providers	100	100	0.00
OB/GYN Providers	>99.99	99.98	0.02
Pediatric Dentists	>99.99	100	<0.01
Hospitals	99.94	100	0.06
Pharmacies	99.95	100	0.05
Specialists			
Allergy and Immunology	98.14	98.22	0.08
Cardiology	100	100	0.00
Cardiothoracic Surgery	99.93	100	0.07
Dermatology	99.96	100	0.04
Endocrinology	99.94	100	0.06
ENT/Otolaryngology	100	100	0.00
Gastroenterology	100	100	0.00
Infectious Disease	>99.99	97.73	2.27
Nephrology	100	100	0.00
Neurology	100	100	0.00
Neurosurgery	99.62	99.84	0.22
Oncology	100	100	0.00
Oral Surgery	97.04	84.12	12.92
Orthopedic Surgery	100	100	0.00
Pulmonology	100	100	0.00
Rehabilitation Medicine	98.34	98.58	0.24
Rheumatology	>99.99	100	<0.01
Urology	100	100	0.00

* The contract standards require that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standards, except for pharmacy providers, which requires that 100 percent of enrollees have access to providers within the access standard.

\+ The difference between urban and rural counties represents the absolute difference between urban and rural. It does not indicate better performance for enrollees residing in either urban or rural areas.

Based on enrollees residing in **urban** areas, provider categories that did not meet time/distance standards in applicable regions are shown in Table 4. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standards across all regions.

Table 4—Summary of Regions for Urban Pediatric Enrollees Not Within Time/Distance Access Standards

Provider Categories	BCBSIL	IlliniCare	Meridian	Molina
Pharmacies	Regions 1, 2, 5	Region 2	Regions 2, 5	Regions 1, 2
Allergy and Immunology	Regions 1, 3	✓	✓	Region 2
Cardiothoracic Surgery	Region 1	✓	✓	✓
Neurosurgery	Regions 1, 3	✓	✓	✓
Oral Surgery	Regions 1, 2	✓	Regions 1, 2	✓
Rehabilitation Medicine	✓	✓	✓	Region 2

Based on enrollees residing in **rural** areas, provider categories that did not meet time/distance standards in applicable regions are shown in Table 5. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standards across all regions.

Table 5—Summary of Regions for Rural Pediatric Enrollees Not Within Time/Distance Access Standards

Provider Categories	BCBSIL	IlliniCare	Meridian	Molina
Allergy and Immunology	✓	✓	✓	Regions 2, 3
Infectious Disease	✓	✓	Region 2	✓
Oral Surgery	Region 3	Region 3	Region 3	Region 3
Rehabilitation Medicine	✓	✓	✓	Region 2

Table 6 shows the health plans' compliance with the time/distance standards stratified by urban and rural counties as shown in Table B-1. A checkmark (✓) indicates that the health plan complied with the specific time/distance access standard across all regions. Numerical values in red indicate regions in which the health plan failed to meet the time/distance access standard. A region might fail in a specific urbanicity, but when reviewed in Table 2, is not shown. This is because, when evaluated statewide, the provider category met time/distance access standards (e.g., Meridian, Infectious Disease, Rural).

Table 6—Regional Summary for Pediatric Enrollees With Access to Providers Within Time/Distance-Based Access Standards and Non-Compliant Provider Categories by Urbanicity*

Health Plan	BCBSIL		IlliniCare		Meridian		Molina		CountyCare
Provider Categories	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**
Pediatric PCPs	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pediatric Behavioral Health Service Providers	✓	✓	✓	✓	✓	✓	✓	✓	✓
OB/GYN Providers	✓	✓	✓	✓	✓	✓	✓	✓	✓

Health Plan	BCBSIL		IlliniCare		Meridian		Molina		CountyCare
Provider Categories	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**	**Rural**	**Urban**
Pediatric Dentists	✓	✓	✓	✓	✓	✓	✓	✓	✓
Hospitals	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pharmacies	1,2,5	✓	2	✓	2,5	✓	1,2	✓	✓
Pediatric Specialists									
Allergy and Immunology	1,3	✓	✓	✓	✓	✓	2	2,3	✓
Cardiology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cardiothoracic Surgery	1	✓	✓	✓	✓	✓	✓	✓	✓
Dermatology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Endocrinology	✓	✓	✓	✓	✓	✓	✓	✓	✓
ENT/Otolaryngology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Gastroenterology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Infectious Disease	✓	✓	✓	✓	✓	2	✓	✓	✓
Nephrology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neurology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Neurosurgery	1,3	✓	✓	✓	✓	✓	✓	✓	✓
Oncology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ophthalmology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Oral Surgery	1,2	3	✓	3	1,2	3	✓	3	✓
Orthopedic Surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓
Pulmonology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rehabilitation Medicine	✓	✓	✓	✓	✓	✓	2	2	✓
Rheumatology	✓	✓	✓	✓	✓	✓	✓	✓	✓
Urology	✓	✓	✓	✓	✓	✓	✓	✓	✓

* The contract standards require that at least 90.0 percent of a health plan's enrollees in each county have access to providers within the access standards, except for pharmacy providers, which requires that 100 percent of enrollees have access to providers within the access standard. A check mark (✓) indicates that the health plan met the time/distance-based access standards in all regions for the identified provider category. Numeric values in red font indicate the region number in which the health plan was non-compliant.

Detailed time/distance results by health plan, provider category, and region are presented in the supplemental Microsoft (MS) Excel workbook that accompanies this report.

Recommendations

The following recommendations are provided based on the results of the provider network time/distance study.

- Future time/distance analyses should focus on identifying the specific locations of the enrollees without access to determine if outreach to providers in those areas can help close the gaps. HFS should consider conducting a saturation analysis for each time/distance standard in which a health plan was not in compliance. A saturation analysis will assist HFS in determining the extent to which deficiencies in the provider network resulted from the health plan's failure to contract with available providers (i.e., providers contracted with a different HealthChoice Illinois health plan), versus a lack of available providers for the provider type and/or region.
- Section 5.7.4 of the Medicaid Model contract requires health plans to notify HFS when material gaps in the Contractor's Provider Network are identified. As required by contract, health plans must notify HFS within five (5) business days and develop and implement a recruitment strategy to address the network gaps identified in the time/distance analysis.
- Based on the results of the previous and current time/distance studies, access to oral surgery providers was identified as a network gap in Regions 1, 2, and 3; however, health plans have reported a limited number of oral surgery providers available for contracting. Health plans should continue to explore contracting opportunities for ensuring access to oral surgery.
- Health plans should examine the accuracy of the provider network data for each of the specialties not meeting the time/distance standards by verifying the enrollee age groups covered by contracted specialty providers.
- Health plans are required to remediate network gaps identified as a follow-up to the findings in this report.
- Health plans are required to work with contracted providers (i.e. dental and pharmacy) to ensure vendor provider data is accurate and complete.
- HFS should conduct an in-depth review of provider categories for which all statewide health plans struggled to meet the time/distance access standards (i.e., Oral Surgery—Region 3 and Pharmacies—Region 2), with the goal of determining whether failure to meet the time/distance access standard(s) resulted from a lack of providers or an inability to contract with providers in the geographic area.
- 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 and provider directory validations to assess the accuracy of provider information available to enrollees. 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.

Appendix A. Summary of Counties by Health Plan Not Meeting Contract Requirements

For each health plan, Appendix A lists counties that did not meet the contract requirements for each provider category. Detailed information about number of enrollees without access for each provider category by Region and County is available in the accompanying MS Excel workbook.

BCBSIL

Allergy and Immunology

- **Region 1—Northwest:** Peoria, Rock Island
- **Region 2—Central:** Champaign, Vermilion
- **Region 3—Southern:** Crawford, Edwards, Lawrence, Madison, Richland, Wabash

Cardiothoracic Surgery

- **Region 1—Northwest:** Rock Island

Dermatology

- **Region 2—Central:** Vermilion

Endocrinology

- **Region 1—Northwest:** Rock Island

Hospitals

- **Region 2—Central:** Vermilion

Infectious Disease

- **Region 2—Central:** Adams, Hancock

Neurosurgery

- **Region 1—Northwest:** Henry, Knox, Mercer, Peoria, Rock Island, Tazewell
- **Region 3—Southern:** Madison, St. Clair

OB/GYN Providers

- **Region 1—Northwest:** Jo Daviess

Oral Surgery

- **Region 1—Northwest:** Peoria, Tazewell
- **Region 2—Central:** Sangamon
- **Region 3— Southern:** Alexander, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, White, Williamson

IlliniCare

Oral Surgery

- **Region 2—Central:** Adams
- **Region 3—Southern:** Alexander, Franklin, Gallatin, Hardin, Jackson, Johnson, Massac, Pope, Pulaski, Saline, Union, Williamson

Meridian

Infectious Disease

- **Region 2—Central:** Adams, Hancock

Oral Surgery

- **Region 1—Northwest:** Peoria, Tazewell
- **Region 2—Central:** Sangamon
- **Region 3—Southern:** Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Lawrence, Massac, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, Williamson

Molina

Allergy and Immunology

- **Region 1—Northwest:** Carroll, Jo Daviess, Rock Island
- **Region 2—Central:** Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Hancock, Macon, Moultrie, Piatt, Sangamon, Shelby, Vermilion

- **Region 3—Southern:** Crawford, Edwards, Jasper, Lawrence, Richland, Wabash, White

Hospitals

- **Region 5—Collar:** Lake

Oral Surgery

- **Region 2—Central:** Adams
- **Region 3—Southern:** Alexander, Clay, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Johnson, Lawrence, Massac, Pope, Pulaski, Richland, Saline, Union, Wabash, Wayne, White, Williamson

Rehabilitation Medicine

- **Region 1—Northwest:** Carroll, Jo Daviess, Rock Island
- **Region 2—Central:** Adams, Champaign, Clark, Coles, Cumberland, Douglas, Edgar, Hancock, Macon, Moultrie, Piatt, Sangamon, Shelby, Vermilion
- **Region 3—Southern:** Crawford, Effingham, Jasper

CountyCare

Not applicable

Appendix B. 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 that met the following criteria:

- Enrollee demographic data as of May 31, 2020.
- Enrollee eligibility and enrollment data including start and end dates for enrollment with the health plan.
- Health plan provider network data files submitted on May 15, 2020. The most recent provider data file was used for health plans with one or more resubmissions.

Data Processing

HSAG cleaned, processed, and used the provided 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. Analyses for pediatric PCPs, pediatric dentists, and pediatric specialists were limited to enrollees younger than 21 years of age. Analyses for obstetrics and gynecology (OB/GYN) providers were limited to female enrollees between the ages of 15 and 21 years.

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 B-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 B-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/distance access standard. Analyses were conducted by region to illustrate differences by region 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. In addition to enrollees that could not be geocoded, several enrollees (i.e., 693 enrollees) were listed as a subscriber to CountyCare; however, those enrollees resided outside of Cook County. These enrollees were also excluded from the results.

Table B-1—Provider Categories, Enrollee Criteria, and Network Access Standards

Provider Category	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Pediatric PCPs[2]	All children (up to 21st birthday) enrolled in a health plan	Access to two PCPs within 30 miles or 30 minutes	Access to one PCP within 60 miles or 60 minutes
Pediatric Behavioral Health Service Providers[3]	All children (up to 21st birthday) enrolled in a health plan	Access to two behavioral health service providers within 30 miles or 30 minutes	Access to one behavioral health service provider within 60 miles or 60 minutes
OB/GYN Providers[4]	Female pediatric enrollees (on or after 15th birthday) enrolled in a health plan	Access to two OB/GYN providers within 30 miles or 30 minutes	Access to one OB/GYN provider within 60 miles or 60 minutes
Pediatric Dentists	All children (up to 21st birthday) enrolled in a health plan	Access to one pediatric dentist within 30 miles or 30 minutes	Access to one pediatric dentist within 60 miles or 60 minutes
Hospitals	All enrollees enrolled in a health plan	Access to one general or critical access hospital within 30 miles or 30 minutes	Access to one general or critical access hospital within 60 miles or 60 minutes
Pharmacies	All enrollees enrolled in a health plan	Access to one pharmacy within 15 miles or 15 minutes	Access to one pharmacy within 60 miles or 60 minutes
Pediatric Specialists[5]			
Allergy and Immunology	All children (up to 21st birthday) enrolled in a health plan	Access to one specialty services provider within 60 miles or 60 minutes	Access to one specialty services provider within 90 miles or 90 minutes
Cardiology	All children (up to 21st birthday) enrolled in a health plan		
Cardiothoracic Surgery	All children (up to 21st birthday) enrolled in a health plan		
Dermatology	All children (up to 21st birthday) enrolled in a health plan		

Provider Category	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Endocrinology	All children (up to 21st birthday) enrolled in a health plan		
ENT/Otolaryngology[6]	All children (up to 21st birthday) enrolled in a health plan		
Gastroenterology	All children (up to 21st birthday) enrolled in a health plan		
Infectious Disease	All children (up to 21st birthday) enrolled in a health plan		
Nephrology	All children (up to 21st birthday) enrolled in a health plan		
Neurology	All children (up to 21st birthday) enrolled in a health plan		
Neurosurgery	All children (up to 21st birthday) enrolled in a health plan		
Oncology	All children (up to 21st birthday) enrolled in a health plan		
Ophthalmology	All children (up to 21st birthday) enrolled in a health plan		
Oral Surgery	All children (up to 21st birthday) enrolled in a health plan		
Orthopedic Surgery	All children (up to 21st birthday) enrolled in a health plan		
Pulmonology	All children (up to 21st birthday) enrolled in a health plan		
Rehabilitation Medicine	All children (up to 21st birthday) enrolled in a health plan		

Provider Category	Enrollee Criteria	Network Access Standard	
		Urban[1]	Rural[1]
Rheumatology	All children (up to 21st birthday) enrolled in a health plan		
Urology	All children (up to 21st birthday) enrolled in a health plan		

[1] For these analyses, "urban" and "rural" are defined by the Medicaid Model Contract 2018-24-001.
[2] Pediatric PCPs include providers with a specialty of pediatric medicine, pediatric physician assistant, pediatric nurse practitioner, and a PCP flag indicator.
[3] Pediatric behavioral health service providers are 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. Enrollee population is limited to female enrollees between 15 and 21 years of age.
[5] Only pediatric providers are included for analyzing access to specialty providers (i.e., providers with a pediatric specialty such as pediatric cardiologists and pediatric neurologists).
[6] ENT/Otolaryngology providers include providers with a specialty of ear, nose, and throat.

Time/Distance Analyses

HSAG used Quest Analytics Suite software to review enrollee and provider addresses to ensure they could be geocoded to the exact geographic locations (i.e., latitude and longitude). Geocoded enrollee and provider addresses were assembled into datasets used to conduct the following three spatial-derived analyses for each health plan for the provider categories listed in Table B-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.[B-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[B-2] (driving times in minutes) to the nearest three providers.

[B-1] For Pharmacy providers, the contract requirement states that 100 percent of enrollees must have access within the stated time or distance standard.
[B-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.

- A shorter driving distance or travel time indicates greater accessibility to providers since enrollees must travel fewer miles or minutes to access care.
- Results from the average travel distances and travel times to each provider category are presented by health plan in the accompanying MS Excel workbook.

Study Limitations

- Time/distance metrics represent a high-level measurement of the similarity of the geographic distribution of providers relative to enrollees. These results 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. 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.
- HFS' enrollee address data may not always reflect an enrollee's place of residence (e.g., use of post office boxes). While mapping software may assign enrollees to geographic coordinates, these coordinates may not align with the enrollee's exact residential location for records that do not use a standard street address. Additionally, county names included in the enrollment data were used to determine enrollees' urbanicity and region. Approximately 4.9 percent of enrollees did not have a valid county name in the data provided by HFS. As such, county names produced by Quest Analytics during geocoding were used to assign urbanicity and a region to these enrollees.
- No national distance-based or time-based access standards have been established for Medicaid. While time- and distance-based access standards are defined for the HealthChoice Illinois Medicaid provider categories noted in the methodology, network adequacy cannot be measured against national benchmarks at this time.
- When evaluating the results of these analyses, average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- The availability of 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. HSAG calculates the 25 time/distance standards, but these do not reflect all potential healthcare needs or service delivery options for the HealthChoice Illinois pediatric enrollees. Selected time/distance standards may also be addressed using telehealth, mobile service providers, mail delivery for prescriptions, or other emerging service delivery approaches that may be evaluated using metrics other than time/distance calculation results.
- 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.

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. Aetna, BCBSIL, CountyCare, Meridian, and Molina were responsible for contracting with a CAHPS vendor to administer the CAHPS surveys on their behalf.[F1-1] Results for all five health plans were forwarded to HSAG for analysis. For the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/CHIP) programs, HSAG administered the CAHPS survey and performed the analysis and reporting on behalf of HFS.

The CAHPS results are presented by program type by population. Both the adult and child Medicaid populations were surveyed under HealthChoice Illinois for Aetna, BCBSIL, CountyCare, Meridian, and Molina.[F1-2] Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and Illinois Medicaid programs were surveyed.[F1-3]

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

Overview

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

Technical Methods of Data Collection and Analysis

HealthChoice Health Plans

The technical method of data collection was through the administration of the CAHPS 5.1H Adult Medicaid Survey to the adult populations and the CAHPS 5.1H Child Medicaid Survey to the child populations. Aetna, BCBSIL, CountyCare, Meridian, and Molina used a mixed-mode methodology,

[F1-1] In 2020, SPH Analytics administered the CAHPS surveys on behalf of all health plans. In 2021, the Center for the Study of Services (CSS) administered the CAHPS surveys on behalf of Aetna, and SPH Analytics administered the CAHPS surveys on behalf of BCBSIL, CountyCare, Meridian, and Molina.

[F1-2] Aetna Better Health was formerly known as IlliniCare Health Plan.

[F1-3] 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.[F1-4] Aetna, BCBSIL, CountyCare, and Meridian included the option to complete the surveys in English and Spanish for both the adult and child populations. Molina included the option to complete the surveys in English 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 5.1 Child Medicaid Survey with the Children with Chronic Conditions (CCC) measurement set to a statewide sample of the child population enrolled in each program. For All Kids and Illinois Medicaid, a sample representing the general child population and a CCC supplemental sample (i.e., a sample of child members who were identified as more likely to have a chronic condition) were selected from each program. All Kids and Illinois Medicaid used a standard mixed-mode methodology for data collection, which included both mail and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

Survey Measures for CAHPS

The survey questions were categorized into eight measures of experience. These measures included four global ratings and four composite measures. The global ratings reflected members' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). For All Kids and Illinois Medicaid, the CAHPS survey also included the CCC measurement set of survey questions, which are categorized into five additional measures of experience. These measures included three CCC composite measures and two CCC individual item measures. The CCC composites and items are sets of questions and individual questions that examine different aspects of care for the CCC population (e.g., access to prescription medicines or access to specialized services). The CCC composites and items are only calculated for the population of children identified as having a chronic condition (i.e., CCC population); they are not calculated for the general child population.

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

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage was referred to as a question summary rate (or top-box score). For each of the composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices were "Never," "Sometimes," "Usually," and "Always." For the composite measures (*Getting Needed*

[F1-4] In 2020 and 2021, Aetna (formerly IlliniCare) and BCBSIL used a standard Internet mixed-methodology protocol for administration of the CAHPS 5.1H Adult Medicaid Survey and CAHPS 5.1H Child Medicaid Survey. This protocol allowed sampled members the option to complete the survey via the Internet.

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 2021 top-box scores were compared to their corresponding 2020 scores to determine whether there were statistically significant differences. Statistically significant differences between the 2021 top-box scores and the 2020 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2021 than 2020 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2021 than 2020 are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Additionally, for each CAHPS measure, the resulting 2021 top-box scores were compared to NCQA's 2020 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.[F1-5,F1-6] 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.

[F1-5] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA. September 2019.

[F1-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2020*. Washington, DC: NCQA. September 2020.

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

Appendix F2. Beneficiary Experience With Care Detailed Results

Adult CAHPS Medicaid Survey

Response Rates

The 2021 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—2021 Adult Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
15.09%	31.58%	18.44%	16.07%	14.33%	18.95%

Adult Health Plan-Specific Findings and Comparisons

The 2020 and 2021 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—2020 and 2021 Adult Health Plan-Specific Results

Health Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2020	82.0% ★★	79.6% ★	93.3% ★★★	89.6% ★★★
	2021	78.9% ★	78.2% ★	91.1% ★	83.0% ★
BCBSIL	2020	79.6% ★	82.2% ★★	94.6% ★★★★	90.7% ★★★
	2021	87.9% ★★★★	83.9% ★★★	93.4% ★★	90.7% ★★★
CountyCare	2020	81.4% ★★	81.8% ★★	92.0% ★★	87.1% ★
	2021	78.9% ★	78.2% ★	90.3% ★	86.3% ★
Meridian	2020	76.1% ★	77.9% ★	92.1% ★★★	87.7% ★★
	2021	87.1% ★★★★	82.6% ★★	93.1% ★★	88.0% ★★

Experience With Care

Adult CAHPS Results

Health Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2020	80.7% ★★	83.8% ★★★	92.8% ★★★	85.4% ★
	2021	83.3% ★★	80.4% ★★	89.8% ★	88.1%+ ★★+
Statewide Aggregate	2020	79.5% ★	80.1% ★★	92.9% ★★★	88.5% ★★
	2021	83.1% ★★	80.5% ★★	91.6% ★	86.6% ★

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

Strengths

For BCBSIL and Meridian, experience survey results were at or above the 75th percentile for *Getting Needed Care*, which indicates that the members in these health plans perceive they have adequate access to getting the care they need.

Opportunities for Improvement

Opportunity: Experience survey results for Aetna, CountyCare, Molina, and the statewide aggregate were below the 50th percentile for *Getting Needed Care*, which indicates that these members perceive a lack of access to getting the care they need.

Why the Opportunity Exists: Aetna, CountyCare, and Molina members may have difficulty obtaining the care, tests, or treatments they need.

Opportunity: Experience survey results for Aetna, CountyCare, Meridian, Molina, and the statewide aggregate were below the 50th percentile for *Getting Care Quickly* and *Customer Service*, which indicates that these members perceive a lack of timeliness to getting the care they need and quality of care with their health plan's customer service.

Why the Opportunity Exists: Aetna, CountyCare, Meridian, and Molina members may have difficulty getting a timely appointment with their provider. Additionally, customer service staff may not be providing the information members need or treating them with courtesy and respect.

Opportunity: Experience survey results for every health plan and the statewide aggregate were below the 50th percentile for *How Well Doctors Communicate*, which indicates that members perceive an overall lack of quality of care with their doctors' communication.

Why the Opportunity Exists: Providers may not be communicating with members in an understandable, respective, and attentive way, or spending enough time with members.

Recommendation: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why their members are not getting timely care, the quality of care they need, or do not have access to care. The

health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Global Ratings

Table F2-3—2020 and 2021 Adult Health Plan-Specific Results

Health Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
Aetna	2020	54.3% ★★	68.4% ★★★	65.2% ★★	57.4% ★★
	2021	50.6% ★	66.4% ★★	65.1% ★	49.7% ★
BCBSIL	2020	59.6% ★★★★	72.6% ★★★★	67.4% ★★	60.8% ★★
	2021	59.9% ★★★	74.5% ★★★★	69.6% ★★	69.7% ★★★★
CountyCare	2020	61.3% ★★★★★	72.3% ★★★★	73.2% ★★★★★	68.3% ★★★★★
	2021	56.2% ★★	64.2% ★	60.6% ★	59.8% ★★
Meridian	2020	51.2% ★	67.1% ★★	62.8% ★	53.2% ★
	2021	66.3% ★★★★★	69.5% ★★	76.9% ★★★★★	63.2% ★★★
Molina	2020	59.9% ★★★★	70.7% ★★★★	69.4% ★★★	57.8% ★★
	2021	56.6% ★★	66.1% ★	71.3%+ ★★★+	55.6% ★
Statewide Aggregate	2020	55.5% ★★★	69.3% ★★★	66.2% ★★	58.1% ★★
	2021	59.3% ★★★	67.3% ★★	70.0% ★★	58.6% ★★

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

Experience With Care

Adult CAHPS Results

Strengths	Experience survey results were at or above the 90th percentile for Meridian for both *Rating of All Health Care* and *Rating of Specialist Seen Most Often*, which indicates that Meridian members had positive experiences with their specialists and overall healthcare services. Additionally, BCBSIL's experience survey results were at or between the 75th and 89th percentiles for *Rating of Personal Doctor* and *Rating of Health Plan*, which indicates that BCBSIL members had positive experiences with their personal doctor and their health plan overall.
Opportunities for Improvement	**Opportunity:** Experience survey results for CountyCare and Molina were below the 50th percentile, and Aetna was below the 25th percentile for *Rating of All Health Care,* which indicates a lack of quality of care. **Why the Opportunity Exists:** Aetna, CountyCare, and Molina members may perceive access and timeliness issues with their providers and the care they need, leading to an overall lower level of experience in how they view the quality of the care they received.
	Opportunity: Experience survey results for Aetna, Meridian, and the statewide aggregate were below the 50th percentile, and CountyCare and Molina were below the 25th percentile for *Rating of Personal Doctor,* which indicates that members may feel they are not getting quality care from their personal doctors. **Why the Opportunity Exists:** Aetna, CountyCare, Meridian, and Molina members may have received poor communication or service from their personal doctor.
	Opportunity: Experience survey results for BCBSIL and the statewide aggregate were below the 50th percentile, and Aetna and CountyCare were below the 25th percentile for *Rating of Specialist Seen Most Often,* which indicates that members perceive a lack of quality of care with specialists. **Why the Opportunity Exists:** Aetna, BCBSIL, and CountyCare members may feel they are not getting quality care or treatment from the specialists they see most often.
	Opportunity: Experience survey results for CountyCare and the statewide aggregate were below the 50th percentile, and Aetna and Molina were below the 25th percentile for *Rating of Health Plan,* which indicates that members perceive an overall lack of quality of care and service with these health plans. **Why the Opportunity Exists:** Aetna, CountyCare, and Molina members may have felt they received inadequate information, poor communication or service, or a lack of quality of care from their providers or the health plan staff, which led to an overall lower rating of the health plan.

Recommendations: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why their members perceive a lack of quality of care from their personal doctors and specialists, as well as an overall lack of quality of the care and services they receive. The health plans could consider if there are disparities within their populations that contribute to the lower performances in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Child CAHPS Medicaid Survey

Response Rates

The 2021 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—2021 Child Response Rates

Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Aggregate
15.84%	14.50%	14.45%	15.70%	11.37%	13.81%

Child Health Plan-Specific Findings and Comparisons

The 2020 and 2021 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—2020 and 2021 Child Health Plan-Specific Results

Health Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2020	81.5%+ ★★+	90.1%+ ★★★+	93.6% ★★	83.8%+ ★+
	2021	86.6%+ ★★★+	86.4%+ ★+	97.1% ★★★★	87.0%+ ★+
BCBSIL	2020	77.0% ★	82.4% ★	94.3% ★★★	88.5% ★★
	2021	76.9% ★	76.0% ★	92.3% ★	86.1% ★
CountyCare	2020	74.9% ★	87.3% ★★	91.6% ★	87.0% ★★
	2021	78.9% ★	79.0%+ ★+	91.5% ★	86.7%+ ★+
Meridian	2020	78.2% ★	83.4% ★	92.9% ★★	81.7% ★
	2021	79.0% ★	86.2% ★	91.3% ★	85.8%+ ★+

Experience With Care

Child CAHPS Results

Health Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Molina	2020	85.0% ★★★	91.3% ★★★	96.0% ★★★★	90.1% ★★★★
	2021	84.7% ★★	83.7% ★	93.8% ★	83.9% ★
Statewide Aggregate	2020	78.6% ★	85.5% ★	93.4% ★★	85.0% ★
	2021	80.2% ★	82.6% ★	92.6% ★	86.0% ★

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

Strengths

Experience survey results were at or between the 75th percentile and 89th percentiles for Aetna for *How Well Doctors Communicate*, which indicates that parents/caretakers of child members perceive they are not receiving thorough communication from their child's doctors.

Opportunities for Improvement

Opportunity: Experience survey results show that all health plans were below the 25th percentile for *Getting Care Quickly* and *Customer Service*, which indicates parents/caretakers of child members perceive a lack of timeliness of care as well as a lack of quality customer service being provided.

Why the Opportunity Exists: Lower ratings for these measures may indicate that parents/caretakers of child members have difficulty scheduling the care their child needs with a provider or at a facility in a timely manner. Additionally, when parents/caretakers of child members need assistance from customer service, they may not be receiving needed information or quality treatment.

Opportunity: Excluding Aetna, experience survey results for *How Well Doctors Communicate* were below the 25th percentile for all health plans, which indicates parents/caretaker of child members do not feel they are understanding or being fully informed when doctors are communicating about their child's care.

Why the Opportunity Exists: When a child member is receiving care, providers may not be communicating well with parents/caretakers or spending adequate time educating or explaining as much as the parent/caretaker expects or needs.

Opportunity: Experience survey results for BCBSIL, CountyCare, Meridian, and the statewide aggregate were below the 25th percentile, and Molina was below the 50th percentile for *Getting Needed Care*, which indicates that parents/caretakers of child members may perceive challenges with a lack of timeliness of care for their child.

Why the Opportunity Exists: Parents/caretakers of child members may have difficulty scheduling the care their child needs with a provider or at a facility in a timely manner

Recommendation: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why child members may not have adequate access to or timeliness of care, as well as what may be contributing to a lack of communication with their child's doctor and positive customer service experience. The health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans can then determine what appropriate interventions, education, and actions can be taken to improve performance.

Global Ratings

Table F2-6—2020 and 2021 Child Health Plan-Specific Results

Health Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
Aetna	2020	70.6% ★★	72.0% ★	71.4%+ ★★+	60.2% ★
	2021	67.8% ★	75.8% ★	78.8%+ ★★★★★+	58.1% ★
BCBSIL	2020	78.4% ★★★★★	78.4% ★★★	79.8%+ ★★★★★+	75.9% ★★★★
	2021	76.6% ★★★★	78.2% ★★	68.1%+ ★+	71.6% ★★
CountyCare	2020	70.3% ★★	78.7% ★★★	73.3%+ ★★+	71.1% ★★
	2021	70.7% ★★	80.3% ★★★	71.8%+ ★★+	70.6% ★★
Meridian	2020	65.6% ★	77.1% ★★	71.4% ★★	60.3% ★
	2021	75.9% ★★★★	81.5% ★★★★	69.5%+ ★+	71.8% ★★
Molina	2020	74.0% ★★★	76.1% ★★	75.0%+ ★★★+	63.5% ★
	2021	72.7% ★★★	79.3% ★★★	79.6%+ ★★★★★+	64.4% ★

Experience With Care

Child CAHPS Results

Health Plan Name	Year	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*	*Rating of Health Plan*
Statewide Aggregate	2020	70.5% ★★	76.8% ★★	73.8% ★★	65.4% ★
	2021	73.8% ★★★	79.5% ★★★	71.9% ★★	68.8% ★

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

Strengths

Experience survey results for Aetna and Molina were at or above the 90th percentile for *Rating of Specialist Seen Most Often*, which indicates parents/caretakers of child members had positive experiences with specialists providing care for their child. Additionally, experience survey results for BCBSIL and Meridian were at or between the 75th and 89th percentiles for *Rating of All Health Care*, which indicates parents/caretakers had positive experiences with the quality of care their child members received. Also, experience survey results for Meridian were at or between the 75th and 89th percentiles for *Rating of Personal Doctor*, which indicates parents/caretakers had positive experiences with the quality of care their child members received from their child's personal doctor.

Opportunities for Improvement

Opportunity: Experience survey results for CountyCare were below the 50th percentile, and Aetna was below the 25th percentile for *Rating of All Health Care,* which indicates that parents/caretakers of child members may feel they are not getting quality healthcare services.

Why the Opportunity Exists: Parents/caretakers of Aetna and CountyCare child members may perceive access and timeliness issues with their providers and the care they need, leading to an overall lower level of experience in how they view the quality of the care they received.

Opportunity: Experience survey results for BCBSIL were below the 50th percentile, and Aetna were below the 25th percentile for *Rating of Personal Doctor*, which indicates that parents/caretakers may feel they are not getting quality care from their child's personal doctor.

Why the Opportunity Exists: Parents/caretakers of child members may have felt they received poor communication or service from their child's personal doctor.

Opportunity: Experience survey results for CountyCare and the statewide aggregate were below the 50th percentile, and BCBSIL and Meridian were below the 25th percentile for *Rating of Specialist Seen Most Often,* which indicates that parents/caretakers of child members may feel they are not getting quality care from specialists.

Why the Opportunity Exists: Parents/caretakers of BCBSIL, CountyCare, and Meridian child members may feel they are not getting quality care or treatment from the specialists their child sees most often.

Opportunity: Experience survey results were below the 50th percentile for all health plans and the statewide aggregate for *Rating of Health Plan*, which indicates an overall lack of quality of care across all health plans.

Why the Opportunity Exists: Parents/caretakers of child members may have felt they received inadequate information, poor communication or service, and/or a lack of quality of care from their providers or health plan staff.

Recommendation: HSAG recommends that the health plans conduct root cause analyses or focus studies to determine why parents/caretakers of child members perceive a lack of quality of care from their personal doctors and specialists, as well as an overall lack of quality of care and services. The health plans could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the health plans should implement appropriate interventions to improve the performance related to the care members need.

Statewide CAHPS Medicaid Survey

Response Rates

The table below presents the 2021 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—2021 Statewide Survey Response Rates

Program Name	2021 Response Rate
All Kids	33.75%
Illinois Medicaid	21.14%
Illinois Statewide Aggregate	27.47%

General Child Population Findings and Comparisons

The 2020 and 2021 general child populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[F2-1]

Table F2-8—2020 and 2021 Statewide Survey General Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2020	84.2% ★★	81.9% ★★	88.4% ★★★★
	2021	81.1% ★	81.5% ★	80.5% ★
Getting Care Quickly	2020	88.3% ★★	88.1% ★★	88.3% ★★
	2021	81.5% ★	80.4% ★	83.5% ★

[F2-1] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

Experience With Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2020	94.2% ★★★	95.2% ★★★	92.7% ★★
	2021	94.2% ★	95.3% ★★	92.6% ★
Customer Service	2020	79.1% ★	78.4%+ ★+	80.1%+ ★+
	2021	86.3% ★	85.8% ★	86.9%+ ★+
Global Ratings				
Rating of All Health Care	2020	70.2% ★★	70.2% ★★	70.1% ★★
	2021	68.4% ★	66.7% ★	71.3% ★★
Rating of Personal Doctor	2020	76.3% ★★	76.7% ★★	75.7% ★★
	2021	76.5% ★★	77.4% ★★	75.0% ★
Rating of Specialist Seen Most Often	2020	75.9% ★★★	80.8%+ ★★★★★+	66.7%+ ★+
	2021	70.6% ★	77.8%+ ★★★★★+	57.8%+ ★+
Rating of Health Plan	2020	61.3% ★	59.9% ★	63.7% ★
	2021	61.8% ★	63.7% ★	58.9% ★

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

Strengths	General child experience survey results for the All Kids program were at or above the 90th percentile for *Rating of Specialist Seen Most Often*, which indicates parents/caretakers of All Kids members have had positive experiences and received quality care from specialists who are providing care to their child.
Opportunities for Improvement	**Opportunity:** Excluding *Rating of Specialist Seen Most Often* for All Kids, general child experience survey results for the Illinois Statewide Aggregate, All Kids program, and Illinois Medicaid program were below the 50th percentile for all measures which indicates parents/caretakers may not be receiving the access to, timeliness of, and quality of healthcare services they feel their child needs, lack of quality and understanding when doctors communicate with parents/caretakers of child members, and lack of quality care and service. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty trying to schedule appointments within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. Additionally, parents/caretakers may not be able to access providers within a reasonable distance or have limited options to choose from within a specialty. Additionally, parents/caretakers of child members may feel they are not getting the time they need with or appropriate communication from their child's personal doctor, or the adequate materials they require to understand the information presented. **Recommendation:** HSAG recommends that the All Kids and Illinois Medicaid programs conduct root cause analyses or focus studies related to child populations to determine why child members may not be getting timely care, the quality of care they need, or do not have access to care. The programs could consider if there are disparities within their child populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, the programs should implement appropriate interventions to improve access and timeliness to care and the quality of care members need. Additionally, HSAG recommends that the programs determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the program that could be contributing to a lack of network adequacy and access issues.

CCC Child Population Findings and Comparisons

The 2020 and 2021 CCC populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) are presented in the tables below for All Kids, Illinois Medicaid, and the Illinois statewide program aggregate.[F2-2]

Table F2-9—2020 and 2021 Statewide Survey CCC Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2020	85.5% ★★	84.8% ★★	86.4%+ ★★★+
	2021	84.7% ★	86.4% ★★	82.4% ★
Getting Care Quickly	2020	90.7% ★	91.5% ★★	89.7%+ ★+
	2021	86.0% ★	85.5% ★	86.5% ★
How Well Doctors Communicate	2020	95.0% ★★★	96.5% ★★★★	93.1% ★
	2021	95.2% ★★	95.7% ★★	94.5% ★
Customer Service	2020	84.7% ★	83.3%+ ★+	86.2%+ ★+
	2021	85.2% ★	84.0%+ ★+	86.5%+ ★+
Global Ratings				
Rating of All Health Care	2020	67.6% ★★	71.3% ★★★	62.6% ★
	2021	61.6% ★	64.2% ★	58.0% ★
Rating of Personal Doctor	2020	75.5% ★★	80.3% ★★★★	69.5% ★
	2021	74.0% ★	73.7% ★	74.4% ★

[F2-2] NCQA does not publish separate benchmarks and thresholds for the CHIP population; therefore, caution should be exercised when interpreting the results of the National Comparisons analysis (i.e., star ratings).

Experience With Care

Statewide Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Rating of Specialist Seen Most Often	2020	76.3% ★★★	83.5%+ ★★★★★+	66.1%+ ★+
	2021	73.5% ★★	76.7% ★★★	68.3%+ ★+
Rating of Health Plan	2020	57.9% ★	57.7% ★	58.1% ★
	2021	57.9% ★	60.0% ★	55.1% ★
CCC Composites and Items				
Access to Specialized Services	2020	70.5%+ ★+	67.4%+ ★+	75.2%+ ★★+
	2021	60.6% ★	64.3%+ ★+	56.5%+ ★+
FCC: Personal Doctor Who Knows Child	2020	89.9% ★	92.2% ★★★	86.9% ★
	2021	91.7% ★★	90.0% ★	93.7% ★★★★
Coordination of Care for Children with Chronic Conditions	2020	81.9%+ ★★★★★+	79.4%+ ★★★★+	85.4%+ ★★★★★+
	2021	78.6% ★★★	77.9%+ ★★+	79.5%+ ★★★★+
Access to Prescription Medicines	2020	90.3% ★★	90.7% ★★	89.8% ★
	2021	89.0% ★	91.7% ★★★	85.8% ★
FCC: Getting Needed Information	2020	92.4% ★★★	92.3% ★★★	92.7% ★★★
	2021	87.9% ★	90.3% ★	84.4% ★

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

Strengths	CCC experience survey results for Illinois Medicaid were above the 75th percentile for *FCC*: *Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions*, which indicates parents/caretakers perceive quality of care from their child's personal doctor and with their child's coordination of care for the specific needs of their children with chronic conditions.
Opportunities for Improvement	**Opportunity:** CCC experience survey results for the Illinois Statewide Aggregate, All Kids program, and Illinois Medicaid program were below the 50th percentile for *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Health Plan*, *Access to Specialized Services,* and *FCC: Getting Needed Information*. In addition, CCC experience survey results were below the 50th percentile for *FCC: Personal Doctor Who Knows Child* and *Coordination of Care for Children with Chronic Conditions* for the All Kids program and were below the 50th percentile for *Access to Prescription Medicines* for the Illinois Medicaid program. These results indicate parents/caretakers of child members are experiencing poor timeliness in appointments, poor access to the medical equipment/prescription medicines or treatment needed for their child with chronic conditions and overall access to care and services, and poor quality of care from customer service staff and their child's personal doctor. **Why the Opportunity Exists:** Parents/caretakers of child members may have difficulty trying to schedule appointments with their child's personal doctor or a specialist within times they feel are appropriate for the care they are seeking for their child. This could be due to potential patient load or open office hour availability of network providers. Additionally, there may be a lack of access to providers within a reasonable distance or limited options to choose from within a specialty. Additionally, parents/caretakers of child members may feel they are not getting the time needed with their child's personal doctor or the adequate materials needed to understand the information presented. **Recommendation:** HSAG recommends that the All Kids and Illinois Medicaid programs conduct root cause analyses or focus studies related to CCC child populations to determine why CCC child members may not be getting timely care, the quality of care they need, or do not have access to care. The programs could consider if there are disparities within their populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Also, the programs could review complaints and grievances to assist in identifying potential problematic providers, facilities, or overall barriers to quality of care, adequate network access, and timely care. Upon identification of a root cause, the programs should implement appropriate interventions to improve access and timeliness to care and the quality performance related to the care CCC child members need. Additionally, HSAG recommends that the

programs determine if there is a shortage of specialists in the area or an unwillingness of the specialists to contract with the program that could be contributing to a lack of network adequacy and access issues.

Appendix G1. 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

SFY21 Annual Report

December 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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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) 2021 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 2021 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 18 CMS waiver performance measures, and additional HealthChoice contract measures. During SFY 2021, 1,457 HealthChoice and 1,507 MLTSS records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,272 HealthChoice and 1,391 MLTSS findings of non-compliance were identified.

Although reviews in SFY 2021 occurred virtually due to pandemic restrictions, SFY 2021 performance was not impacted by pandemic emergency protocols due to the retrospective lookback period for the reviews. HSAG will report on the impact of performance in SFY 2022 reports.

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 2021.

Table 1.1—SFY 2021 HealthChoice Health Plans

HealthChoice Health Plan Name
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare (CountyCare)
Aetna Better Health (previously IlliniCare Health Plan [Aetna])
Meridian Health (Meridian)
Molina Healthcare of Illinois (Molina)

Successes

SFY 2021 represented the fourth year of review for the HealthChoice population, and several successes were identified.

☑ Twelve of the 18 CMS performance measures averaged 90 percent or greater compliance.

☑ Five of the 18 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2021 when compared to SFY 2020.

☑ Four of the five health plans averaged greater than 90 percent compliance.

☑ Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for five measures in SFY 2021.

☑ Compared to SFY 2020, CountyCare realized a statistically significant increase in performance for seven measures in SFY 2021.

☑ Compared to SFY 2020, Meridian realized a statistically significant increase in performance for four measures in SFY 2021.

☑ Compared to SFY 2020, the BI waiver realized a statistically significant increase in performance for two measures in SFY 2021.

☑ Compared to SFY 2020, the ELD waiver realized a statistically significant increase in performance for three measures in SFY 2021.

☑ Compared to SFY 2020, the HIV waiver realized a statistically significant increase in performance for three measures in SFY 2021.

☑ Compared to SFY 2020, the PD waiver realized a statistically significant increase in performance for two measures in SFY 2021.

Opportunities for Improvement

Review of SFY 2021 performance identified the following opportunities for improvement:

Aetna demonstrated a statistically significant decrease in overall performance as well as in five performance measures when Q4 performance was compared to Q1 performance.

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 28 percent compliance. All five health plans performed at a rate of less than 50 percent. A detailed analysis is provided in Section 3 of this report.

Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date,* averaged 7 percent compliance in SFY 2021. All five health plans performed at a rate of less than 25 percent in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 20C, *a PA evaluation was completed annually,* averaged 73 percent compliance in SFY 2021. A detailed analysis 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 68 percent and 66 percent compliance for the BI and HIV waivers, respectively. A detailed analysis related to 36D is provided in Section 3 of this report.

Analysis of SFY 2021 Performance on SFY 2020 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 2020 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 2020 Recommendation	SFY 2021 Analysis of Performance
Plan-Specific	
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.	BCBSIL realized a four-percentage point increase in performance on measure 4A when compared to SFY 2020. BCBSIL realized a statistically significant increase in performance on measure 39D when compared to SFY 2020. BCSBIL should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the Performance Measure-Specific recommendations.
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.	CountyCare realized a six-percentage point increase in performance on measure 4A when compared to SFY 2020. CountyCare realized a statistically significant increase in performance on measures 36D, 37D, and 39D when compared to SFY 2020. CountyCare should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the Performance Measure-Specific recommendations.
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.	Aetna (previously IlliniCare) demonstrated stable performance on measures 4A and 36D. Aetna realized a statistically significant increase in performance on measure 39D when compared to SFY 2020. Aetna should focus efforts on measures 4A, 12C, 36D, and 39D. The health plan may benefit from utilizing recommendations indicated in the Performance Measure-Specific recommendations.

SFY 2020 Recommendation	SFY 2021 Analysis of Performance
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.	Meridian realized a six-percentage point increase in performance on measure 4A when compared to SFY 2020. Meridian realized a statistically significant increase in performance on measures 36D and 39D when compared to SFY 2020. Meridian demonstrated stable performance on measure 37D. Meridian should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the Performance Measure-Specific recommendations.
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.	Molina demonstrated a 19-percentage point increase in performance on measure 4A when compared to SFY 2020. Molina demonstrated a nine-percentage point and a six-percentage point increase in performance on measures 36D and 39D, respectively, when compared to SFY 2020. Molina should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the Performance Measure-Specific recommendations.
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 2020 to SFY 2021. 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, realized a statistically significant increase in performance from SFY 2020 to SFY 2021. Focused efforts related to measure 36D were recommended during SFY 2020 and remain as a recommendation for SFY 2021.
Performance-measure specific	

SFY 2020 Recommendation	SFY 2021 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 28 percent in SFY 2021. 36D: Overall performance averaged 68 percent and 66 percent compliance for the BI and HIV waivers, respectively, in SFY 2021. 37D: Overall performance was 89 percent in SFY 2021. 39D: Overall performance for measure 39D was 88 percent in SFY 2021, a statistically significant increase from SFY 2020 performance. Focused efforts will continue to remain as recommendations for measures 4A and 36D.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY 2021. 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 completion of annual reassessments, care plan and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.

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.

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

BCSBIL should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

CountyCare should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Aetna should focus efforts on measures 4A, 12C, and 39D. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Meridian should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Molina should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

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, 12C, 20C, and 36D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A, 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 measures 12C and 20C, efforts might include:

- 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 complete PA evaluations.
- Educate care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

For measure 36D, efforts might include:

- Conduct root cause analysis to determine opportunities to affect change.
- 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.

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. Management of the Home and Community-Based Services (HCBS) waiver populations was initiated in 2013.

In addition to the ICP, some enrollees received 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.

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 and then expanded into additional regions.

Illinois transitioned to an integrated Medicaid program, HealthChoice Illinois Managed Care Program (HealthChoice), on January 1, 2018, which combined the FHP/ACA, ICP, and MLTSS populations into one managed care program and was established statewide for the FHP/ACA and ICP; MLTSS was expanded statewide effective July 1, 2019.

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 (FY) 2014 to monitor ICP health plan performance on the HCBS waiver performance measures and added FHP/ACA upon waiver service provision inclusion in FY 2016. MLTSS was included in Quarter 3 (Q3) FY 2018.

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) 2021 review, HFS identified 18 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 2021, the following changes were identified from FY 2020 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2021 to include all waivers (excluded the BI and SLP waivers during FY2020).
- Measure 20C, was a PA evaluation completed annually, was added for waiver enrollees who have a personal assistant (PA).
- Measure 12C, if the PA evaluation was not completed annually, was it completed within 60 days of the expected annual date, was added for waiver enrollees who have a PA.
- Measure 44C, did the enrollee report satisfaction with his/her PA, was added for waiver enrollees who have a PA.

Other performance measures had language revisions to ensure consistency with waiver language; those changes did not result in impact to comparisons to historic data.

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 in this methodology were selected in May 2020 and include waiver members enrolled as of May 1, 2020. Due to NextLevel's exit from the Illinois Medicaid managed care program at the end of FY 2020, the initial sample selected for NextLevel was redistributed to the other health plans to ensure that the waiver population was represented. Table 2.1 and Table 2.2 display the FY 2021 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	5,755	391	108	68	46	94	84
CountyCare	4,275	327	72	85	76	72	28
IlliniCare	4,304	296	75	55	46	75	51
Meridian	5,275	315	94	55	28	96	50
Molina	1,457	96	21	11	13	32	22
Statewide Total	**21,503**	**1,457**	**370**	**274**	**209**	**369**	**235**

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	11,077	511	125	69	56	118	151
CountyCare	4,551	214	59	58	39	46	18
IlliniCare	7,071	318	83	55	26	80	80
Meridian	7,160	331	83	52	38	83	83
Molina	2,391	102	28	11	11	36	19
Statewide Total	**33,076**	**1,507**	**378**	**245**	**170**	**363**	**351**

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 2021 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2019 – May 31, 2020
- Quarter 2, SFY 2021: March 1, 2020 – August 31, 2020
- Quarter 3, SFY 2021: June 1, 2020 – November 30, 2020
- Quarter 4, SFY 2021: September 1, 2020 – February 28, 2021

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 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%.

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 completed 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 SFY 2021

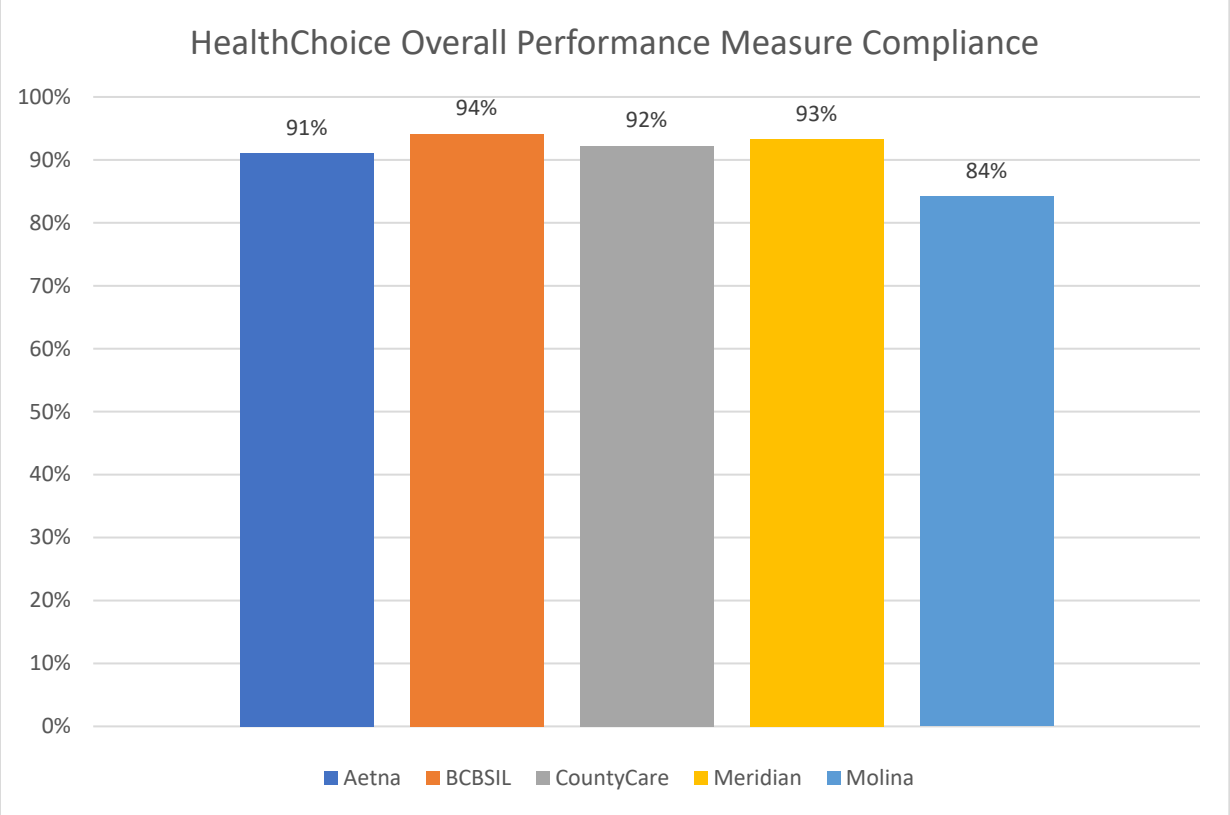
Overall Performance

Overall Health Plan Performance and Comparisons

Five health plans were reviewed during SFY 2021. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 18 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 18 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.

Four of the five health plans averaged greater than 90 percent compliance in SFY 2021. There was a 10-percentage point difference (84% 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.
- Meridian performed at a statistically significant higher rate than CountyCare.
- Molina performed at a statistically significant lower rate than all other health plans.
- Aetna performed at a statistically significant lower rate than BCBSIL, CountyCare, and Meridian.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2021. Comparisons for overall performance from SFY 2020 to SFY 2021 were not completed, as the total number of performance measures reviewed was different in each fiscal year. 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)

Analysis identified that BCBSIL performed at 90 percent or greater compliance in 14 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, BCBSIL realized a statistically significant increase in two performance measures. When SFY 2021 performance was compared to SFY 2020, BCBSIL realized a statistically significant increase in five performance measures.

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 2 percent (2 of 89 records). BCBSIL also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 28 percent (20 of 72 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 76 percent (295 of 386 records).

CountyCare Health Plan (CountyCare)

Analysis identified that CountyCare performed at 90 percent or greater compliance in 13 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, CountyCare realized a statistically significant increase in overall performance as well as in three performance measures; CountyCare also demonstrated a statistically significant decrease in one measure. When SFY 2021 performance was compared to SFY 2020, CountyCare realized a statistically significant increase in seven performance measures.

Analysis identified that CountyCare's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 10 percent (8 of 82 records). CountyCare also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 21 percent (9 of 43 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 75 percent (242 of 323 records).

Aetna Better Health, previously IlliniCare Health Plan, Inc. (Aetna)

Analysis identified that Aetna performed at 90 percent or greater compliance in 12 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Aetna demonstrated a statistically significant decrease in overall performance as well as in five performance measures. When SFY 2021 performance was compared to SFY 2020, Aetna realized a statistically significant increase in one measure and demonstrated a statistically significant decrease in one measure.

Analysis identified that Aetna's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 20 percent (8 of 40 records). Aetna also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 32 percent (26 of 82 records), and 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 (495 of 602 records).

Meridian Health Plan, Inc. (Meridian)

Analysis identified that Meridian performed at 90 percent or greater compliance in 13 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Meridian realized a statistically significant increase in overall performance as well as in two performance measures. When SFY 2021 performance was compared to SFY 2020, Meridian realized a statistically significant increase in four performance measures.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 9 percent (9 of 97 records). Meridian also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 31 percent (22 of 72 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 68 percent (208 of 305 records).

Molina Healthcare of Illinois, Inc. (Molina)

Analysis identified that Molina performed at 90 percent or greater compliance in nine of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Molina realized a statistically significant increase in one performance measure. When SFY 2021 performance was compared to SFY 2020, Molina demonstrated stable performance.

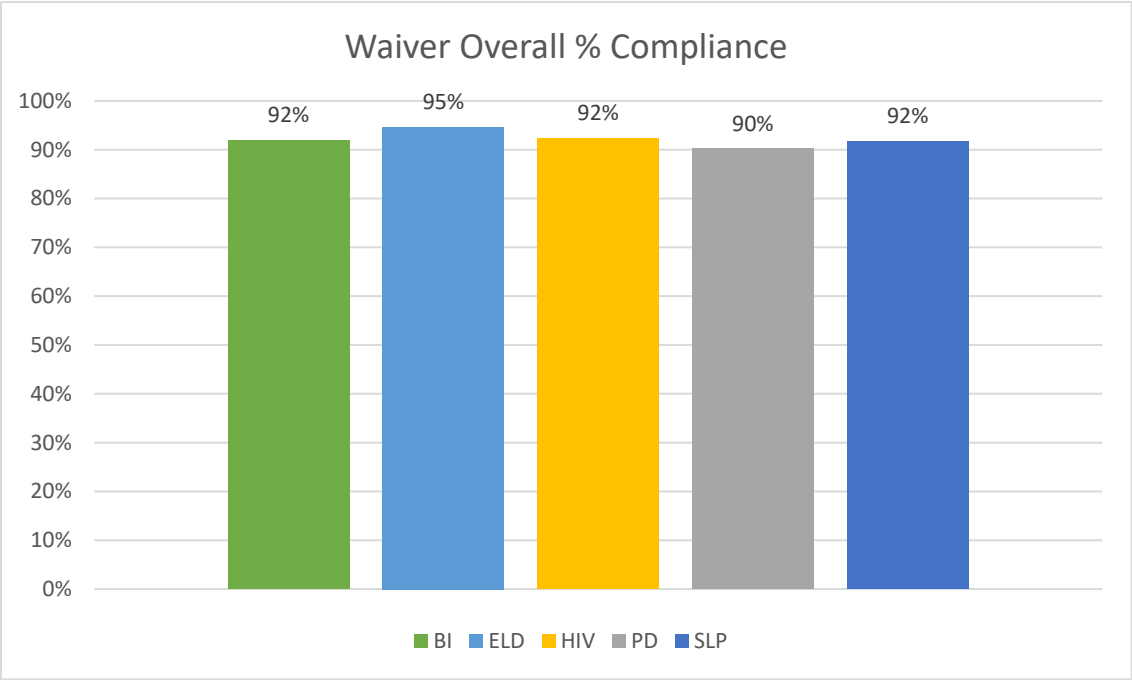
Analysis identified that Molina's greatest opportunity for improvement related to 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 0 percent (0 of 59 records). Molina also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 19 percent (6 of 31 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 39 percent (38 of 98 records).

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 90 percent or greater overall compliance in SFY 2021.

Figure 3.2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver's overall compliance from Q1 to Q4 SFY 2021. Comparisons for overall performance from SFY 2020 to SFY 2021 were not completed, as the total number of performance measures reviewed was different in each fiscal year. Individual waiver performance analysis identified the following.

BI Waiver

Fifteen performance measures are assessed for the BI waiver. Analysis identified that the BI waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the BI waiver realized a statistically significant increase in two performance measures; the BI waiver also demonstrated a statistically significant decrease in one measure. When SFY 2021 performance was compared to SFY 2020, the BI waiver realized a statistically significant increase in two performance measures.

Analysis identified that greatest opportunity for improvement for the BI waiver related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 3 percent (3 of 89 records). The BI waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 55 percent (11 of 20 records), and 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 68 percent (355 of 519 records).

ELD Waiver

Fifteen performance measures are assessed for the ELD waiver. Analysis identified that the ELD waiver performed at 90 percent or greater compliance in 12 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the ELD waiver realized a statistically significant increase in one performance measure. When SFY 2021 performance was compared to SFY 2020, the ELD waiver realized a statistically significant increase in three performance measures.

Analysis identified that greatest opportunity for improvement for the ELD waiver related to measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 26 percent (22 of 86 records). The ELD waiver 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 performed at a rate of 80 percent (586 of 731 records).

HIV Waiver

Fifteen performance measures are assessed for the HIV waiver. Analysis identified that the HIV waiver performed at 90 percent or greater compliance in 11 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the HIV waiver realized a statistically significant increase in two measures; the HIV waiver also demonstrated a statistically significant decrease in one measure. When SFY 2021 performance was compared to SFY 2020, the HIV waiver realized a statistically significant increase in three performance measures.

Analysis identified that greatest opportunity for improvement for the HIV waiver related to measure 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 66 percent (249 of 379 records). The HIV waiver also had opportunity for improvement in measure and 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 10 percent (6 of 61 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 81 percent (265 of 327 records).

PD Waiver

Fifteen performance measures are assessed for the PD waiver. Analysis identified that the PD waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the PD waiver demonstrated stable performance. When SFY 2021 performance was compared to SFY 2020, the PD waiver realized a statistically significant increase in two performance measures.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 8 percent (18 of 217 records). The PD waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 29 percent (23 of 80 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 64 percent (400 of 622 records).

SLP Waiver

Ten performance measures are assessed for the SLP waiver. Analysis identified that the SLP waiver performed at 90 percent or greater compliance in eight of the 10 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the SLP waiver demonstrated a statistically significant decrease in overall performance and one performance measure. When SFY 2021 performance was compared to SFY 2020, the SLP waiver demonstrated stable performance.

Analysis identified that greatest opportunity for improvement for the SLP waiver related to measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 21 percent (21 of 102 records). The SLP waiver also had opportunity for improvement in measure 37D: the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 81 percent (472 of 586 records).

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	FY2021
4A	*Overdue service plan was completed within 30 days of expected renewal.*	33% (1/3)	NA (0/0)	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)	100% (28/28)
32D	*The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)	96% (27/28)
33D	*The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.*	92% (12/13)	91% (20/22)	100% (28/28)
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)	100% (28/28)
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)	100% (28/28)
38D	*The service plan was updated when the enrollee needs changed.*	0% (0/1)	NA (0/0)	100% (3/3)
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)	100% 28/28)
41D	*The enrollee has been given the opportunity to participate in choosing types of services and providers.*	92% (12/13)	59% (13/22)	96% (27/28)
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)	93% (26/28)

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 2021 Analysis**	**Trend Analysis to SFY 2020**
4A *Overdue service plan was completed within 30 days of expected renewal.*	Overall, this measure demonstrated stable performance from Q1 to Q4. Compared to Q1, Molina realized a statistically significant increase in performance in Q4.	Comparisons between SFY 2020 and SFY 2021 were unable to be made as the waiver types applicable to this measure changed in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
	This measure was one of the lowest performing, performing at a rate of 28% over SFY 2021.	
12C *If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.* (Captured for only enrollees with PA service)	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. Compared to Q1, CountyCare realized a statistically significant increase in performance in Q4. This measure was one of the lowest performing, performing at a rate of 7% over SFY 2021.	New measure in SFY 2021.
20C *A PA evaluation was completed annually.* (Captured for only enrollees with PA service)	Overall, this measure demonstrated stable performance from Q1 to Q4. This measure was one of the lowest performing, performing at a rate of 73% over SFY 2021.	New measure in SFY 2021.
31D *The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.*	Overall, this measure demonstrated stable performance from Q1 to Q4. Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL and CountyCare realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the PD waiver realized a statistically significant increase in this measure in SFY 2021.
32D *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL realized a statistically significant increase in this measure in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
33D *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
35D *The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.*	Overall, this measure demonstrated a statistically significant decrease in performance from Q1 to Q4. Compared to Q1, Aetna and CountyCare demonstrated a statistically significant decrease in this measure in Q4. Compared to Q1, the BI and HIV waiver demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.
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.* *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 realized a statistically significant increase in performance from Q1 to Q4. Meridian realized a statistically significant increase in performance from Q1 to Q4. The HIV waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, Aetna, BCBSIL, CountyCare, and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the BI, ELD, and HIV waiver realized a statistically significant increase in this measure in SFY 2021.
37D *The most recent care/service plan is in the record and completed in a*	Overall, this measure demonstrated a statistically significant decrease in performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
timely manner. (Completed within 12 months from review date)	Compared to Q1, Aetna and BCBSIL demonstrated a statistically significant decrease in this measure in Q4. Compared to Q1, the SLP waiver demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, Aetna demonstrated a statistically significant decrease in this measure in SFY 2021. Compared to SFY 2020, CountyCare realized a statistically significant increase in this measure in SFY 2021.
38D *The care/service plan was updated when the enrollee needs changed.*	Overall, this measure demonstrated stable performance from Q1 to Q4. Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4. Compared to Q1, BCBSIL realized a statistically significant increase in this measure in Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.
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. Compared to Q1, BCBSIL and CountyCare realized a statistically significant increase in performance in Q4. Compared to Q1, the BI and HIV waiver realized a statistically significant increase in performance in Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL, CountyCare, and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the BI, ELD, HIV, and PD waiver realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
41D *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
	Meridian realized a statistically significant increase in performance from Q1 to Q4. The ELD waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2020, CountyCare realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the ELD waiver realized a statistically significant increase in this measure in SFY 2021.
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. Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, CountyCare realized a statistically significant increase in this measure in SFY 2021.
44C *The enrollee reported satisfaction with his/her PA.* (Captured for only enrollees with PA service)	Overall, this measure demonstrated stable performance from Q1 to Q4.	New measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
49G *(ELD, BI, HIV, PD Waivers)* *The most recent service plan includes a backup plan that includes the name of the backup.*	Overall, this measure demonstrated stable performance from Q1 to Q4. CountyCare realized a statistically significant increase in performance from Q1 to Q4. Compared to Q1, the BI waiver realized a statistically significant increase in performance in Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, CountyCare and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the HIV waiver realized a statistically significant increase in this measure in SFY 2021.

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 28 percent compliance during SFY 2021.
- Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, which performed at a rate of 7 percent compliance during SFY 2021.
- Measure 20C, *a PA evaluation was completed annually*, which performed at a rate of 73 percent compliance during SFY 2021.

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 68 percent and 66 percent compliance, respectively, during SFY 2021.

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.

Measures 12C and 20C

Measures 12C and 20C collect information related to the health plan's success in completing annual PA evaluation documentation timely. Measure 20C identifies whether the PA evaluation has been completed annually. Measure 12C measures whether the PA evaluation was completed within 60 days of that expected completion, if overdue. Performance on the measure does not indicate that a PA evaluation was never completed; the evaluation criteria limits performance only to those records that have completion within 60 days (e.g., a PA evaluation completed on day 61 is non-compliant for the measure).

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual PA evaluations in a timely manner. Health plans should also make efforts to ensure that overdue PA evaluations are completed within 60 days of expected

completion, if overdue. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely PA evaluation completions.

Measure 36D

Performance on measure 36D represented a statistically significant increase in SFY 2021 and when SFY 2021 performance is compared against SFY 2020. During SFY 2021, performance on measure 36D for the BI waiver resulted in a rate of 71 percent. Performance related to the HIV waiver resulted in a rate of 72 percent. Results for both waiver types represented a statistically significant increase when SFY 2021 performance is compared against SFY 2020.

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 2021, 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: HealthChoice

Health Plan	Cases Reviewed Q2 (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	12/14	9/9
CountyCare	11/11	19/19
Aetna (IlliniCare)	14/14	19/19
Meridian	16/16	12/12
Molina	9/9	14/14

Table 3.5 – Health Plans Remediation Validation Review Totals: MLTSS

Health Plan	Cases Reviewed Q2* (Compliant/Total Cases)	Cases Reviewed Q4 (Compliant/Total Cases)
BCBSIL	10/10	13/13
CountyCare	21/21	16/16
Aetna (IlliniCare)	18/18	13/13
Meridian	10/10	10/10
Molina	10/10	7/8

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 HealthChoice health plans cases averaged 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. BCBSIL did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. 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 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. Molina did not demonstrate 100 percent compliance; non-compliant remediation validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2022 and will include review of any records that were found to be not fully remediated during the SFY 2021 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

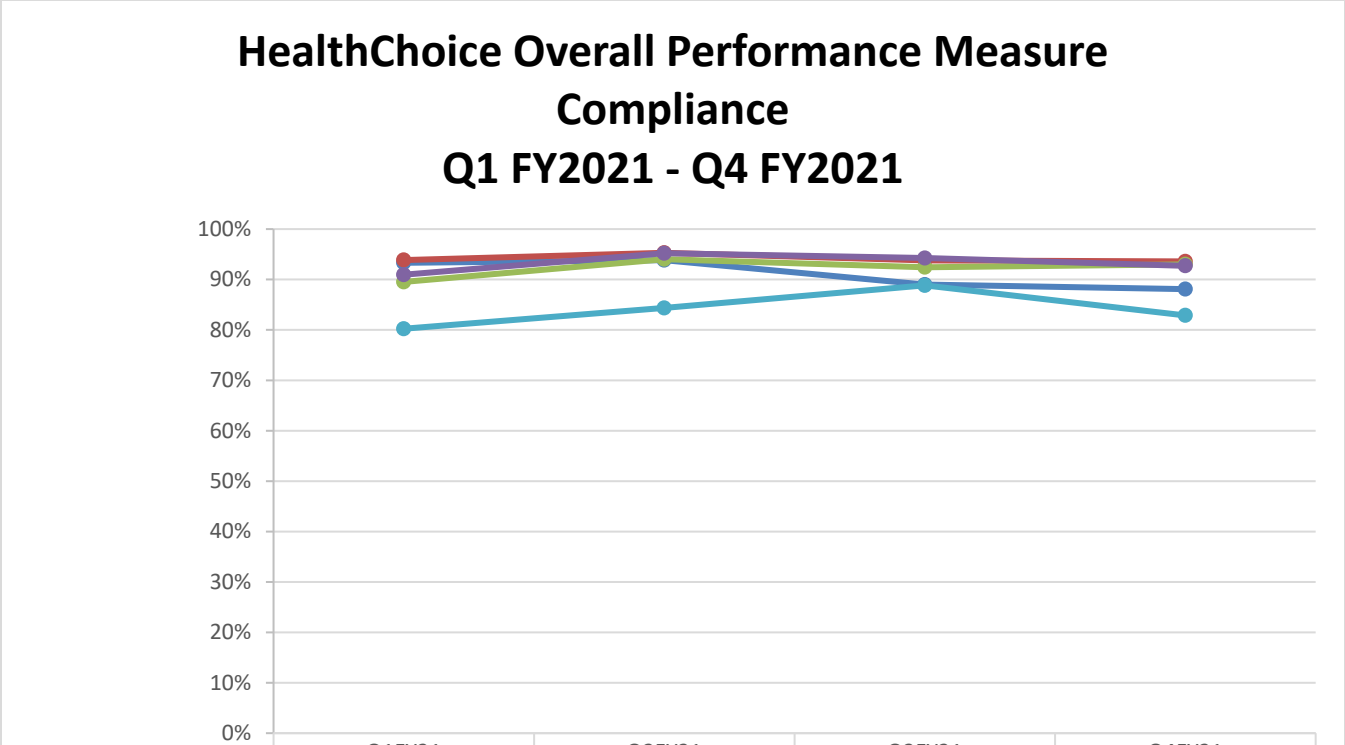
Measure #	Measure Description
4A	Overdue Service Plan was completed within 30 days of expected renewal.
12C	If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date. Captured for only enrollees with PA service
20C	A PA evaluation was completed annually. Captured for only enrollees with PA service
31D	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
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), Case Manager, and SLP provider (if applicable) 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 or upon enrollee request.
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.
44C	The enrollee reported satisfaction with his/her PA. Captured for only enrollees with PA service

Measure #	Measure Description
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 18 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 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.1 – Overall Compliance



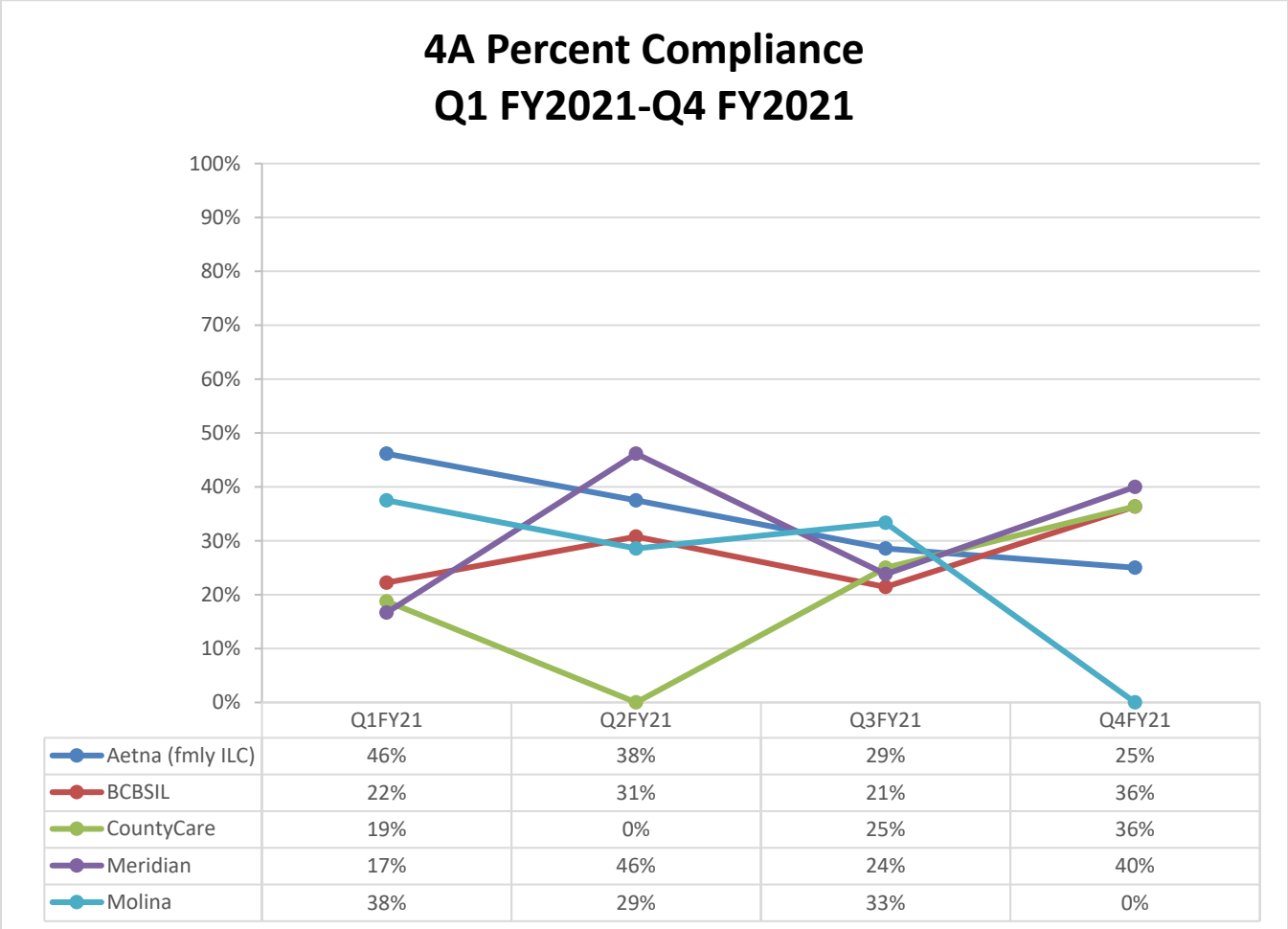
	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	93%	94%	89%	88%
BCBSIL	94%	95%	94%	94%
CountyCare	90%	94%	92%	93%
Meridian	91%	95%	94%	93%
Molina	80%	84%	89%	83%

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal.

Due to changes in performance measure definitions in FY 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.2 – Measure 4A

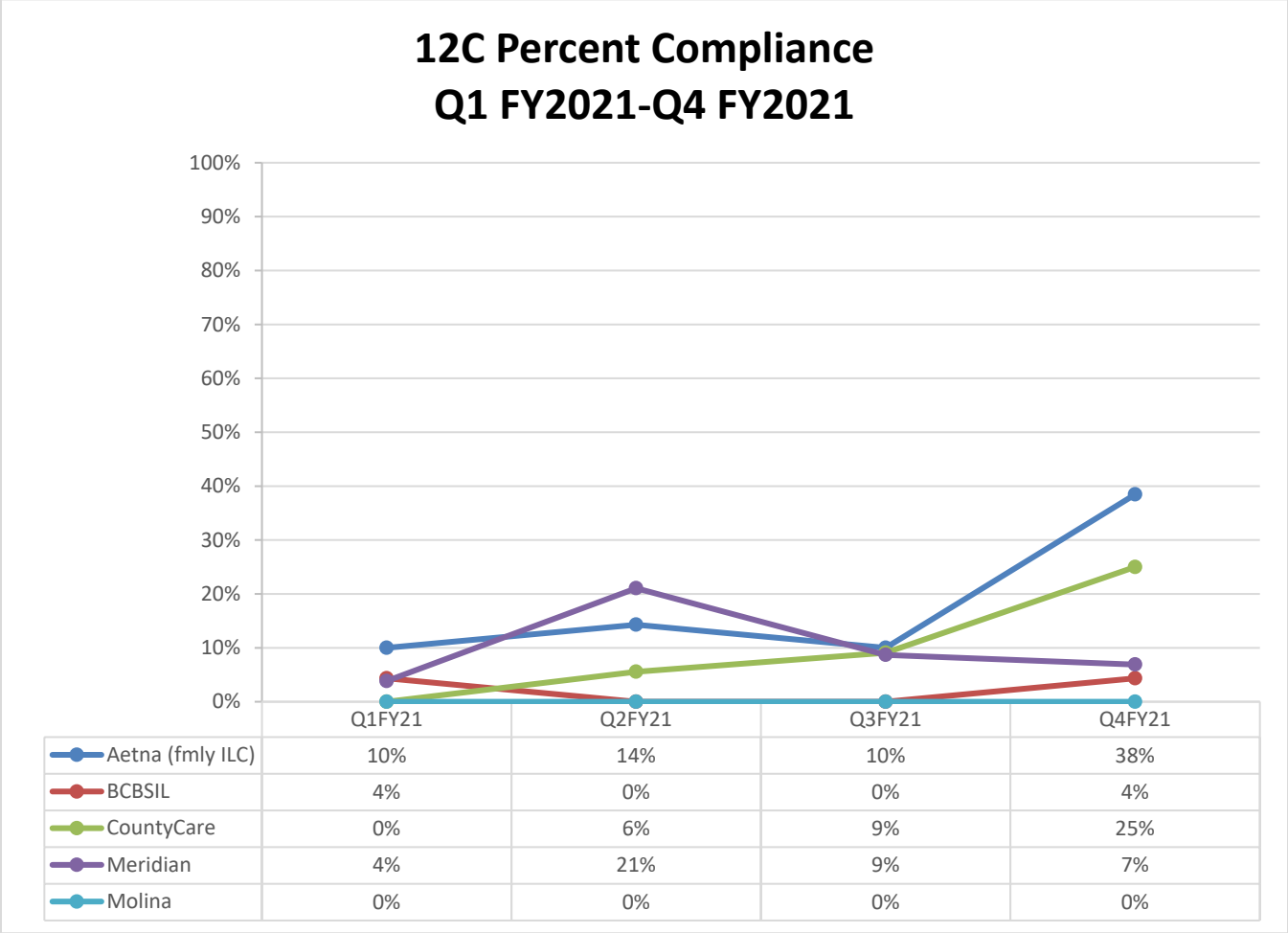


	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	46%	38%	29%	25%
BCBSIL	22%	31%	21%	36%
CountyCare	19%	0%	25%	36%
Meridian	17%	46%	24%	40%
Molina	38%	29%	33%	0%

Measure 12C - If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.

New measure beginning FY 2021.

Figure B.3 – Measure 12C

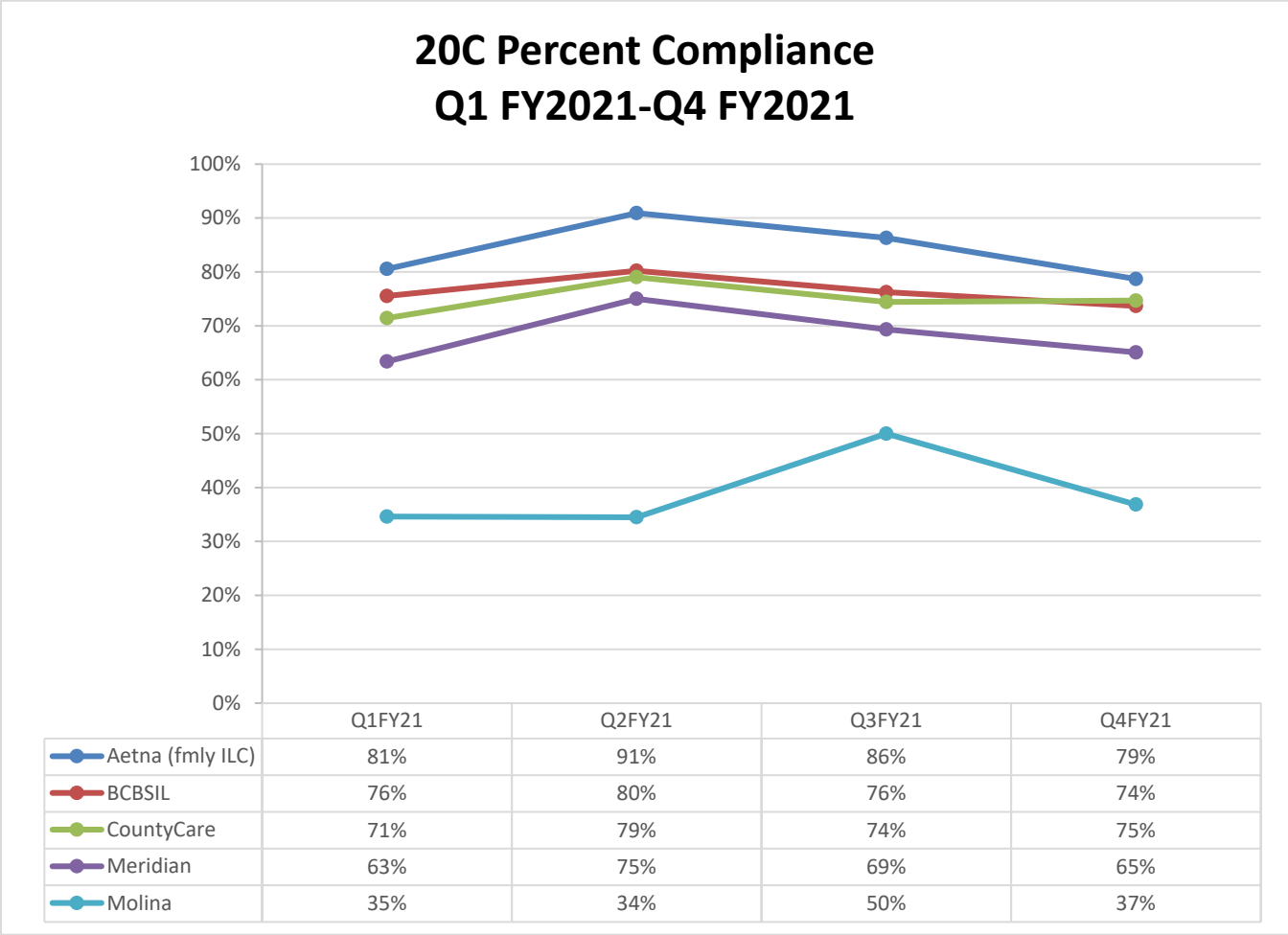


	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	10%	14%	10%	38%
BCBSIL	4%	0%	0%	4%
CountyCare	0%	6%	9%	25%
Meridian	4%	21%	9%	7%
Molina	0%	0%	0%	0%

Measure 20C - A PA evaluation was completed annually.

New measure beginning FY 2021.

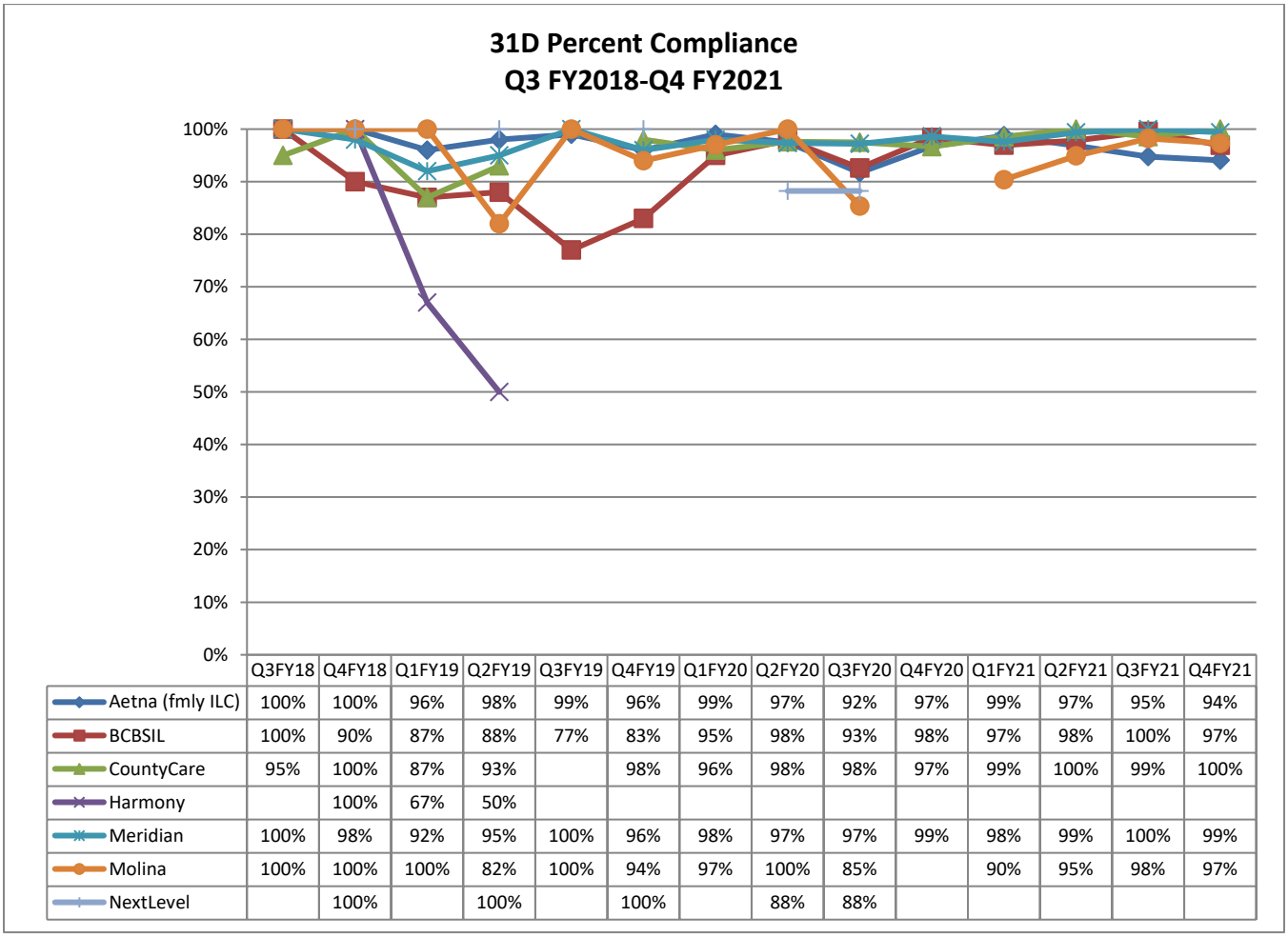
Figure B.4 – Measure 20C



	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	81%	91%	86%	79%
BCBSIL	76%	80%	76%	74%
CountyCare	71%	79%	74%	75%
Meridian	63%	75%	69%	65%
Molina	35%	34%	50%	37%

Measure 31D - The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B.5 – Measure 31D

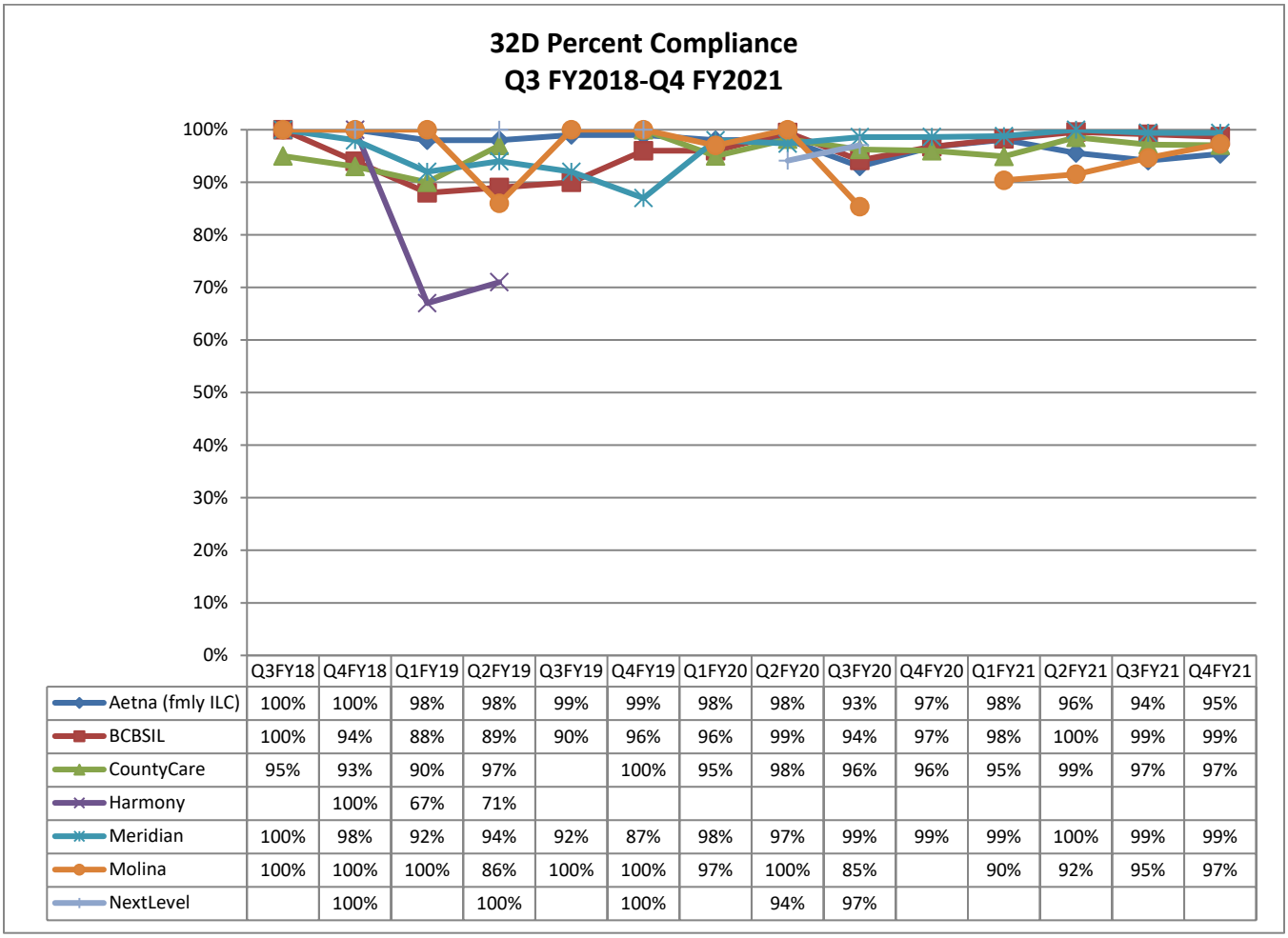


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	96%	98%	99%	96%	99%	97%	92%	97%	99%	97%	95%	94%
BCBSIL	100%	90%	87%	88%	77%	83%	95%	98%	93%	98%	97%	98%	100%	97%
CountyCare	95%	100%	87%	93%		98%	96%	98%	98%	97%	99%	100%	99%	100%
Harmony		100%	67%	50%										
Meridian	100%	98%	92%	95%	100%	96%	98%	97%	97%	99%	98%	99%	100%	99%
Molina	100%	100%	100%	82%	100%	94%	97%	100%	85%		90%	95%	98%	97%
NextLevel		100%		100%		100%		88%	88%					

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 health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B.6 – Measure 32D

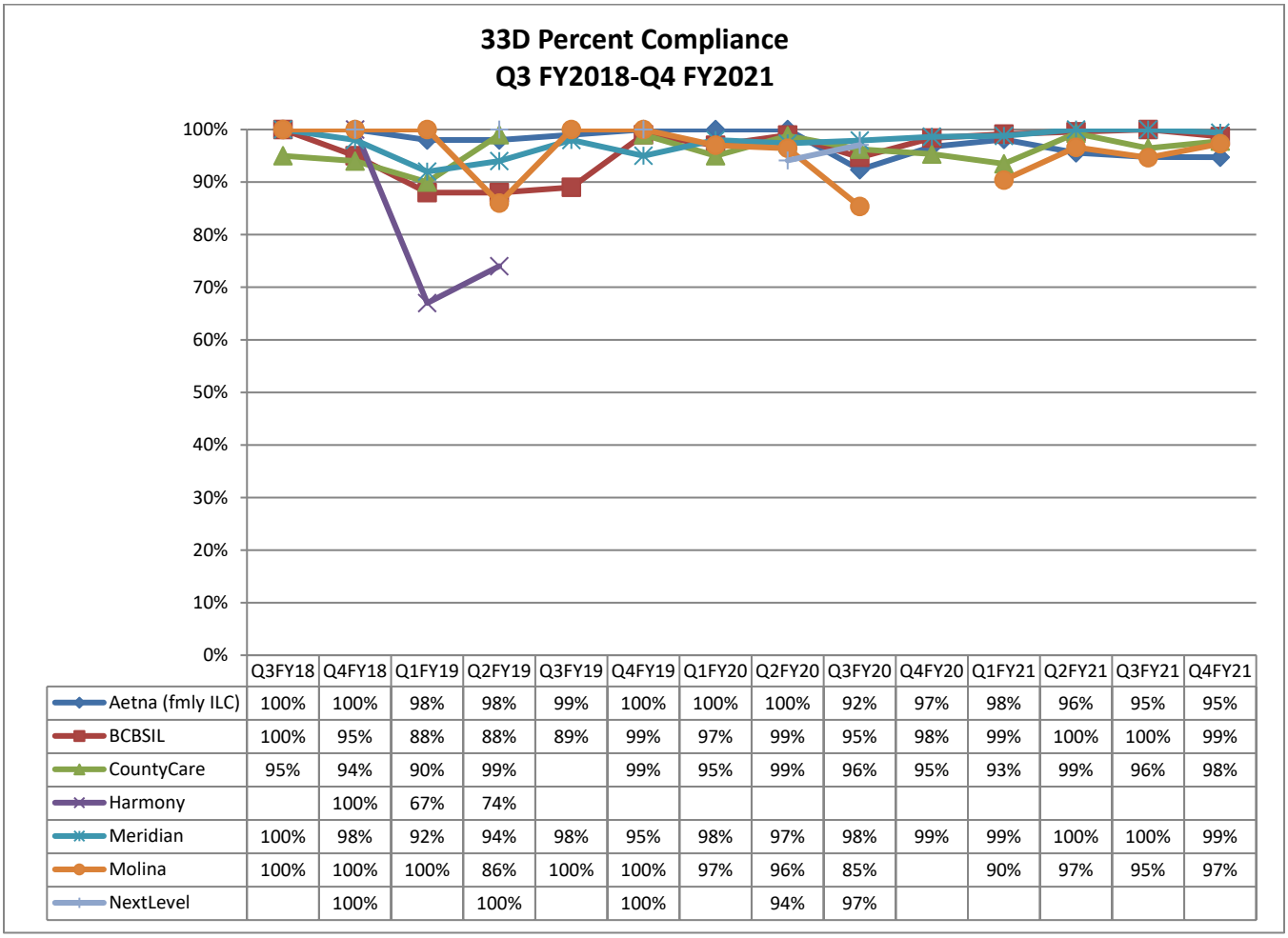


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	98%	98%	99%	99%	98%	98%	93%	97%	98%	96%	94%	95%
BCBSIL	100%	94%	88%	89%	90%	96%	96%	99%	94%	97%	98%	100%	99%	99%
CountyCare	95%	93%	90%	97%		100%	95%	98%	96%	96%	95%	99%	97%	97%
Harmony		100%	67%	71%										
Meridian	100%	98%	92%	94%	92%	87%	98%	97%	99%	99%	99%	100%	99%	99%
Molina	100%	100%	100%	86%	100%	100%	97%	100%	85%		90%	92%	95%	97%
NextLevel		100%		100%		100%		94%	97%					

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 health risk assessment including issues or barriers or ways to reduce the risks.

Figure B.7 – Measure 33D

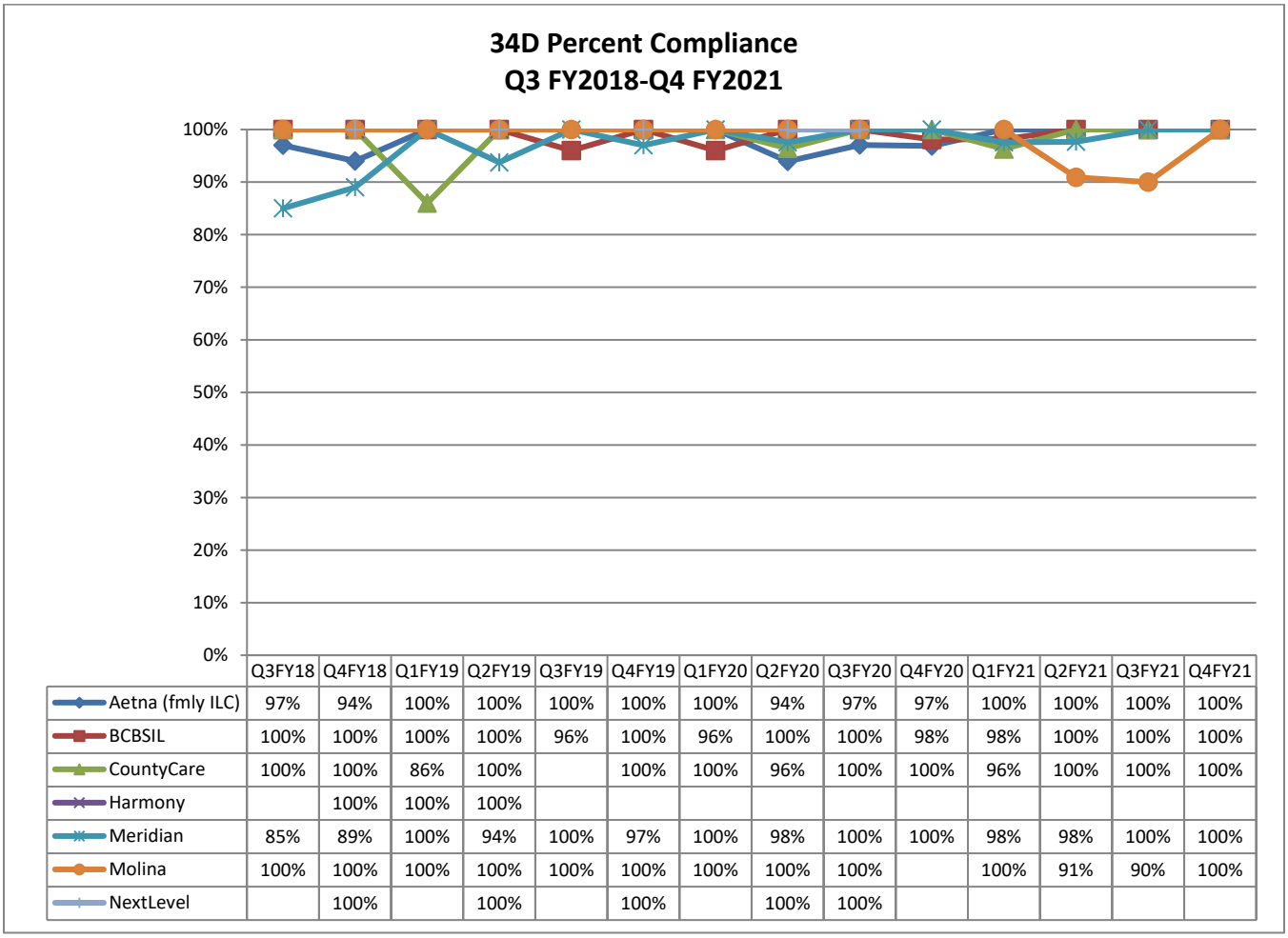


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	98%	98%	99%	100%	100%	100%	92%	97%	98%	96%	95%	95%
BCBSIL	100%	95%	88%	88%	89%	99%	97%	99%	95%	98%	99%	100%	100%	99%
CountyCare	95%	94%	90%	99%		99%	95%	99%	96%	95%	93%	99%	96%	98%
Harmony		100%	67%	74%										
Meridian	100%	98%	92%	94%	98%	95%	98%	97%	98%	99%	99%	100%	100%	99%
Molina	100%	100%	100%	86%	100%	100%	97%	96%	85%		90%	97%	95%	97%
NextLevel		100%		100%		100%		94%	97%					

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.8 – Measure 34D

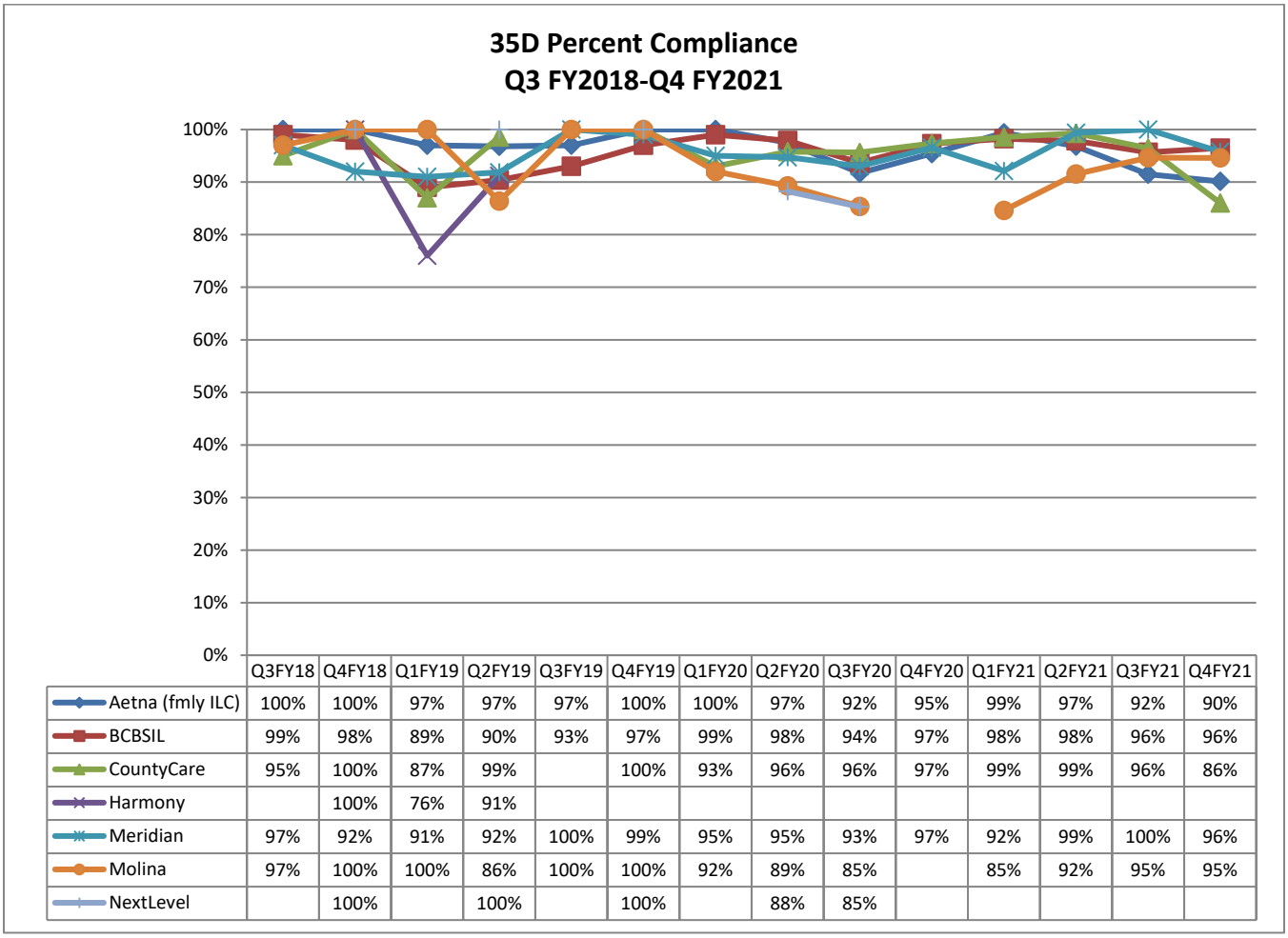


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	97%	94%	100%	100%	100%	100%	100%	94%	97%	97%	100%	100%	100%	100%
BCBSIL	100%	100%	100%	100%	96%	100%	96%	100%	100%	98%	98%	100%	100%	100%
CountyCare	100%	100%	86%	100%		100%	100%	96%	100%	100%	96%	100%	100%	100%
Harmony		100%	100%	100%										
Meridian	85%	89%	100%	94%	100%	97%	100%	98%	100%	100%	98%	98%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	91%	90%	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.

Measure 35D - The most recent service plan includes signature of enrollee (or representative) and case manager, and dates of signatures.

Figure B.9 – Measure 35D



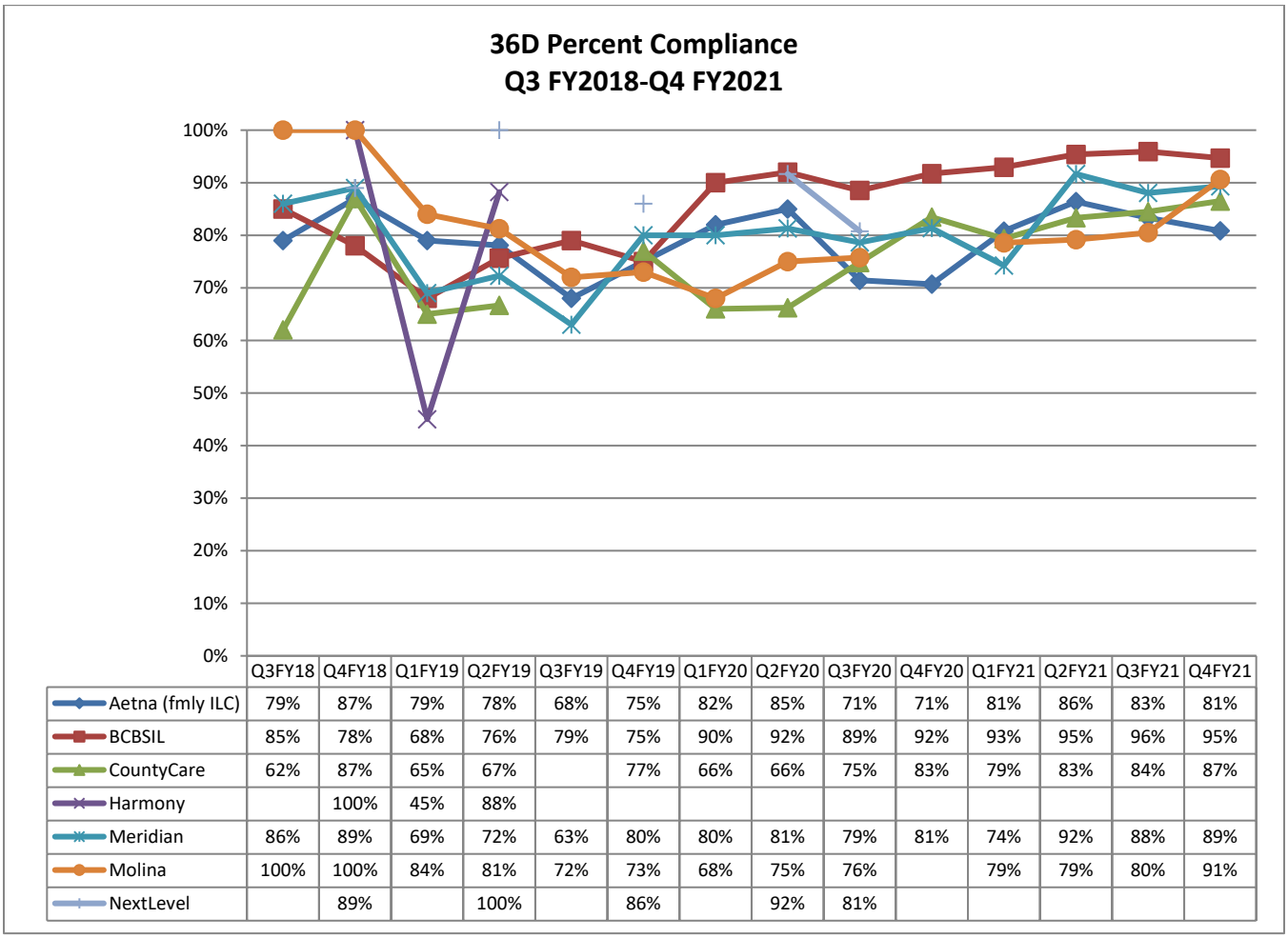
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	97%	97%	97%	100%	100%	97%	92%	95%	99%	97%	92%	90%
BCBSIL	99%	98%	89%	90%	93%	97%	99%	98%	94%	97%	98%	98%	96%	96%
CountyCare	95%	100%	87%	99%		100%	93%	96%	96%	97%	99%	99%	96%	86%
Harmony		100%	76%	91%										
Meridian	97%	92%	91%	92%	100%	99%	95%	95%	93%	97%	92%	99%	100%	96%
Molina	97%	100%	100%	86%	100%	100%	92%	89%	85%		85%	92%	95%	95%
NextLevel		100%		100%		100%		88%	85%					

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.10 – Measure 36D



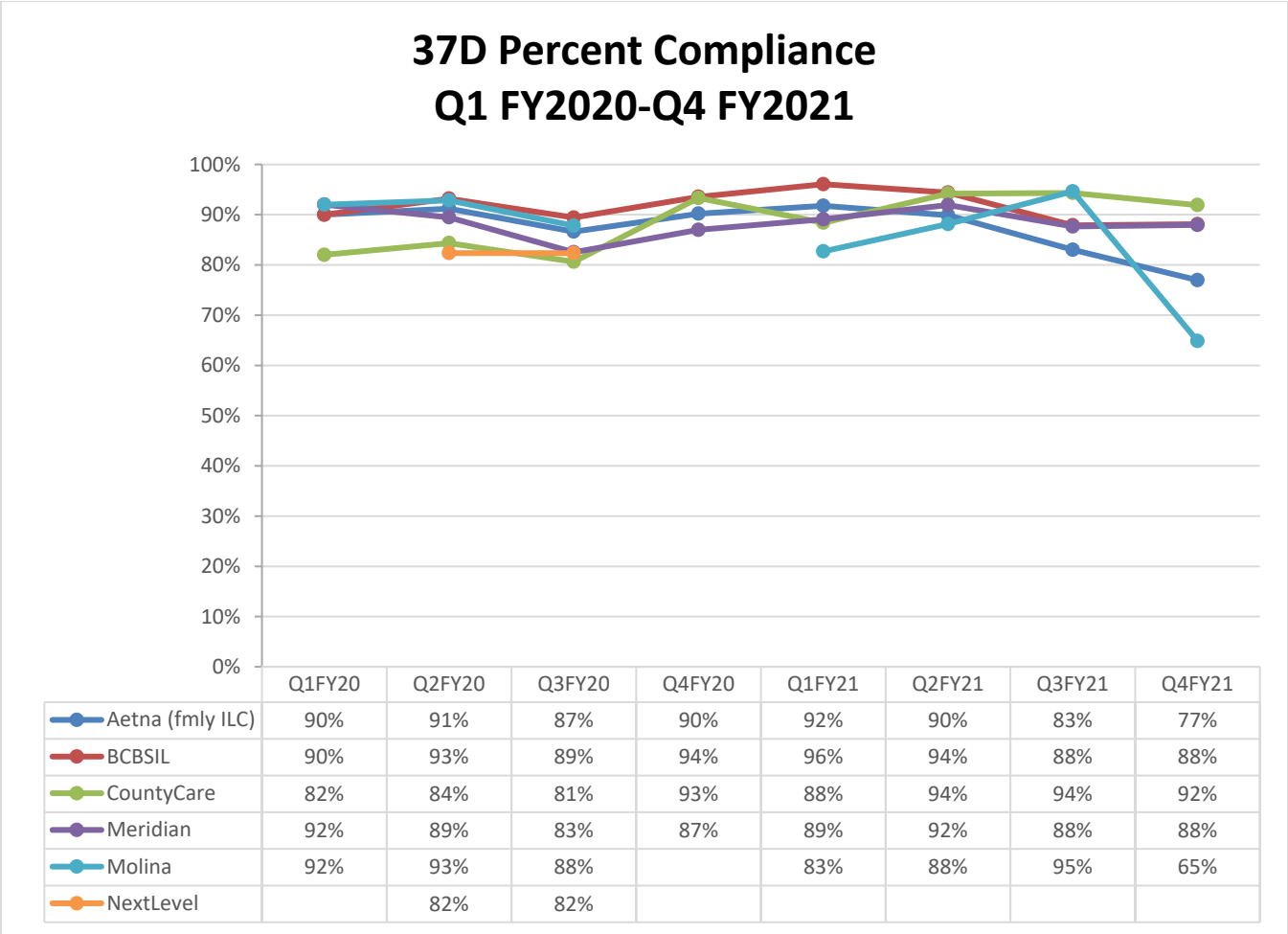
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	79%	87%	79%	78%	68%	75%	82%	85%	71%	71%	81%	86%	83%	81%
BCBSIL	85%	78%	68%	76%	79%	75%	90%	92%	89%	92%	93%	95%	96%	95%
CountyCare	62%	87%	65%	67%		77%	66%	66%	75%	83%	79%	83%	84%	87%
Harmony		100%	45%	88%										
Meridian	86%	89%	69%	72%	63%	80%	80%	81%	79%	81%	74%	92%	88%	89%
Molina	100%	100%	84%	81%	72%	73%	68%	75%	76%		79%	79%	80%	91%
NextLevel		89%		100%		86%		92%	81%					

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 and FY 2021 data is displayed.

Figure B.11 – Measure 37D

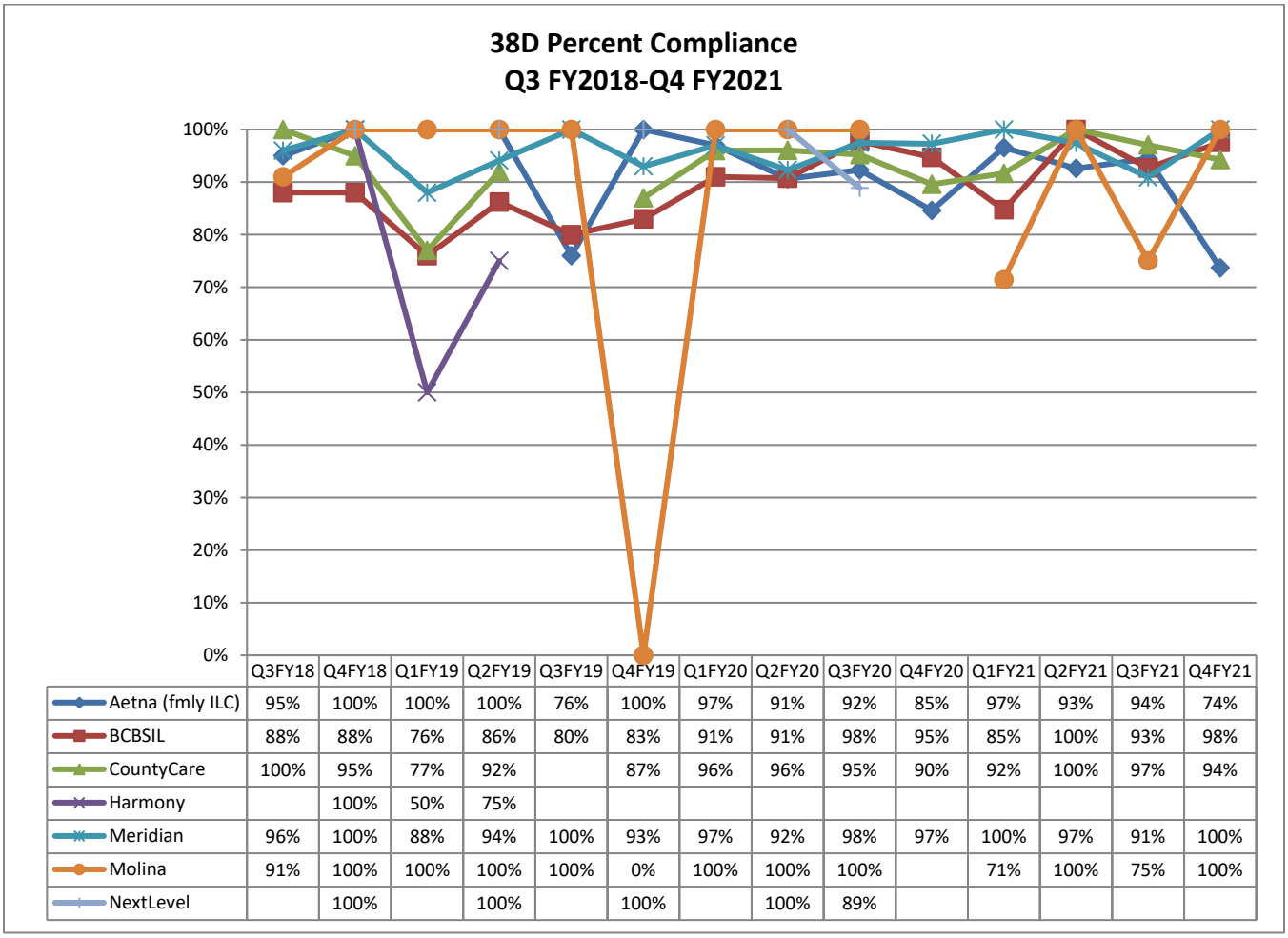


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	90%	91%	87%	90%	92%	90%	83%	77%
BCBSIL	90%	93%	89%	94%	96%	94%	88%	88%
CountyCare	82%	84%	81%	93%	88%	94%	94%	92%
Meridian	92%	89%	83%	87%	89%	92%	88%	88%
Molina	92%	93%	88%		83%	88%	95%	65%
NextLevel		82%	82%					

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 or upon enrollee request.

Figure B.12 – Measure 38D

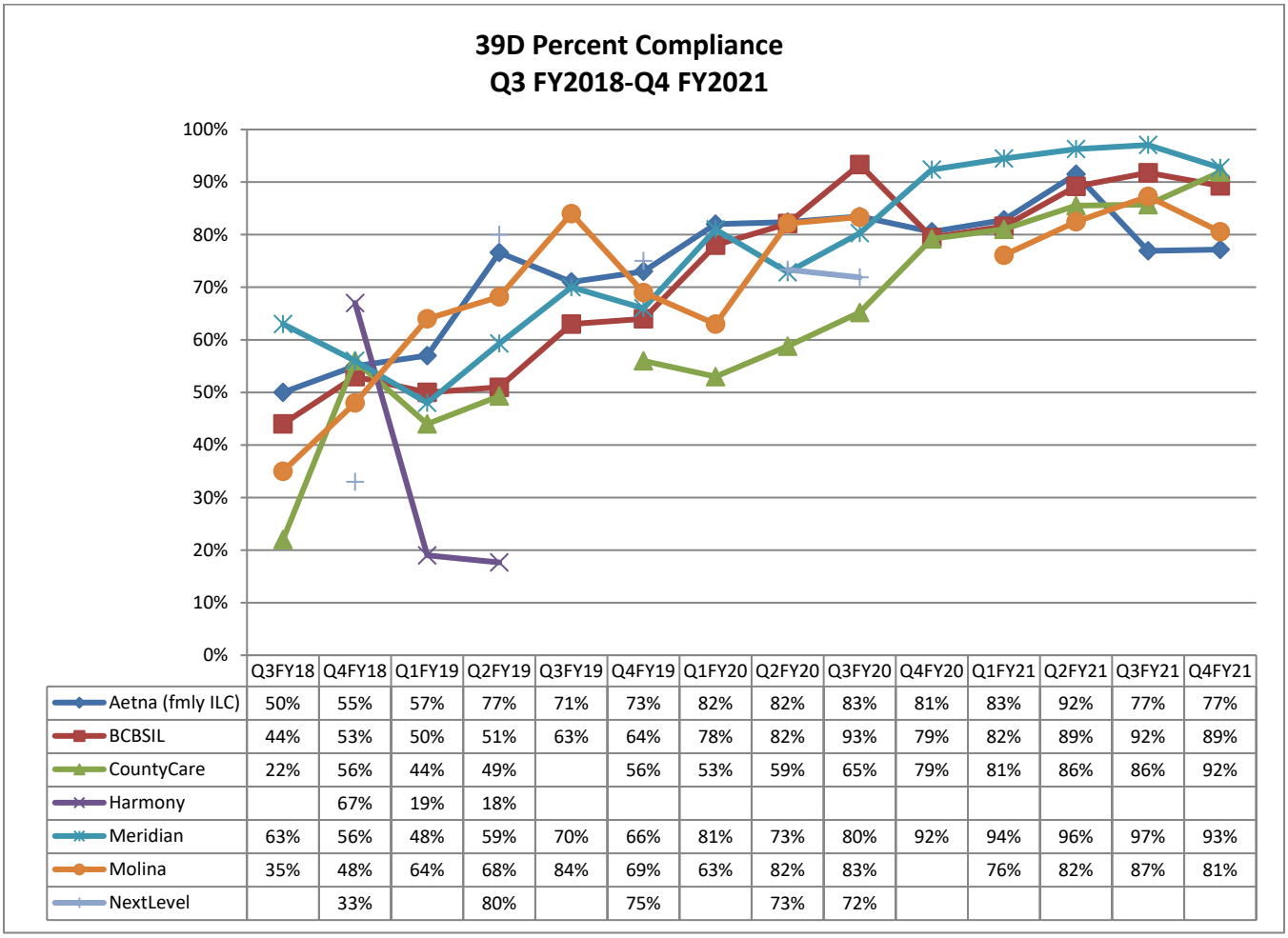


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	95%	100%	100%	100%	76%	100%	97%	91%	92%	85%	97%	93%	94%	74%
BCBSIL	88%	88%	76%	86%	80%	83%	91%	91%	98%	95%	85%	100%	93%	98%
CountyCare	100%	95%	77%	92%		87%	96%	96%	95%	90%	92%	100%	97%	94%
Harmony		100%	50%	75%										
Meridian	96%	100%	88%	94%	100%	93%	97%	92%	98%	97%	100%	97%	91%	100%
Molina	91%	100%	100%	100%	100%	0%	100%	100%	100%		71%	100%	75%	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.

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.13 – Measure 39D

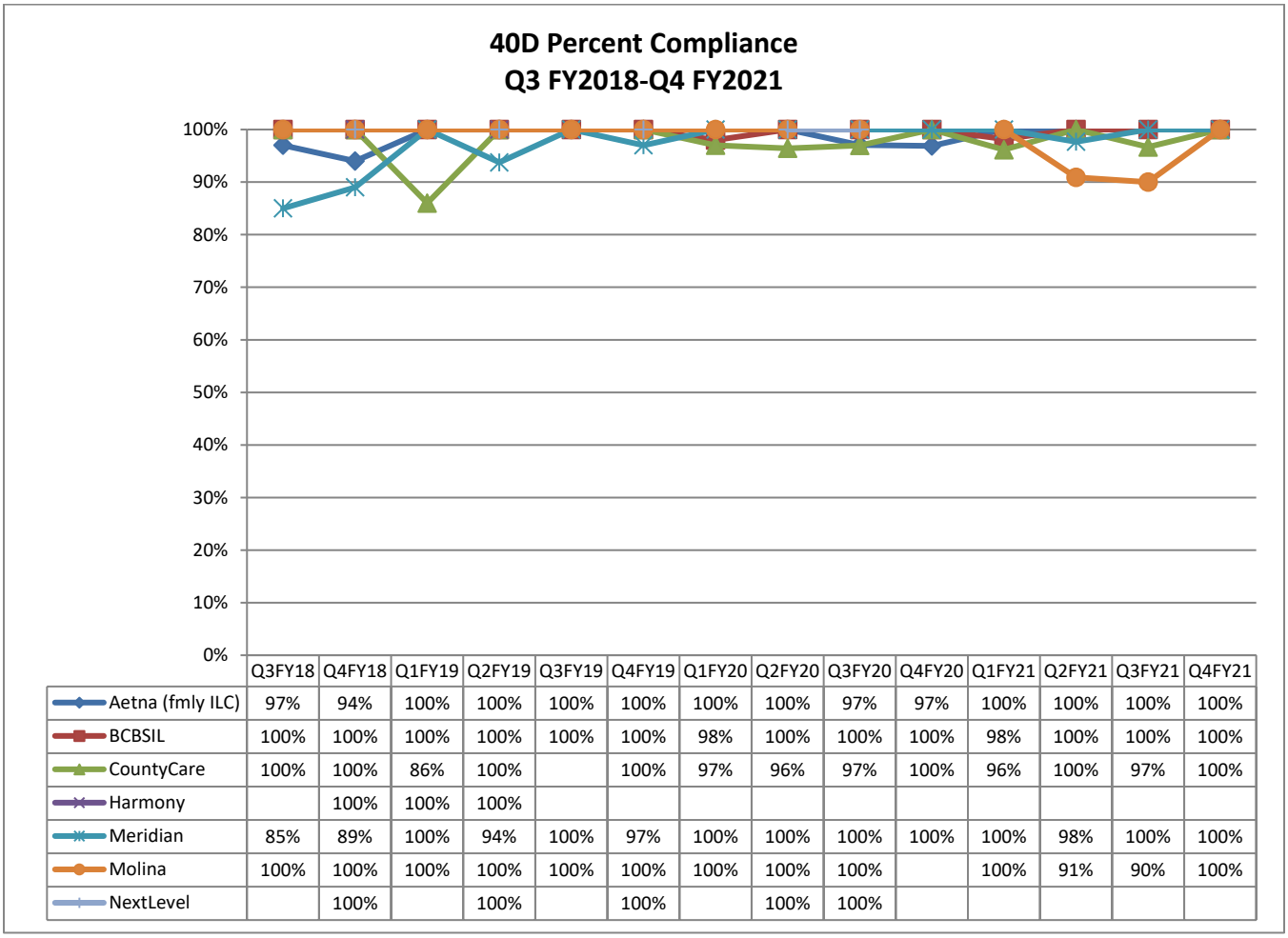


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	50%	55%	57%	77%	71%	73%	82%	82%	83%	81%	83%	92%	77%	77%
BCBSIL	44%	53%	50%	51%	63%	64%	78%	82%	93%	79%	82%	89%	92%	89%
CountyCare	22%	56%	44%	49%		56%	53%	59%	65%	79%	81%	86%	86%	92%
Harmony		67%	19%	18%										
Meridian	63%	56%	48%	59%	70%	66%	81%	73%	80%	92%	94%	96%	97%	93%
Molina	35%	48%	64%	68%	84%	69%	63%	82%	83%		76%	82%	87%	81%
NextLevel		33%		80%		75%		73%	72%					

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.14 – Measure 40D

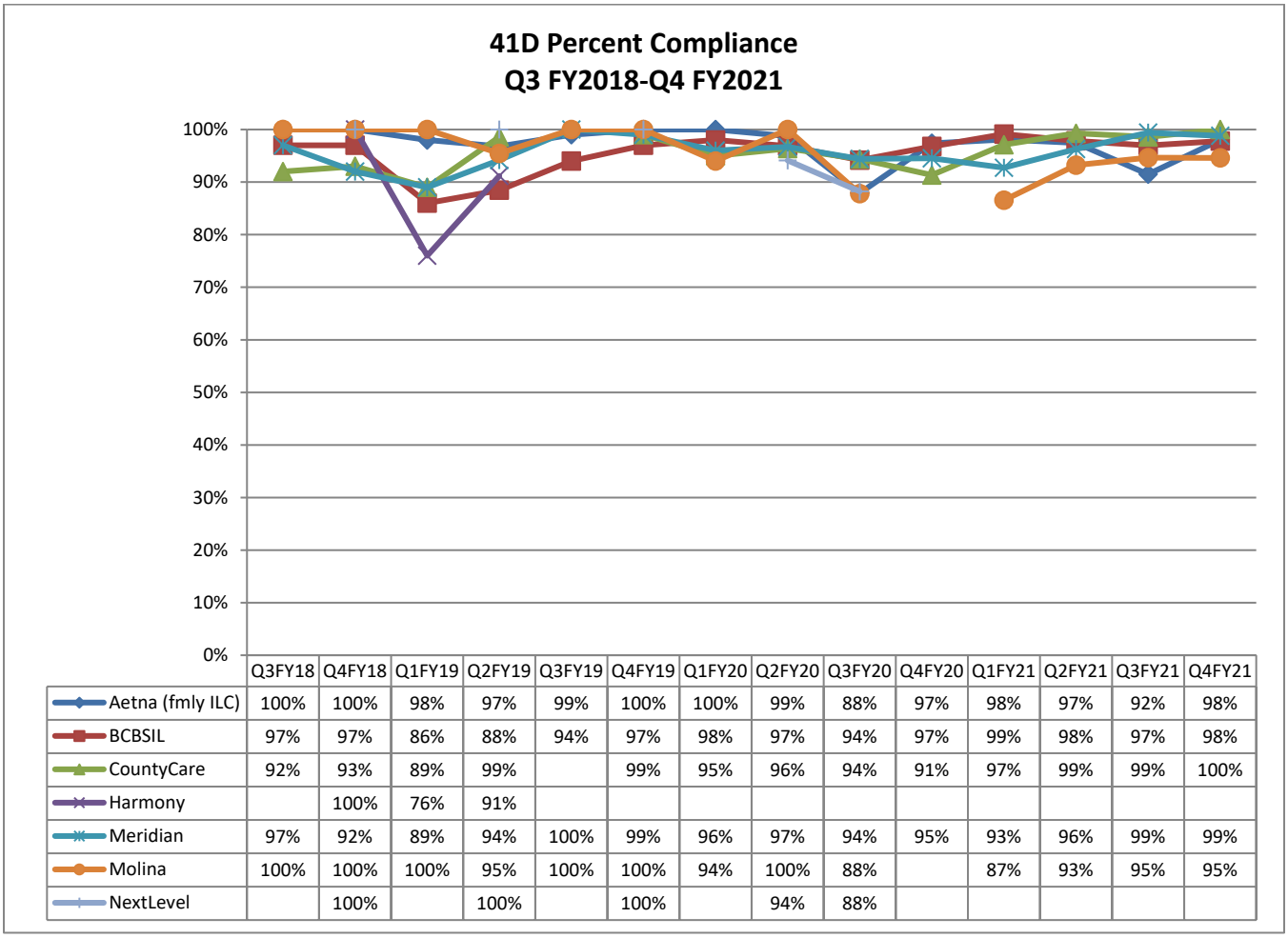


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	97%	94%	100%	100%	100%	100%	100%	100%	97%	97%	100%	100%	100%	100%
BCBSIL	100%	100%	100%	100%	100%	100%	98%	100%	100%	100%	98%	100%	100%	100%
CountyCare	100%	100%	86%	100%		100%	97%	96%	97%	100%	96%	100%	97%	100%
Harmony		100%	100%	100%										
Meridian	85%	89%	100%	94%	100%	97%	100%	100%	100%	100%	100%	98%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	100%		100%	91%	90%	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.

Measure 41D - The enrollee has been given the opportunity to participate in choosing types of services and providers.

Figure B.15 – Measure 41D

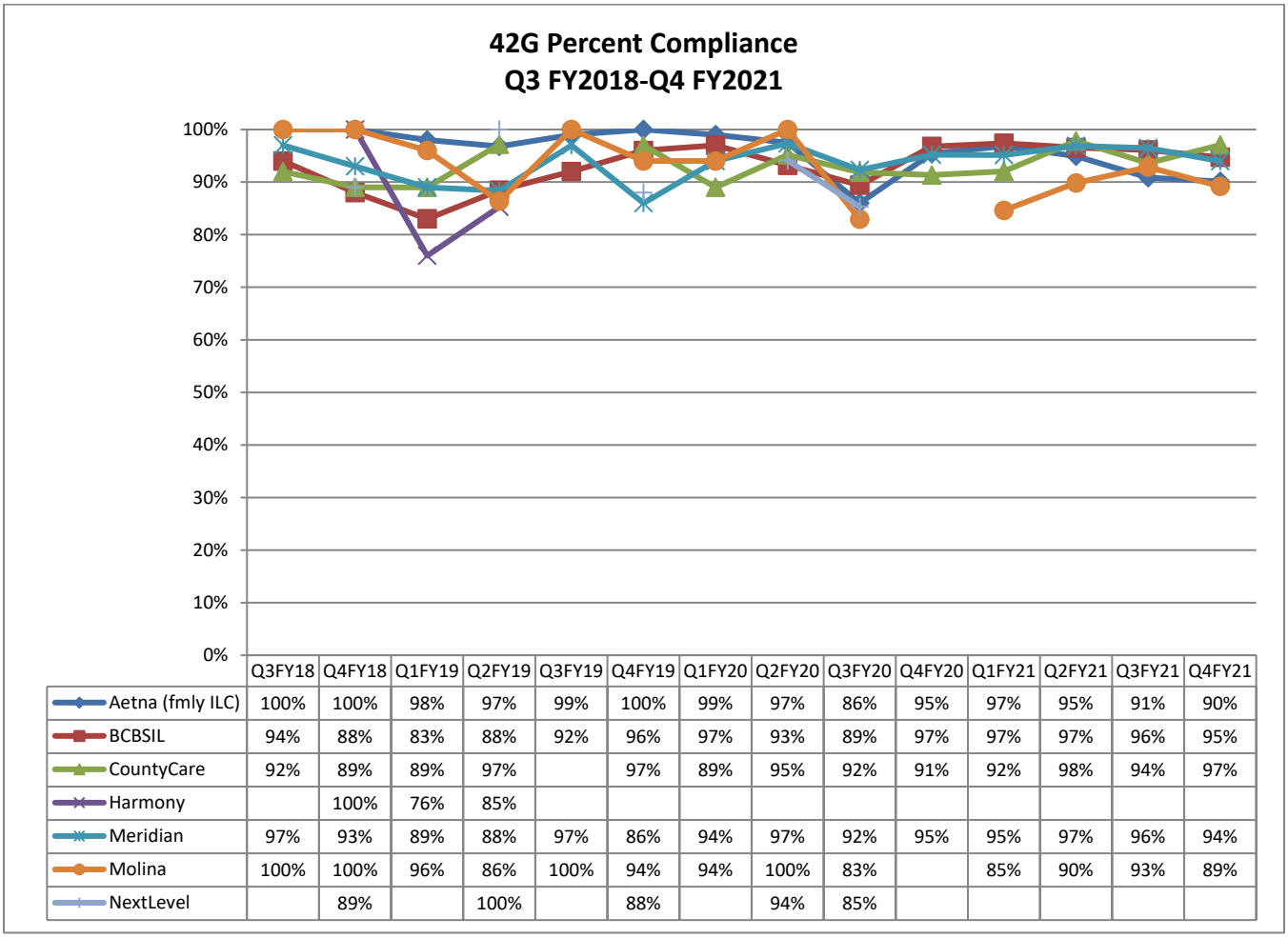


	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	98%	97%	99%	100%	100%	99%	88%	97%	98%	97%	92%	98%
BCBSIL	97%	97%	86%	88%	94%	97%	98%	97%	94%	97%	99%	98%	97%	98%
CountyCare	92%	93%	89%	99%		99%	95%	96%	94%	91%	97%	99%	99%	100%
Harmony		100%	76%	91%										
Meridian	97%	92%	89%	94%	100%	99%	96%	97%	94%	95%	93%	96%	99%	99%
Molina	100%	100%	100%	95%	100%	100%	94%	100%	88%		87%	93%	95%	95%
NextLevel		100%		100%		100%		94%	88%					

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.16 – Measure 42G



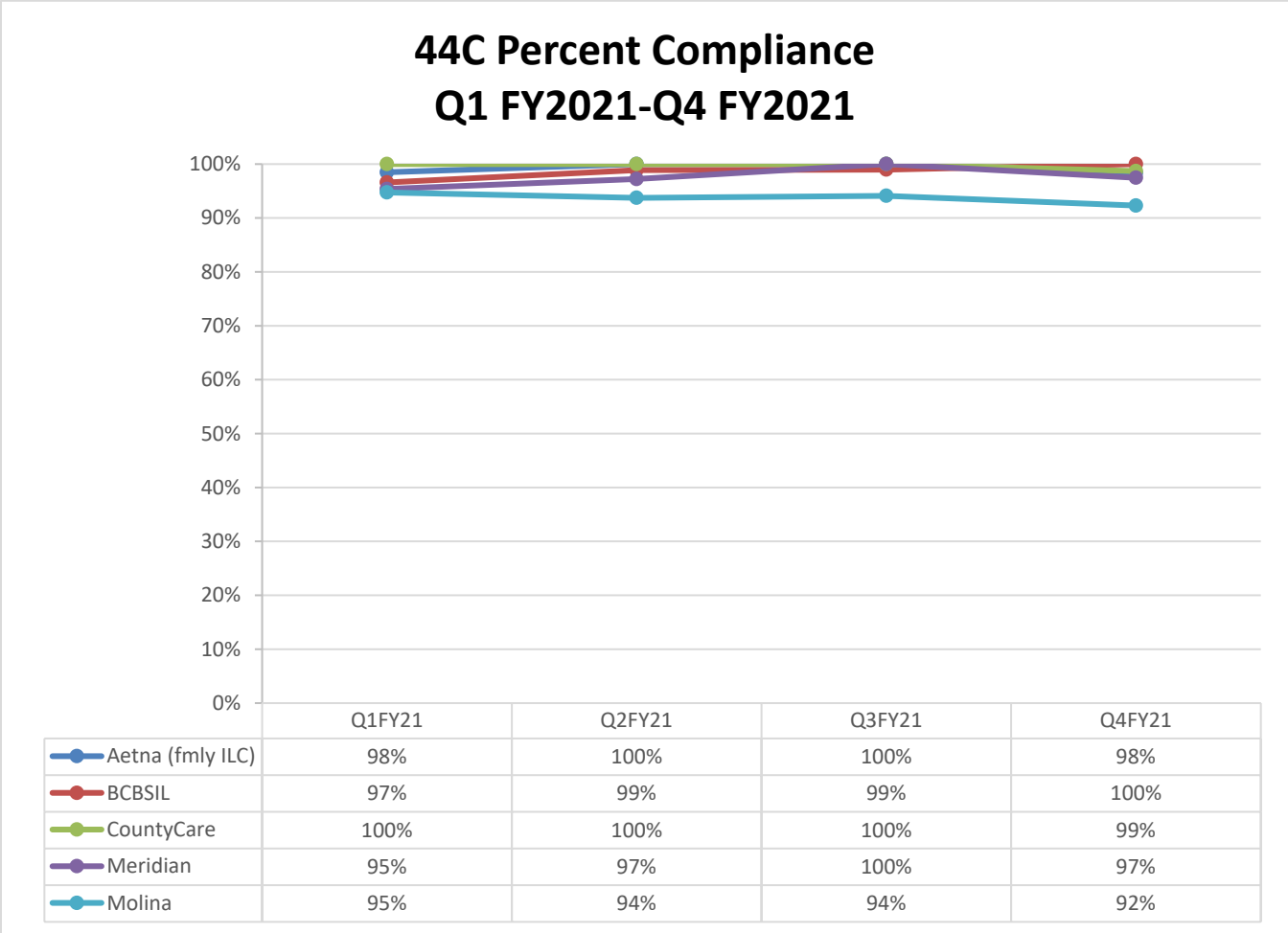
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	100%	100%	98%	97%	99%	100%	99%	97%	86%	95%	97%	95%	91%	90%
BCBSIL	94%	88%	83%	88%	92%	96%	97%	93%	89%	97%	97%	97%	96%	95%
CountyCare	92%	89%	89%	97%		97%	89%	95%	92%	91%	92%	98%	94%	97%
Harmony		100%	76%	85%										
Meridian	97%	93%	89%	88%	97%	86%	94%	97%	92%	95%	95%	97%	96%	94%
Molina	100%	100%	96%	86%	100%	94%	94%	100%	83%		85%	90%	93%	89%
NextLevel		89%		100%		88%		94%	85%					

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 44C – The enrollee reported satisfaction with his/her PA.

New measure beginning FY 2021.

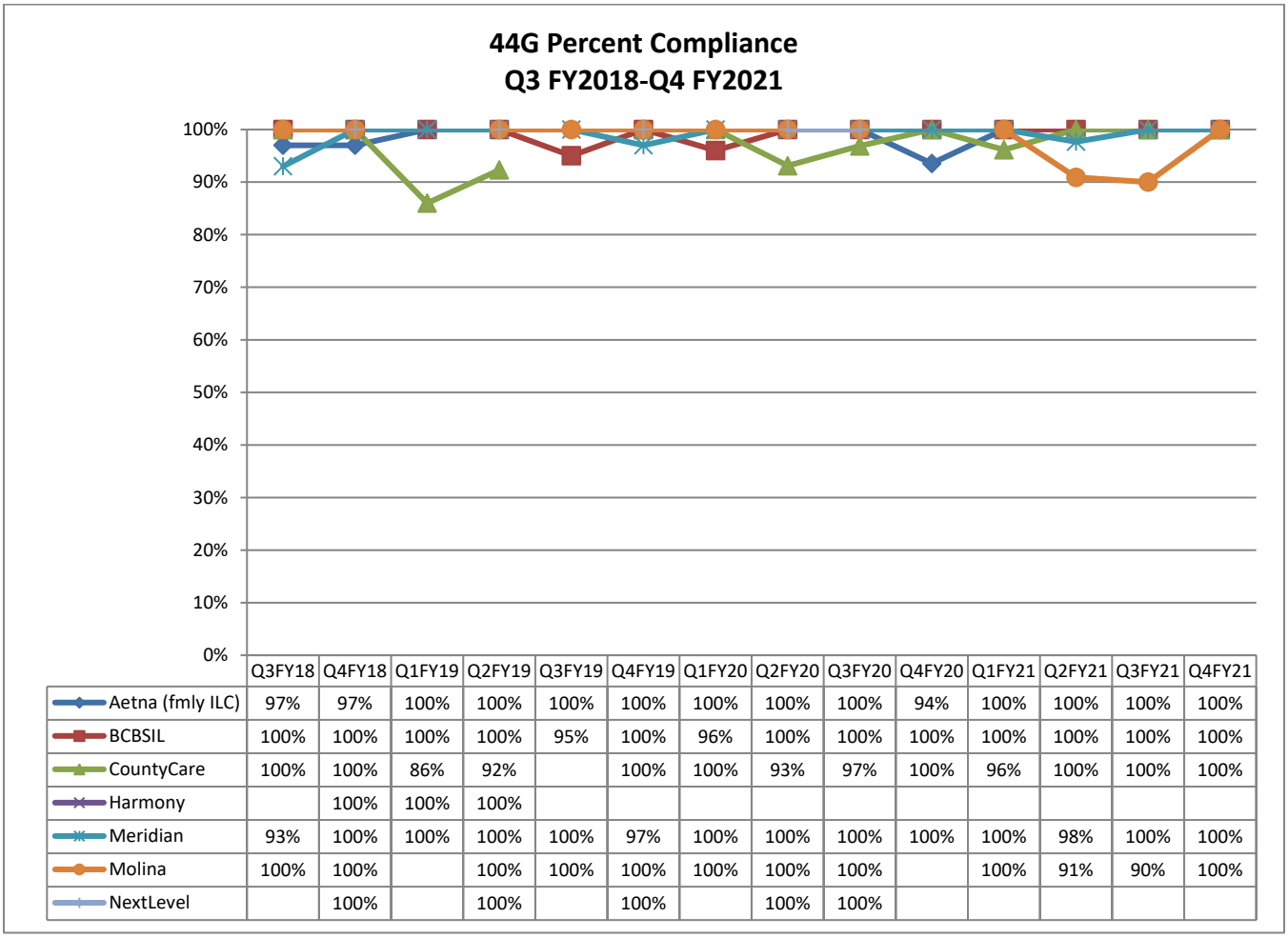
Figure B.17 – Measure 44C



	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	98%	100%	100%	98%
BCBSIL	97%	99%	99%	100%
CountyCare	100%	100%	100%	99%
Meridian	95%	97%	100%	97%
Molina	95%	94%	94%	92%

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.18 – Measure 44G



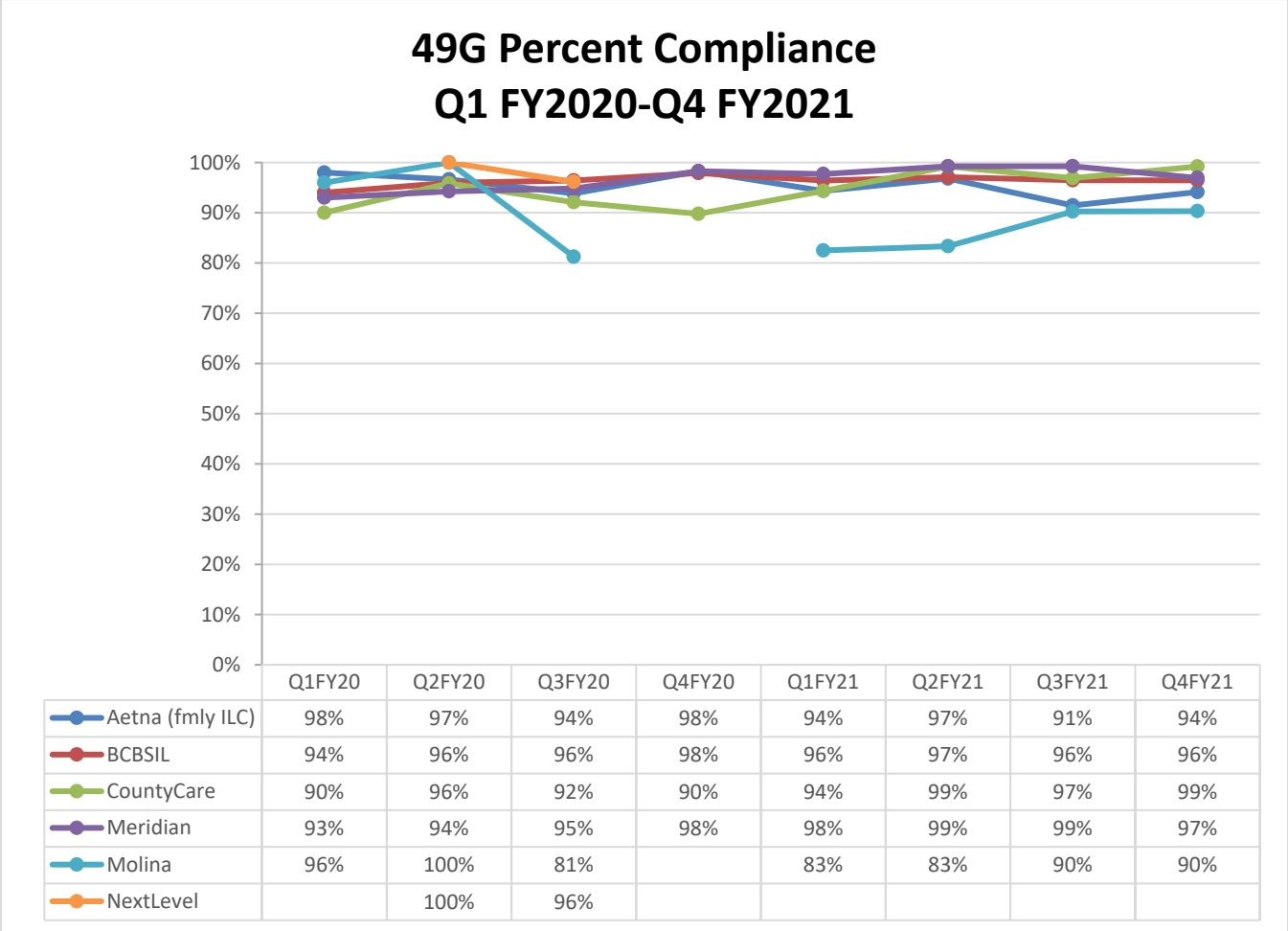
	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	97%	97%	100%	100%	100%	100%	100%	100%	100%	94%	100%	100%	100%	100%
BCBSIL	100%	100%	100%	100%	95%	100%	96%	100%	100%	100%	100%	100%	100%	100%
CountyCare	100%	100%	86%	92%		100%	100%	93%	97%	100%	96%	100%	100%	100%
Harmony		100%	100%	100%										
Meridian	93%	100%	100%	100%	100%	97%	100%	100%	100%	100%	100%	98%	100%	100%
Molina	100%	100%		100%	100%	100%	100%	100%	100%		100%	91%	90%	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.

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 and FY 2021 data is displayed.

Figure B.19 – Measure 49G



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna (fmly ILC)	98%	97%	94%	98%	94%	97%	91%	94%
BCBSIL	94%	96%	96%	98%	96%	97%	96%	96%
CountyCare	90%	96%	92%	90%	94%	99%	97%	99%
Meridian	93%	94%	95%	98%	98%	99%	99%	97%
Molina	96%	100%	81%		83%	83%	90%	90%
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]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**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%
Q1 2021	22%	4%	76%	97%	98%	99%	98%	98%	93%	96%	85%	82%	98%	99%	97%	97%	100%	96%
Q2 2021	31%	0%	80%	98%	100%	100%	100%	98%	95%	94%	100%	89%	100%	98%	97%	99%	100%	97%
Q3 2021	21%	0%	76%	100%	99%	100%	100%	96%	96%	88%	93%	92%	100%	97%	96%	99%	100%	96%
Q4 2021	36%	4%	74%	97%	99%	99%	100%	96%	95%	88%	98%	89%	100%	98%	95%	100%	100%	96%
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%

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]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
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%
Q1 2021	19%	0%	71%	99%	95%	93%	96%	99%	79%	88%	92%	81%	96%	97%	92%	100%	96%	94%
Q2 2021	0%	6%	79%	100%	99%	99%	100%	99%	83%	94%	100%	86%	100%	99%	98%	100%	100%	99%
Q3 2021	25%	9%	74%	99%	97%	96%	100%	96%	84%	94%	97%	86%	97%	99%	94%	100%	100%	97%
Q4 2021	36%	25%	75%	100%	97%	98%	100%	86%	87%	92%	94%	92%	100%	100%	97%	99%	100%	99%
Aetna Better Health (formerly 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%
Q1 2021	46%	10%	81%	99%	98%	98%	100%	99%	81%	92%	97%	83%	100%	98%	97%	98%	100%	94%
Q2 2021	38%	14%	91%	97%	96%	96%	100%	97%	86%	90%	93%	92%	100%	97%	95%	100%	100%	97%
Q3 2021	29%	10%	86%	95%	94%	95%	100%	92%	83%	83%	94%	77%	100%	92%	91%	100%	100%	91%
Q4 2021	25%	38%	79%	94%	95%	95%	100%	90%	81%	77%	74%	77%	100%	98%	90%	98%	100%	94%
Meridian																		
Q3 2018	36%			100%	100%	100%	85%	97%	86%	90%	96%	63%	85%	97%	97%		93%	98%

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]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
Q1 2021	17%	4%	63%	98%	99%	99%	98%	92%	74%	89%	100%	94%	100%	93%	95%	95%	100%	98%
Q2 2021	46%	21%	75%	99%	100%	100%	98%	99%	92%	92%	97%	96%	98%	96%	97%	97%	98%	99%
Q3 2021	24%	9%	69%	100%	99%	100%	100%	100%	88%	88%	91%	97%	100%	99%	96%	100%	100%	99%
Q4 2021	40%	7%	65%	99%	99%	99%	100%	96%	89%	88%	100%	93%	100%	99%	94%	97%	100%	97%
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%
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																		
Q1 2021	38%	0%	35%	90%	90%	90%	100%	85%	79%	83%	71%	76%	100%	87%	85%	95%	100%	83%
Q2 2021	29%	0%	34%	95%	92%	97%	91%	92%	79%	88%	100%	82%	91%	93%	90%	94%	91%	83%
Q3 2021	33%	0%	50%	98%	95%	95%	90%	95%	80%	95%	75%	87%	90%	95%	93%	94%	90%	90%

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]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
Q4 2021	0%	0%	37%	97%	97%	97%	100%	95%	91%	65%	100%	81%	100%	95%	89%	92%	100%	90%
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.*

***Due to exiting HealthChoice Q4 FY2020, NextLevel'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.*

[2]*New measure effective Q1 FY2021.*

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 2021																				
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	91%	93%	91%	92%	93%	96%	96%	94%	90%	94%	93%	92%	89%	93%	91%	88%	96%	92%	88%	92%
4A	80%	100%	14%	60%	9%	28%	44%	26%	100%	100%	0%	29%	19%	25%	35%	32%	38%	23%	13%	20%
12C	0%	0%	0%	12%					5%	20%	12%	7%	4%	8%	6%	16%				
20C	80%	81%	83%	76%					76%	88%	79%	81%	59%	69%	66%	62%				
31D	100%	100%	99%	98%	94%	98%	99%	97%	98%	100%	100%	98%	99%	98%	99%	97%	97%	96%	95%	98%
32D	99%	99%	97%	99%	95%	98%	98%	97%	99%	99%	99%	97%	97%	98%	98%	98%	97%	97%	95%	98%
33D	98%	100%	99%	98%	95%	98%	98%	97%	99%	99%	100%	98%	96%	99%	98%	98%	99%	96%	95%	99%
34D					98%	99%	99%	100%												
35D	100%	98%	99%	94%	93%	98%	98%	94%	98%	98%	98%	90%	96%	99%	98%	93%	96%	94%	87%	92%
36D	61%	75%	67%	71%	97%	99%	99%	99%	52%	69%	73%	70%	99%	99%	100%	99%				
37D	96%	98%	95%	96%	87%	90%	90%	85%	98%	98%	99%	92%	88%	96%	91%	81%	91%	82%	72%	77%
38D	88%	100%	100%	100%	91%	100%	86%	97%	91%	94%	95%	85%	91%	98%	91%	94%	100%	100%	100%	75%
39D	85%	88%	85%	94%	76%	86%	84%	74%	83%	94%	90%	96%	80%	86%	86%	87%	99%	99%	99%	96%
40D					99%	99%	99%	100%												
41D	100%	99%	99%	99%	93%	98%	98%	98%	99%	99%	100%	100%	95%	98%	97%	97%	97%	92%	90%	98%
42G	100%	100%	97%	99%	91%	94%	96%	94%	99%	98%	100%	100%	93%	98%	95%	90%	95%	91%	87%	90%
44C	97%	100%	100%	100%					100%	100%	99%	99%	96%	97%	99%	97%				
44G					99%	99%	99%	100%												
49G	80%	95%	93%	98%	98%	98%	99%	98%	97%	99%	99%	99%	94%	95%	93%	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 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.3—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.4—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

SFY21 Annual Report

December 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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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) 2021 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 2021 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 18 CMS waiver performance measures, and additional HealthChoice contract measures. During SFY 2021, 1,507 MLTSS records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,391 MLTSS findings of non-compliance were identified.

Although reviews in SFY 2021 occurred virtually due to pandemic restrictions, SFY 2021 performance was not impacted by pandemic emergency protocols due to the retrospective lookback period for the reviews. HSAG will report on the impact of performance in SFY 2022 reports.

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 2021.

Table 1.1—SFY 2021 MLTSS Health Plans

HealthChoice Health Plan Name
Blue Cross Blue Shield of Illinois (BCBSIL)
CountyCare (CountyCare)
Aetna Better Health (previously IlliniCare Health Plan [Aetna])
Meridian Health (Meridian)
Molina Healthcare of Illinois (Molina)

Successes

SFY 2021 represented the third year of review for the MLTSS population, and several successes were identified.

☑ Thirteen of the 18 CMS performance measures averaged 90 percent or greater compliance.

☑ Seven of the 18 CMS performance measures realized a statistically significant increase in performance compliance in SFY 2021 when compared to SFY 2020.

☑ Four of the five health plans averaged greater than 90 percent compliance.

☑ Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for four measures in SFY 2021.

☑ Compared to SFY 2020, CountyCare realized a statistically significant increase in performance for four measures in SFY 2021.

☑ Compared to SFY 2020, Meridian realized a statistically significant increase in performance for six measures in SFY 2021.

☑ Compared to SFY 2020, Molina realized a statistically significant increase in performance for one measure in SFY 2021.

☑ Compared to SFY 2020, the BI waiver realized a statistically significant increase in performance for two measures in SFY 2021.

☑ Compared to SFY 2020, the ELD waiver realized a statistically significant increase in performance for one measure in SFY 2021.

☑ Compared to SFY 2020, the HIV waiver realized a statistically significant increase in performance for three measures in SFY 2021.

☑ Compared to SFY 2020, the PD waiver realized a statistically significant increase in performance for six measures in SFY 2021.

Opportunities for Improvement

Review of SFY 2021 performance identified the following opportunities for improvement:

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 28 percent compliance. All five health plans performed at a rate of less than 50 percent. A detailed analysis is provided in Section 3 of this report.

Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date,* averaged 6 percent compliance in SFY 2021. All five health plans performed at a rate of less than 50 percent in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 20C, *a PA evaluation was completed annually,* averaged 70 percent compliance in SFY 2021. A detailed analysis 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 71 percent and 72 percent compliance for the BI and HIV waivers, respectively. A detailed analysis related to 36D 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 SFY 2021. 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 completion of annual reassessments, care plan and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.

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.

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

BCSBIL should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

CountyCare should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Aetna should focus efforts on measures 4A, 12C, and 39D. Aetna should ensure consistent application of a process to validate the provision of waiver services for all members. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Meridian should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Molina should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

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, 12C, 20C, and 36D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A, 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 measures 12C and 20C, efforts might include:

- 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 complete PA evaluations.
- Educate care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

For measure 36D, efforts might include:

- Conduct root cause analysis to determine opportunities to affect change.
- 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.

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 4 (Q4) 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) 2021 review, HFS identified 18 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 2021, the following changes were identified from FY 2020 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2021 to include all waivers (excluded the BI and SLP waivers during FY2020).
- Measure 20C, was a PA evaluation completed annually, was added for waiver enrollees who have a personal assistant (PA).
- Measure 12C, if the PA evaluation was not completed annually, was it completed within 60 days of the expected annual date, was added for waiver enrollees who have a PA.
- Measure 44C, did the enrollee report satisfaction with his/her PA, was added for waiver enrollees who have a PA.

Other performance measures had language revisions to ensure consistency with waiver language; those changes did not result in impact to comparisons to historic data.

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 in this methodology were selected in May 2020 and include waiver members enrolled as of May 1, 2020. Due to NextLevel's exit from the Illinois Medicaid managed care program at the end of FY 2020, the initial sample selected for NextLevel was redistributed to the other health plans to ensure that the waiver population was represented. Table 2.1 displays the FY 2021 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	11,077	511	125	69	56	118	151
CountyCare	4,551	214	59	58	39	46	18
IlliniCare	7,071	318	83	55	26	80	80
Meridian	7,160	331	83	52	38	83	83
Molina	2,391	102	28	11	11	36	19
Statewide Total	**33,076**	**1,507**	**378**	**245**	**170**	**363**	**351**

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 2021 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2019 – May 31, 2020
- Quarter 2, SFY 2021: March 1, 2020 – August 31, 2020
- Quarter 3, SFY 2021: June 1, 2020 – November 30, 2020
- Quarter 4, SFY 2021: September 1, 2020 – February 28, 2021

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)

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 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 percent 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 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent.

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 completed 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 SFY 2021

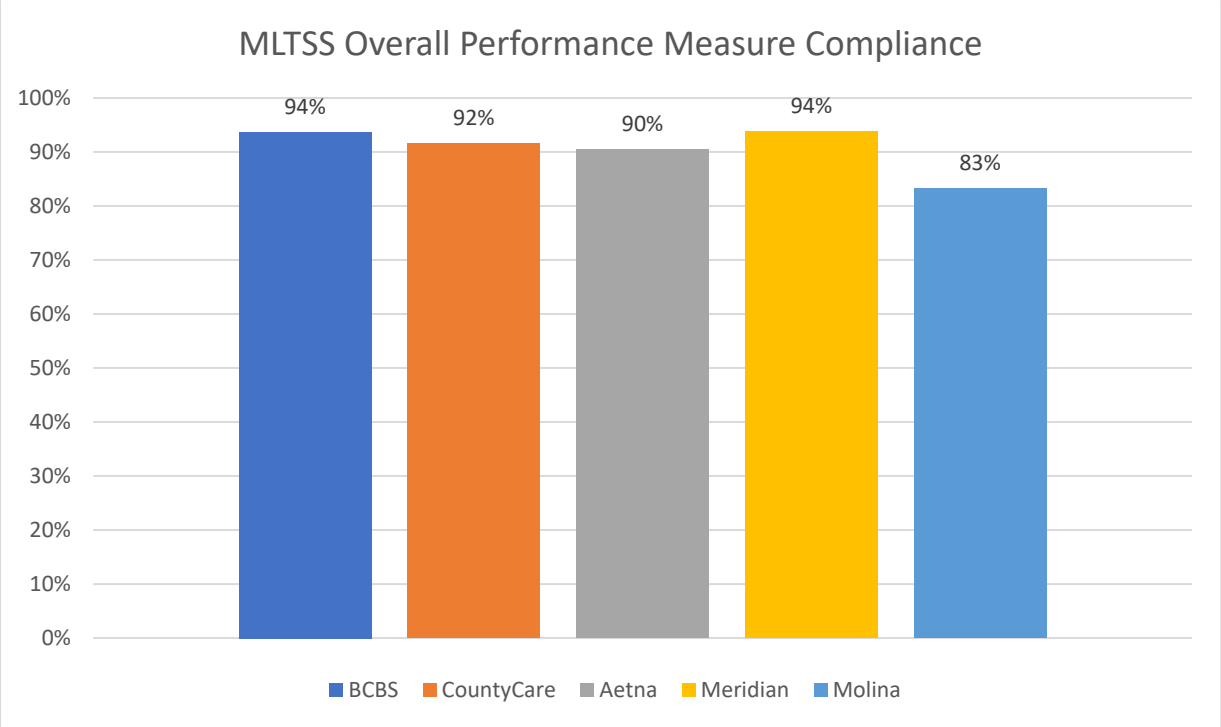
Overall Performance

Overall Health Plan Performance and Comparisons

Five health plans were reviewed during SFY 2021. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 18 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 18 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.

Four of the five health plans averaged greater than 90 percent compliance in SFY 2021. There was an 11-percentage point difference (83% 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 CountyCare, Aetna, and Molina.
- Molina performed at a statistically significant lower rate than all other health plans.
- Meridian performed at a statistically significant lower rate than CountyCare and Aetna.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2021. Comparisons for overall performance from SFY 2020 to SFY 2021 were not completed, as the total number of performance measures reviewed was different in each fiscal year. 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)

Analysis identified that BCBSIL performed at 90 percent or greater compliance in 14 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, BCBSIL realized a statistically significant increase in one performance measure. When SFY 2021 performance was compared to SFY 2020, BCBSIL realized a statistically significant increase in four performance measures.

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 2 percent (1 of 54 records). BCBSIL also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 29 percent (12 of 41 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 73 percent (148 of 203 records).

CountyCare Health Plan (CountyCare)

Analysis identified that CountyCare performed at 90 percent or greater compliance in 13 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, CountyCare realized a statistically significant increase in overall performance as well as in one performance measure. When SFY 2021 performance was compared to SFY 2020, CountyCare realized a statistically significant increase in four performance measures.

Analysis identified that CountyCare's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 3 percent (1 of 39 records). CountyCare also had opportunity

for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 19 percent (3 of 16 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 70 percent (91 of 130 records).

Aetna Better Health, previously IlliniCare Health Plan, Inc. (Aetna)

Analysis identified that Aetna performed at 90 percent or greater compliance in 12 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Aetna demonstrated a statistically significant decrease in overall performance as well as in three performance measures. When SFY 2021 performance was compared to SFY 2020, Aetna demonstrated stable performance.

Analysis identified that Aetna's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 26 percent (5 of 19 records). Aetna also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 28 percent (11 of 40 records), and 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 (241 of 309 records).

Meridian Health Plan, Inc. (Meridian)

Analysis identified that Meridian performed at 90 percent or greater compliance in 14 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Meridian realized a statistically significant increase in overall performance as well as in two performance measures. When SFY 2021 performance was compared to SFY 2020, Meridian realized a statistically significant increase in six performance measures.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 8 percent (4 of 48 records). Meridian also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 38 percent (10 of 26 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 68 percent (100 of 148 records).

Molina Healthcare of Illinois, Inc. (Molina)

Analysis identified that Molina performed at 90 percent or greater compliance in nine of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, Molina demonstrated stable performance. When SFY 2021 performance was compared to SFY 2020, Molina realized a statistically significant increase in one performance measure.

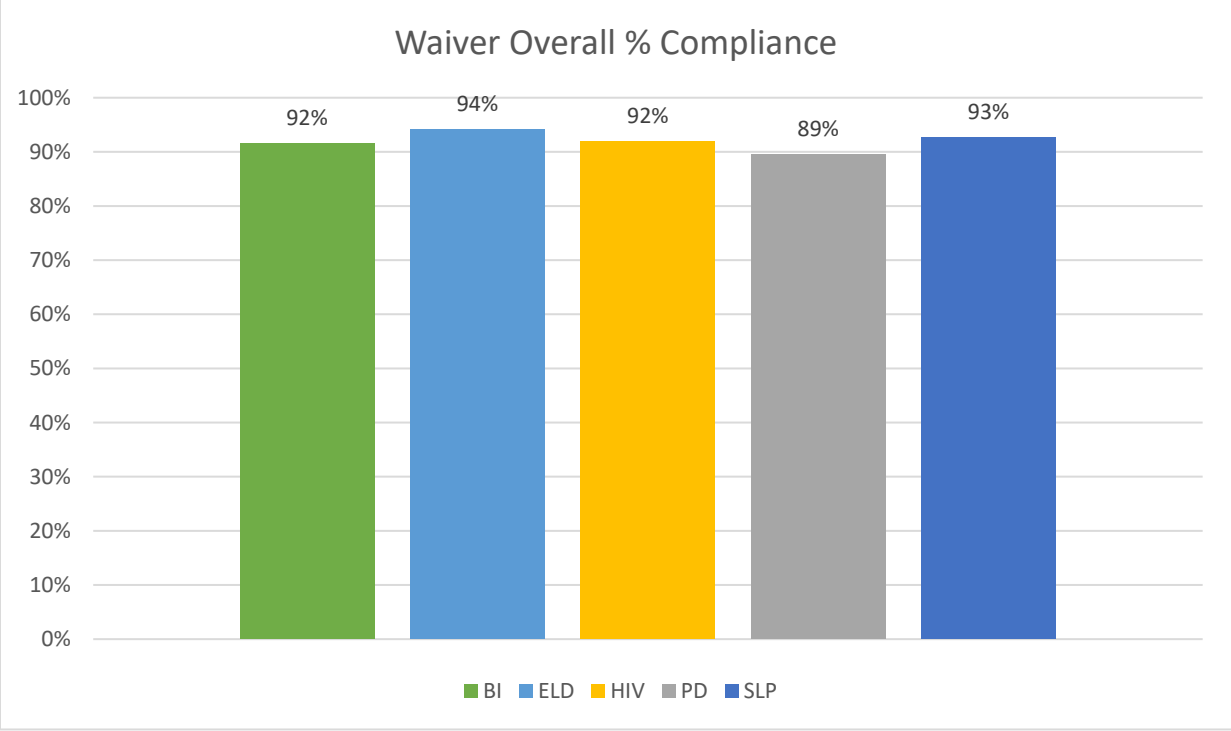
Analysis identified that Molina's greatest opportunity for improvement related to 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 0 percent (0 of 33 records). Molina also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 23 percent (3 of 13 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 35 percent (18 of 51 records).

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 2021.

Figure 3.2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver's overall compliance from Q1 to Q4 SFY 2021. Comparisons for overall performance from SFY 2020 to SFY 2021 were not completed, as the total number of performance measures reviewed was different in each fiscal year. Individual waiver performance analysis identified the following.

BI Waiver

Fifteen performance measures are assessed for the BI waiver. Analysis identified that the BI waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the BI waiver realized a statistically significant increase in overall performance as well as in one performance measure. When SFY 2021 performance was compared to SFY 2020, the BI waiver realized a statistically significant increase in two performance measures.

Analysis identified that greatest opportunity for improvement for the BI waiver related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 0 percent (0 of 46 records). The BI waiver also had opportunity for improvement in measure 20C: a PA evaluation was completed annually, which demonstrated performance of 78 percent (165 of 211 records), and 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 71 percent (173 of 245 records).

ELD Waiver

Fifteen performance measures are assessed for the ELD waiver. Analysis identified that the ELD waiver performed at 90 percent or greater compliance in 12 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the ELD waiver realized a statistically significant increase in overall performance as well as in one performance measure. When SFY 2021 performance was compared to SFY 2020, the ELD waiver realized a statistically significant increase in one performance measure.

Analysis identified that greatest opportunity for improvement for the ELD waiver 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). The ELD waiver 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 performed at a rate of 76 percent (279 of 366 records).

HIV Waiver

Fifteen performance measures are assessed for the HIV waiver. Analysis identified that the HIV waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the HIV waiver realized a statistically significant increase in overall performance. When SFY 2021 performance was compared to SFY 2020, the HIV waiver realized a statistically significant increase in three performance measures.

Analysis identified that greatest opportunity for improvement for the HIV waiver related to measure 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 72 percent (122 of 170 records). The HIV waiver also had opportunity for improvement in measure and 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 6 percent (2 of 36 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 75 percent (110 of 146 records).

PD Waiver

Fifteen performance measures are assessed for the PD waiver. Analysis identified that the PD waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the PD waiver demonstrated stable performance. When SFY 2021 performance was compared to SFY 2020, the PD waiver realized a statistically significant increase in six performance measures.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 8 percent (9 of 111 records). The PD waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 36 percent (14 of 39 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 62 percent (191 of 307 records).

SLP Waiver

Ten performance measures are assessed for the SLP waiver. Analysis identified that the SLP waiver performed at 90 percent or greater compliance in eight of the 10 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, the SLP waiver demonstrated stable performance. When SFY 2021 performance was compared to SFY 2020, the SLP waiver demonstrated stable performance.

Analysis identified that greatest opportunity for improvement for the SLP waiver related to measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 19 percent (9 of 47 records). The SLP waiver also had opportunity for improvement in

measure 37D: the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 84 percent (295 of 351 records).

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 2021 Analysis**	**Trend Analysis to SFY 2020**
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 one of the lowest performing, performing at a rate of 28% over SFY 2021.	Comparisons between SFY 2020 and SFY 2021 were unable to be made as the waiver types applicable to this measure changed in SFY 2021.
12C *If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.* (Captured for only enrollees with PA service)	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. This measure was one of the lowest performing, performing at a rate of 6% over SFY 2021.	New measure in SFY 2021.
20C *A PA evaluation was completed annually.* (Captured for only enrollees with PA service)	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4. This measure was one of the lowest performing, performing at a rate of 70% over SFY 2021. Compared to Q1, CountyCare realized a statistically significant increase in performance in Q4. The BI waiver realized a statistically significant increase in performance from Q1 to Q4.	New measure in SFY 2021.
31D *The most recent service plan includes all enrollee goals as identified in the health risk*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
assessment including enrollee choices, preferences, strengths, and any cultural considerations.		Compared to SFY 2020, BCBSIL, Meridian, and Molina realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the PD waiver realized a statistically significant increase in this measure in SFY 2021.
32D *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the HIV and PD waiver realized a statistically significant increase in this measure in SFY 2021.
33D *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	Overall, this measure realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the PD waiver realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
35D *The most recent service plan includes signature of enrollee (or representative), Case Manager, and*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
SLP provider (if applicable) and dates of signatures.	Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, Meridian realized a statistically significant increase in this measure in SFY 2021.
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.* *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 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 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, BCBSIL and CountyCare realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the BI, HIV, and PD waiver realized a statistically significant increase in this measure in SFY 2021.
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. Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, CountyCare realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
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. Compared to Q1, BCBSIL realized a statistically significant increase in performance in Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, CountyCare and Meridian realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the BI, ELD, and PD waiver realized a statistically significant increase in this measure in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to 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 2020, this measure demonstrated stable performance in SFY 2021.
41D *The enrollee has been given the opportunity to participate in choosing types of services and providers.*	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. The ELD waiver realized a statistically significant increase in performance from Q1 to Q4.	Compared to SFY 2020, this measure realized a statistically significant increase in SFY 2021. Compared to SFY 2020, the PD waiver realized a statistically significant increase in this measure in SFY 2021.
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 a statistically significant decrease from Q1 to Q4. Compared to Q1, Aetna demonstrated a statistically significant decrease in this measure in Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, Meridian realized a statistically significant increase in this measure in SFY 2021.
44C *The enrollee reported satisfaction with his/her PA.* (Captured for only enrollees with PA service)	Overall, this measure demonstrated stable performance from Q1 to Q4.	New measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
49G *(ELD, BI, HIV, PD Waivers)* *The most recent service plan includes a backup plan that includes the name of the backup.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, CountyCare realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the HIV waiver realized a statistically

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis to SFY 2020**
		significant increase in this measure in SFY 2021.

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 28 percent compliance during SFY 2021.
- Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, which performed at a rate of 6 percent compliance during SFY 2021.
- Measure 20C, *a PA evaluation was completed annually*, which performed at a rate of 70 percent compliance during SFY 2021.
- 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 85 percent compliance during SFY 2021.

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 71 percent and 72 percent compliance, respectively, during SFY 2021.

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.

Measures 12C and 20C

Measures 12C and 20C collect information related to the health plan's success in completing annual PA evaluation documentation timely. Measure 20C identifies whether the PA evaluation has been completed annually. Measure 12C measures whether the PA evaluation was completed within 60 days of that expected completion, if overdue. Performance on the measure does not indicate that a PA evaluation was never completed; the evaluation criteria limits performance only to those records that

have completion within 60 days (e.g., a PA evaluation completed on day 61 is non-compliant for the measure).

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual PA evaluations in a timely manner. Health plans should also make efforts to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely PA evaluation completions.

Measure 39D

During record review, measure 39D was collected by validating the services identified on the waiver service plan against claims. Analysis was performed to determine if there were any waiver service types that contributed to performance on measure 39D. Of the non-compliant records, validation of homemaker services and 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 represented a statistically significant increase in SFY 2021 and when SFY 2021 performance is compared against SFY 2020. During SFY 2021, performance on measure 36D for the BI waiver resulted in a rate of 71 percent. Performance related to the HIV waiver resulted in a rate of 72 percent. Results for both waiver types represented a statistically significant increase when SFY 2021 performance is compared against SFY 2020.

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 2021, 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	10/10	13/13
CountyCare	21/21	16/16
Aetna (IlliniCare)	18/18	13/13
Meridian	10/10	10/10
Molina	10/10	7/8

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 99 percent. Four of the five health plans demonstrated 100 percent compliance with remediation validation. Molina did not demonstrate 100 percent compliance; non-compliant remediation

validation cases did not demonstrate correct entry of remediation dates into HSAG's remediation database. HSAG provided technical assistance regarding expectations for correct entry of remediation dates.

Remediation validation reviews will continue in SFY 2022 and will include review of any records that were found to be not fully remediated during the SFY 2021 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

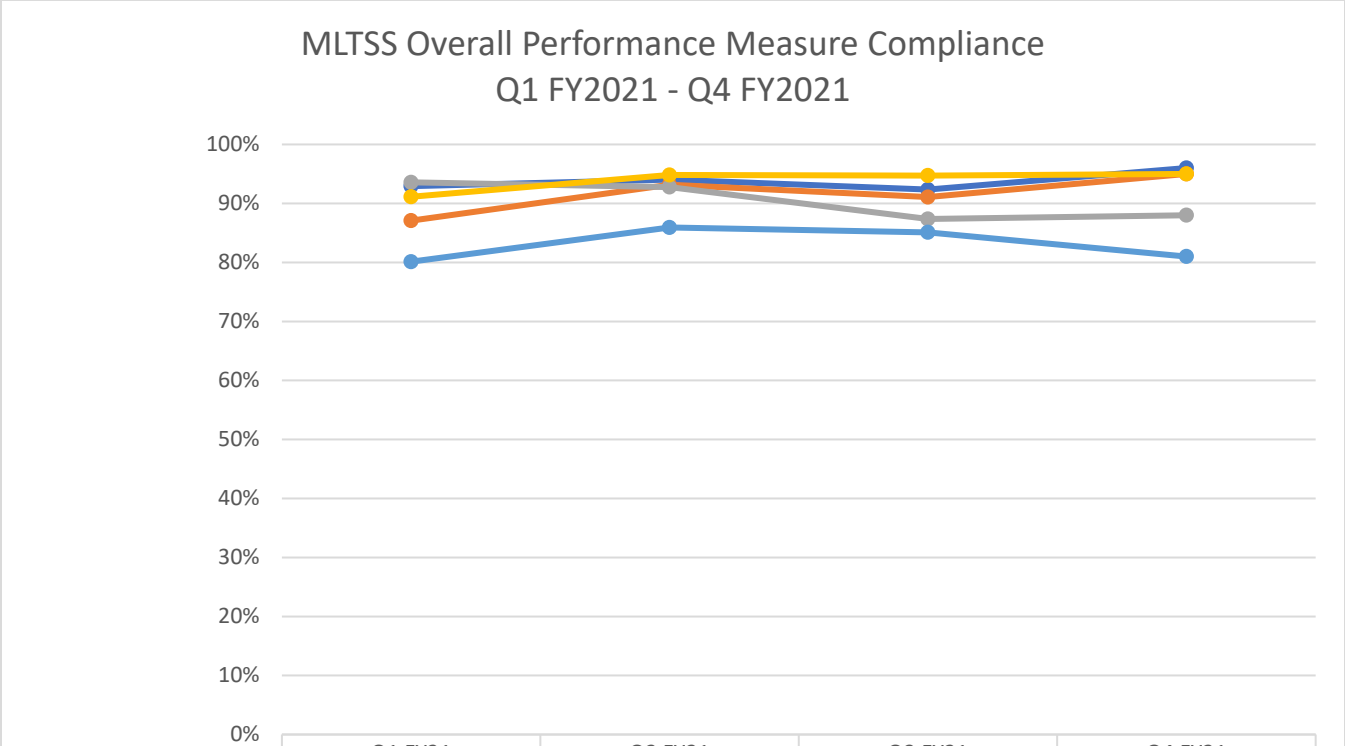
Measure #	Measure Description
4A	Overdue Service Plan was completed within 30 days of expected renewal.
12C	If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date. Captured for only enrollees with PA service
20C	A PA evaluation was completed annually. Captured for only enrollees with PA service
31D	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
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), Case Manager, and SLP provider (if applicable) 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 or upon enrollee request.
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.
44C	The enrollee reported satisfaction with his/her PA. Captured for only enrollees with PA service

Measure #	Measure Description
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 18 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 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.1 – Overall Compliance



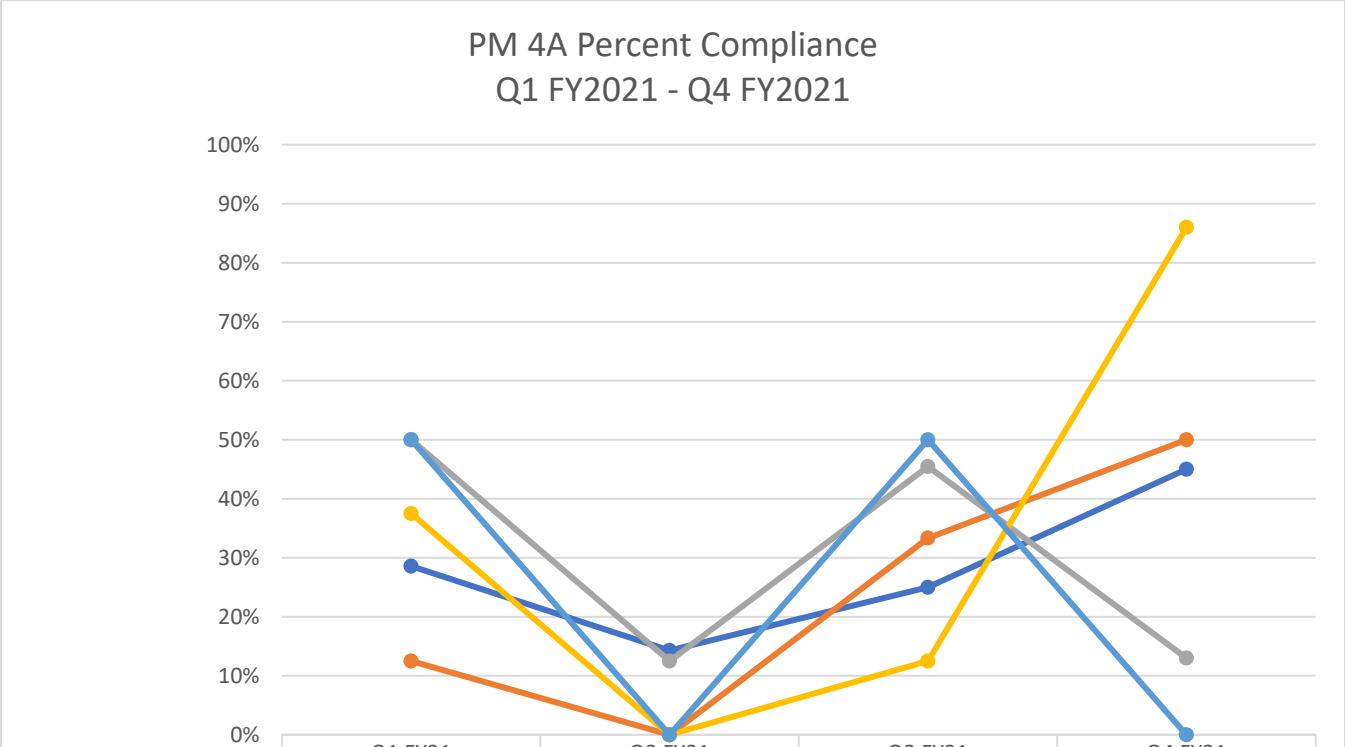
	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	93%	94%	92%	96%
CountyCare	87%	93%	91%	95%
Aetna (fmrly ILC)	94%	93%	87%	88%
Meridian	91%	95%	95%	95%
Molina	80%	86%	85%	81%

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal.

Due to changes in performance measure definitions in FY 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.2 – Measure 4A

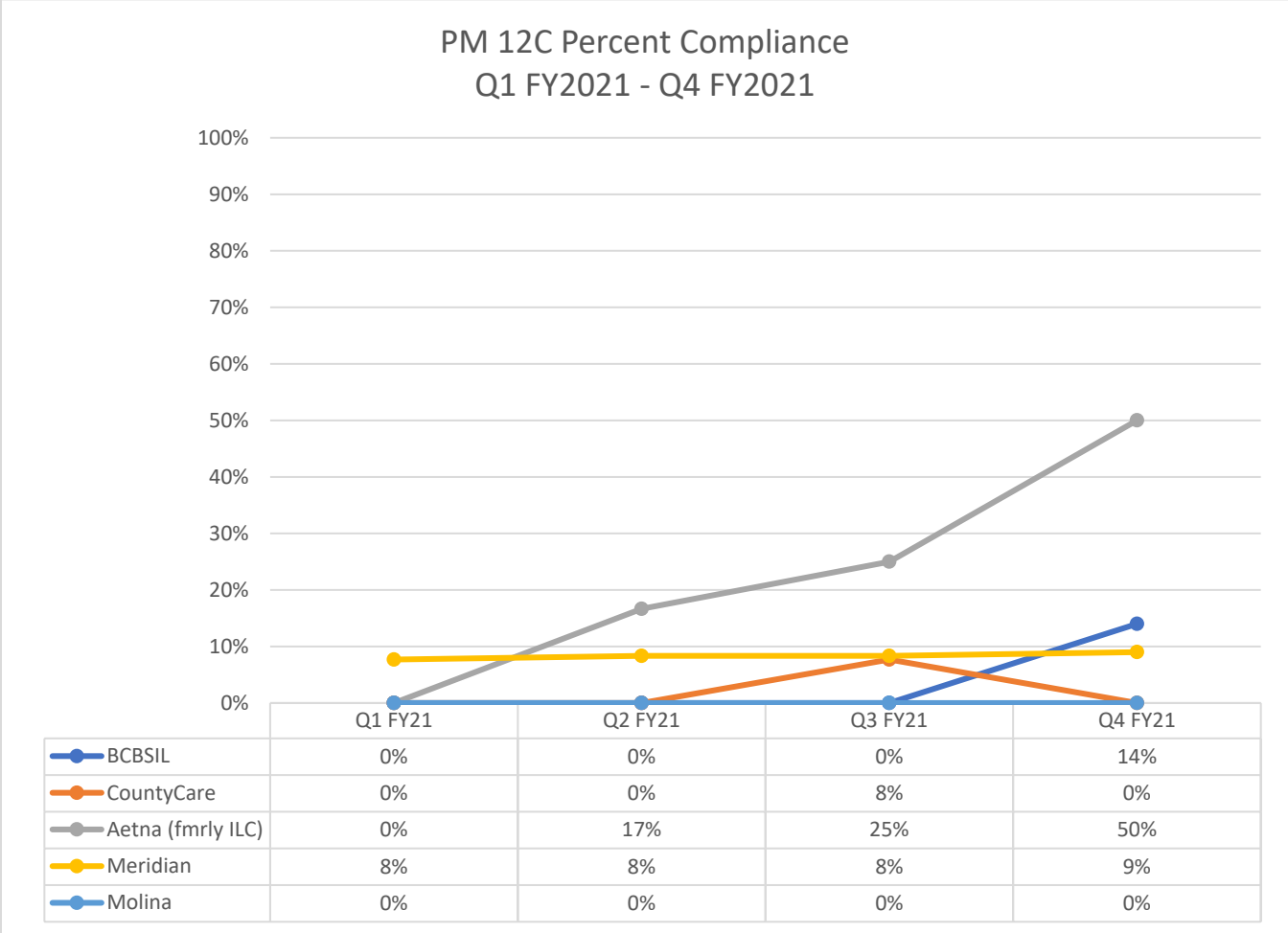


	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	29%	14%	25%	45%
CountyCare	13%	0%	33%	50%
Aetna (fmrly ILC)	50%	13%	45%	13%
Meridian	38%	0%	13%	86%
Molina	50%	0%	50%	0%

Measure 12C - If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.

New measure beginning FY 2021.

Figure B.3 – Measure 12C

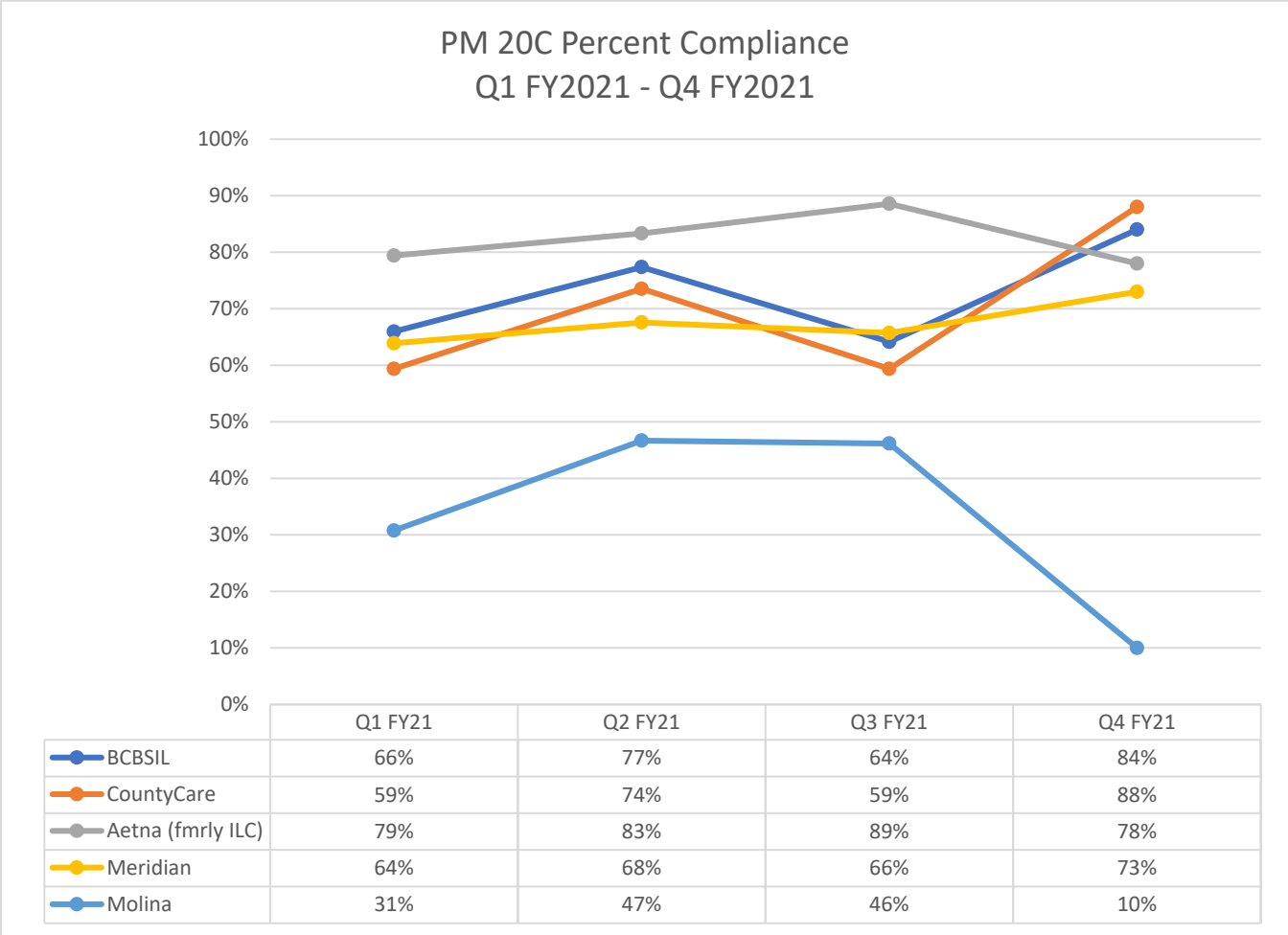


	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	0%	0%	0%	14%
CountyCare	0%	0%	8%	0%
Aetna (fmrly ILC)	0%	17%	25%	50%
Meridian	8%	8%	8%	9%
Molina	0%	0%	0%	0%

Measure 20C - A PA evaluation was completed annually.

New measure beginning FY 2021.

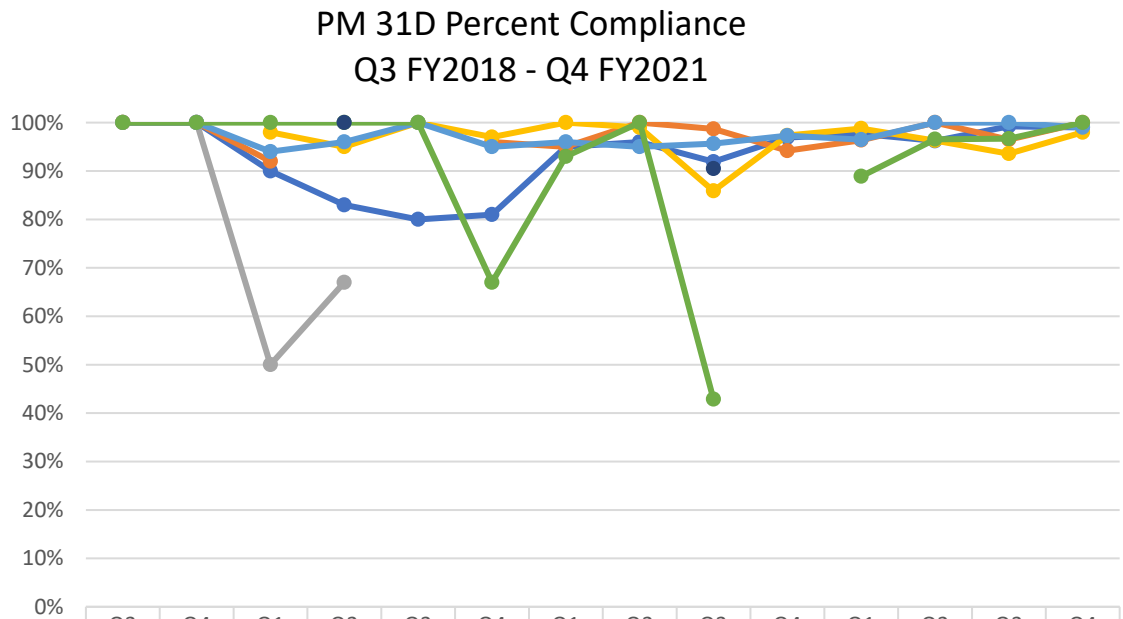
Figure B.4 – Measure 20C



	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	66%	77%	64%	84%
CountyCare	59%	74%	59%	88%
Aetna (fmrly ILC)	79%	83%	89%	78%
Meridian	64%	68%	66%	73%
Molina	31%	47%	46%	10%

Measure 31D - The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B.5 – Measure 31D

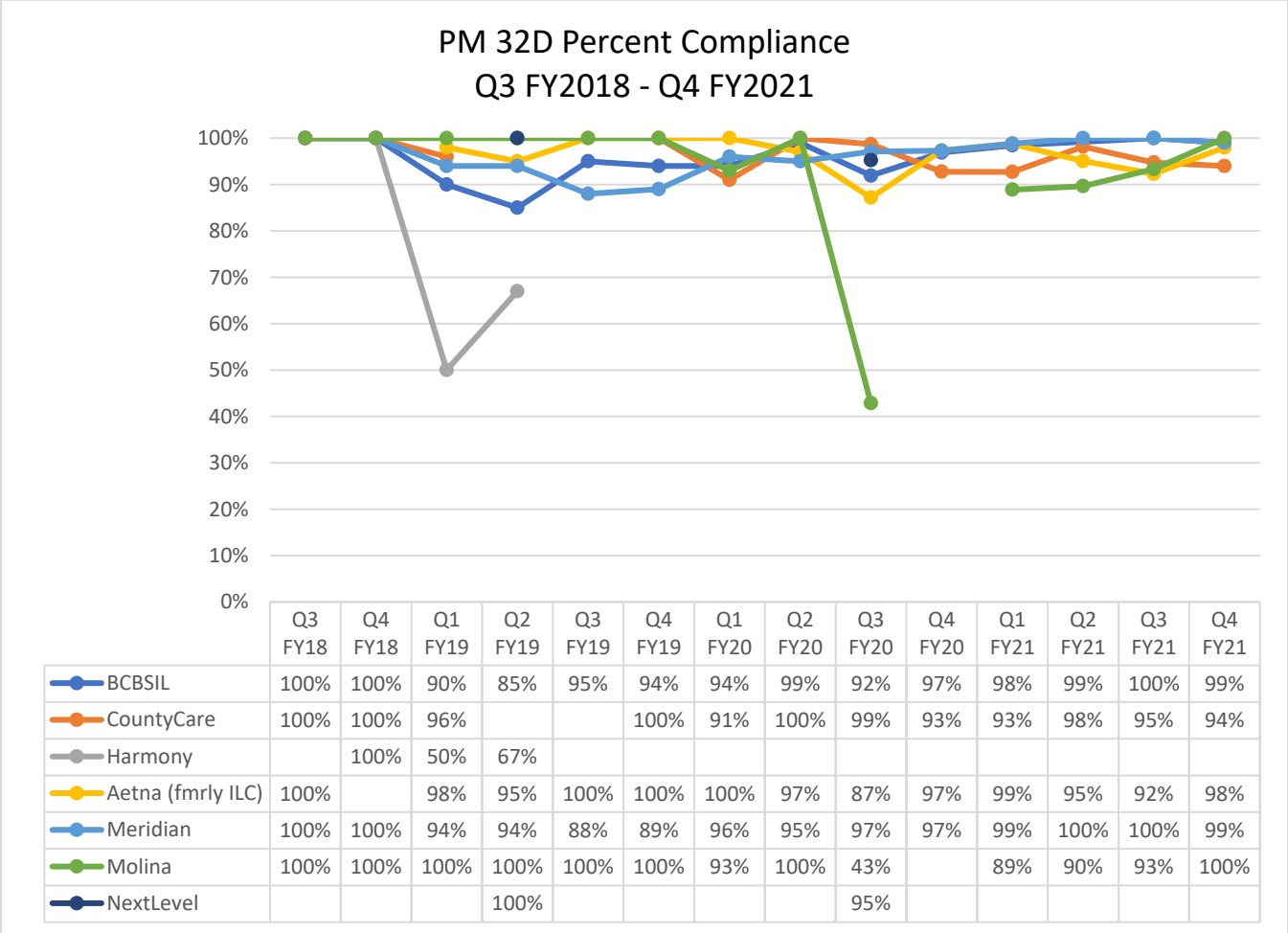


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	90%	83%	80%	81%	95%	96%	92%	97%	98%	96%	99%	99%
CountyCare	100%	100%	92%			96%	95%	100%	99%	94%	96%	100%	96%	100%
Harmony		100%	50%	67%										
Aetna (fmrly ILC)	100%		98%	95%	100%	97%	100%	99%	86%	97%	99%	96%	94%	98%
Meridian	100%	100%	94%	96%	100%	95%	96%	95%	96%	97%	96%	100%	100%	99%
Molina	100%	100%	100%	100%	100%	67%	93%	100%	43%		89%	97%	97%	100%
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 health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B.6 – Measure 32D

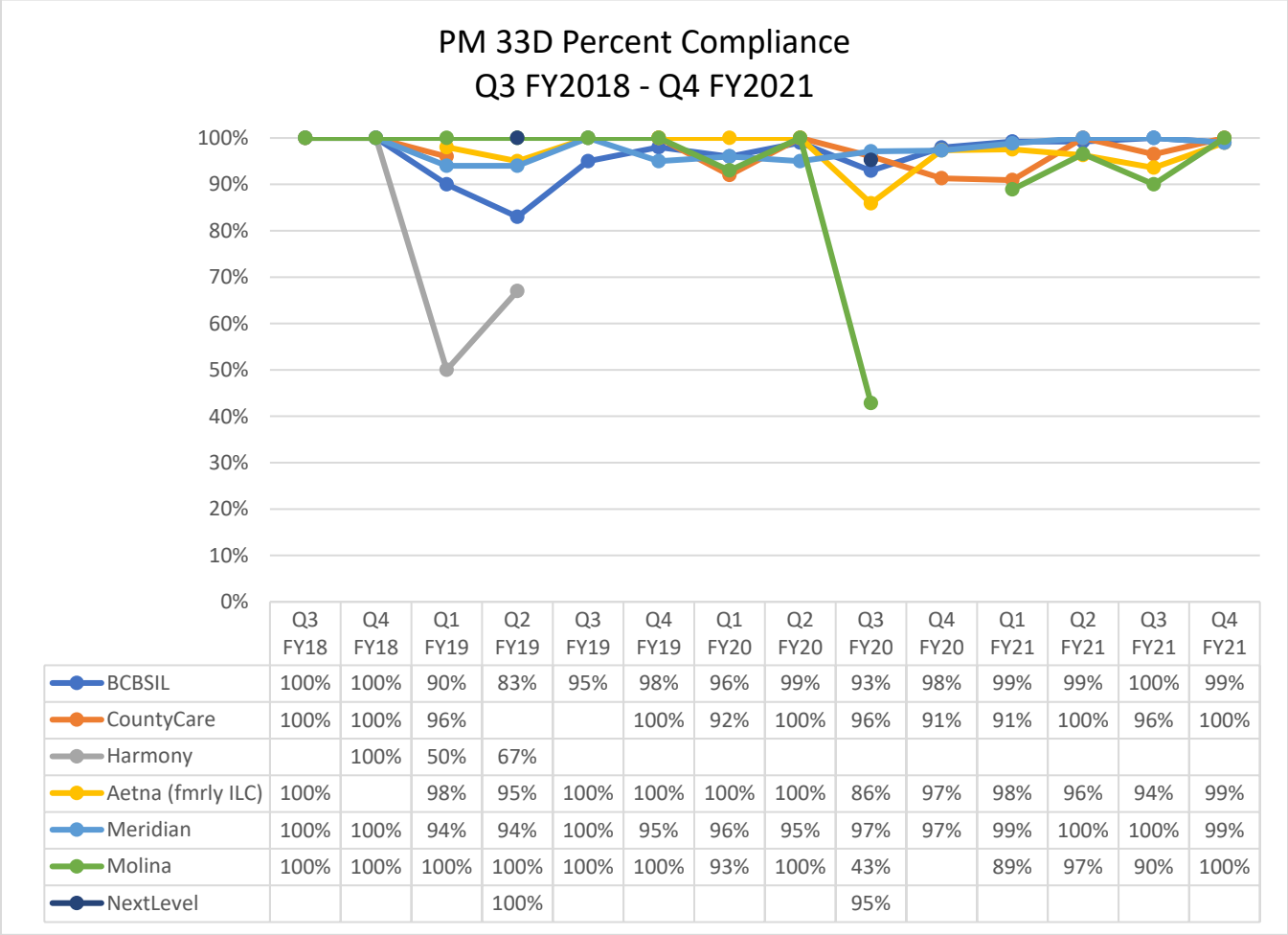


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	90%	85%	95%	94%	94%	99%	92%	97%	98%	99%	100%	99%
CountyCare	100%	100%	96%			100%	91%	100%	99%	93%	93%	98%	95%	94%
Harmony		100%	50%	67%										
Aetna (fmrly ILC)	100%		98%	95%	100%	100%	100%	97%	87%	97%	99%	95%	92%	98%
Meridian	100%	100%	94%	94%	88%	89%	96%	95%	97%	97%	99%	100%	100%	99%
Molina	100%	100%	100%	100%	100%	100%	93%	100%	43%		89%	90%	93%	100%
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 health risk assessment including issues or barriers or ways to reduce the risks.

Figure B.7 – Measure 33D

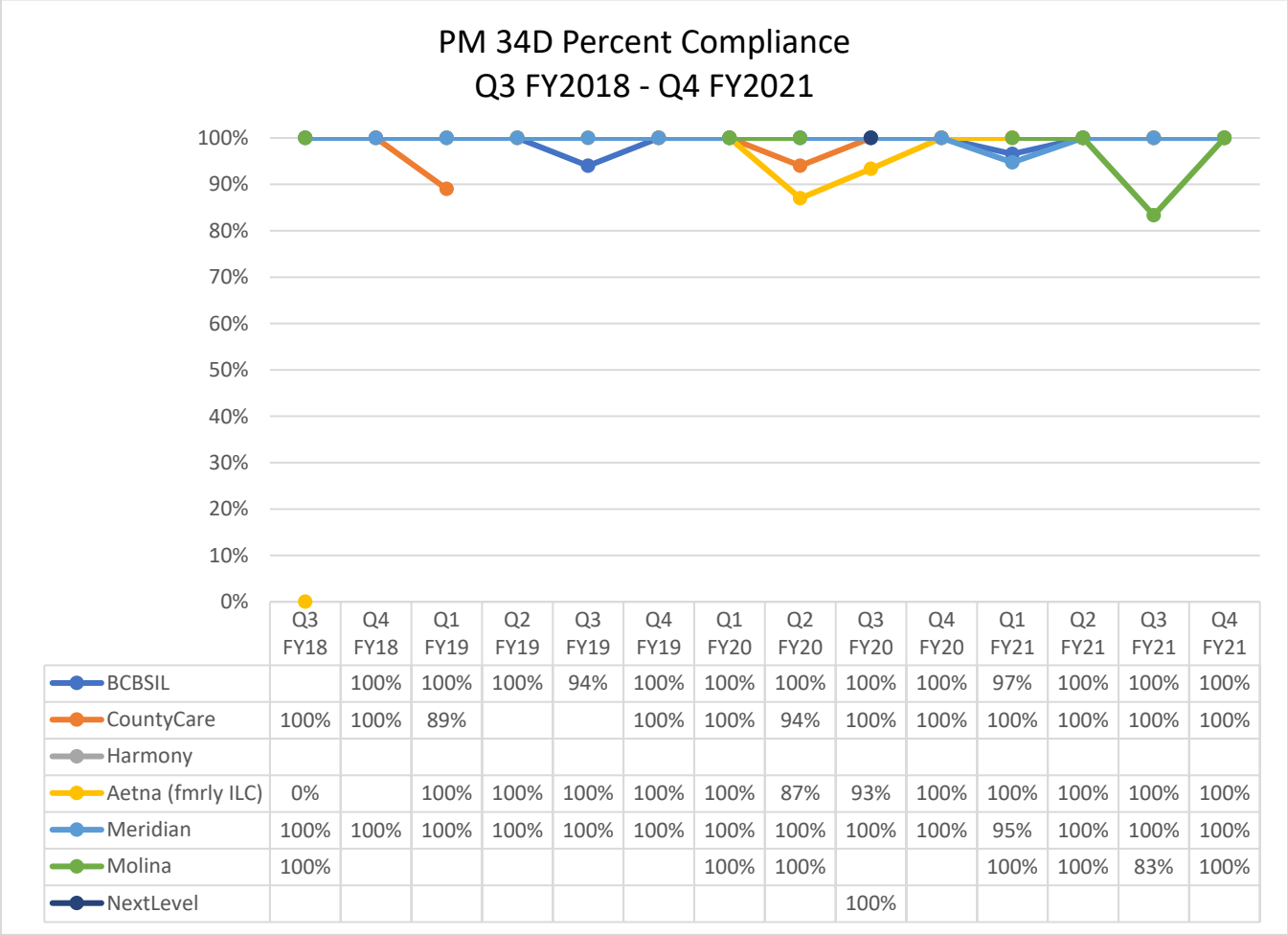


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	90%	83%	95%	98%	96%	99%	93%	98%	99%	99%	100%	99%
CountyCare	100%	100%	96%			100%	92%	100%	96%	91%	91%	100%	96%	100%
Harmony		100%	50%	67%										
Aetna (fmrly ILC)	100%		98%	95%	100%	100%	100%	100%	86%	97%	98%	96%	94%	99%
Meridian	100%	100%	94%	94%	100%	95%	96%	95%	97%	97%	99%	100%	100%	99%
Molina	100%	100%	100%	100%	100%	100%	93%	100%	43%		89%	97%	90%	100%
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.8 – Measure 34D

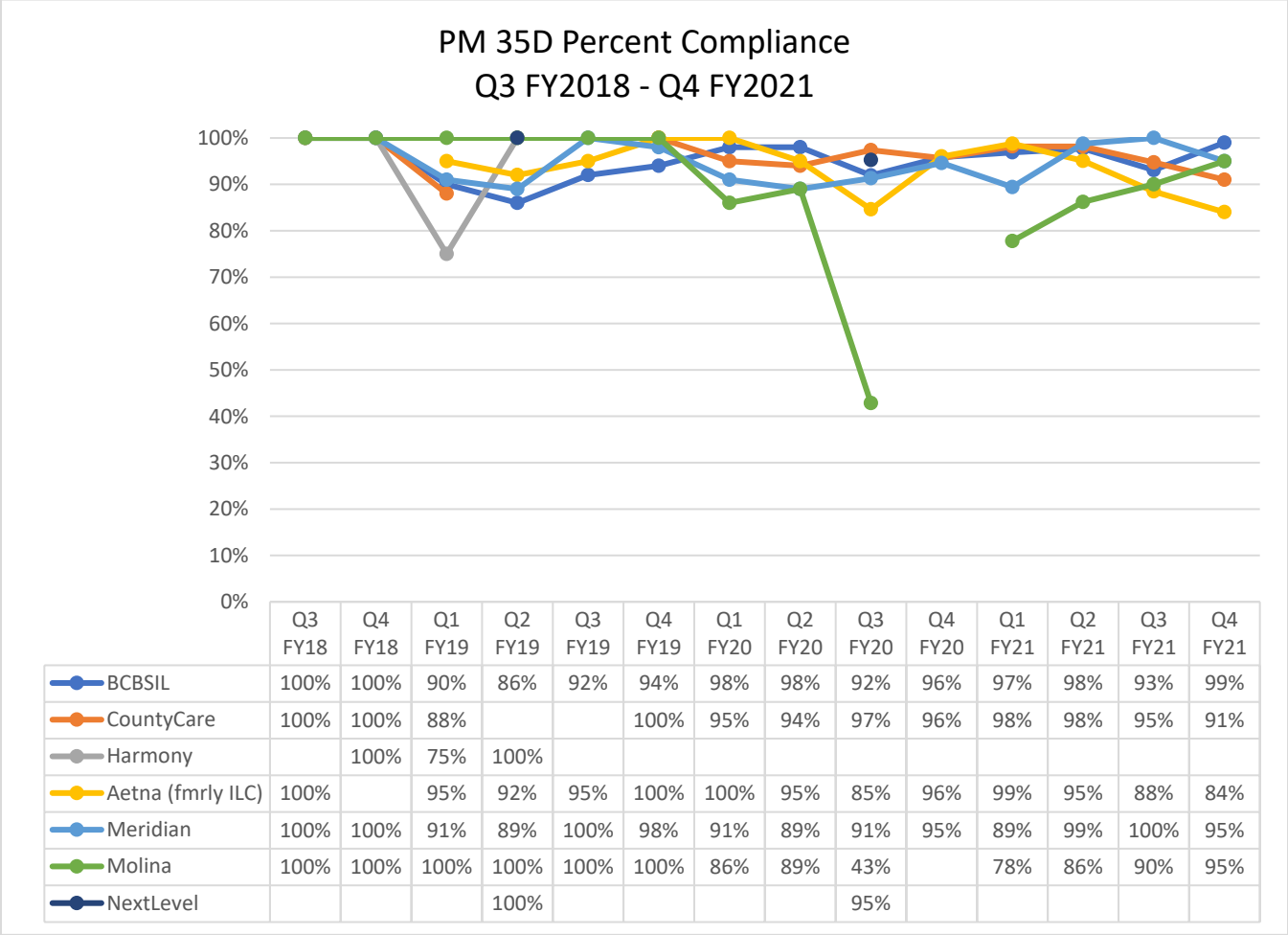


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL		100%	100%	100%	94%	100%	100%	100%	100%	100%	97%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	94%	100%	100%	100%	100%	100%	100%
Harmony														
Aetna (fmrly ILC)	0%		100%	100%	100%	100%	100%	87%	93%	100%	100%	100%	100%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	95%	100%	100%	100%
Molina	100%						100%	100%			100%	100%	83%	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.9 – Measure 35D



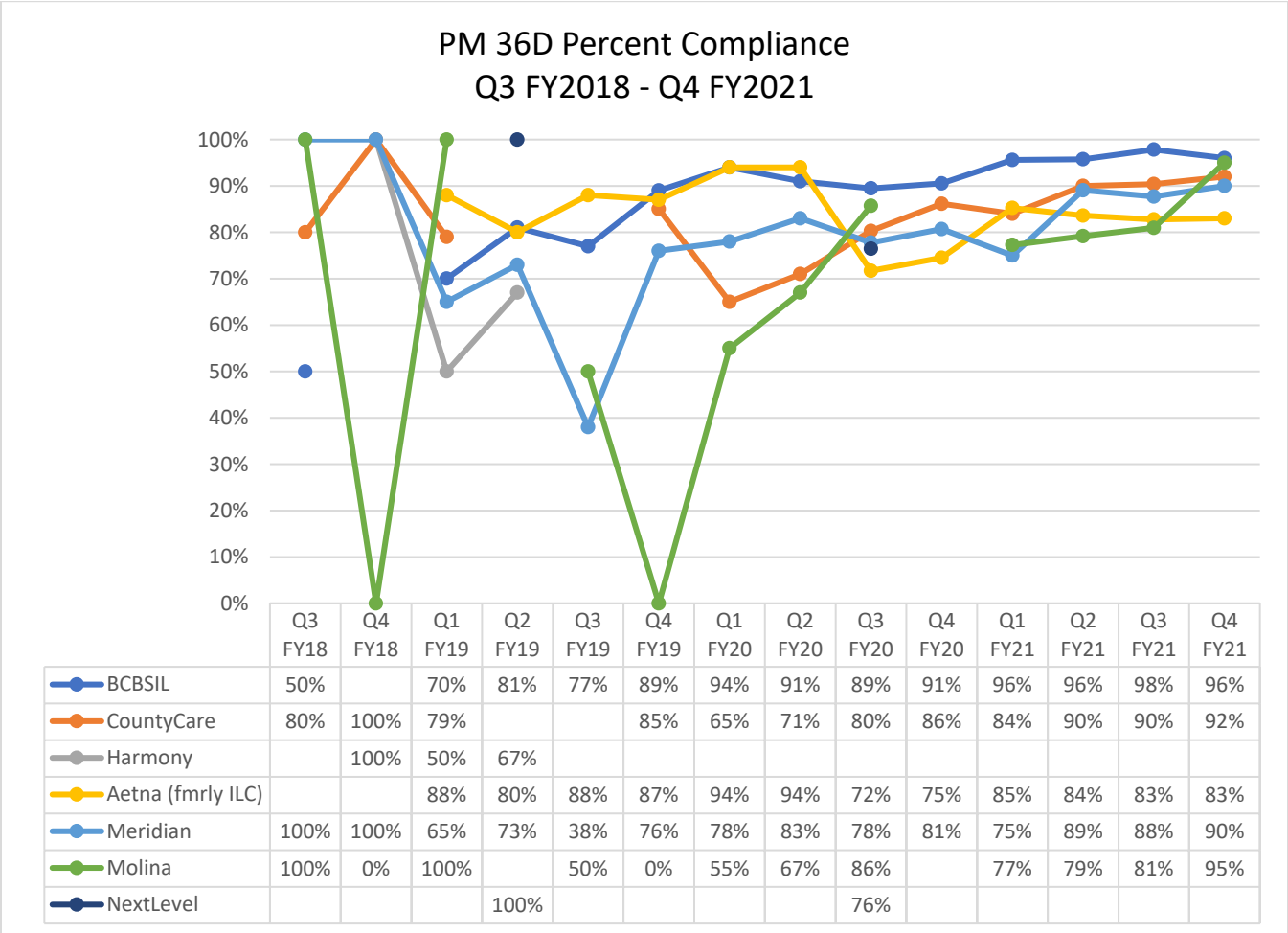
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	90%	86%	92%	94%	98%	98%	92%	96%	97%	98%	93%	99%
CountyCare	100%	100%	88%			100%	95%	94%	97%	96%	98%	98%	95%	91%
Harmony		100%	75%	100%										
Aetna (fmrly ILC)	100%		95%	92%	95%	100%	100%	95%	85%	96%	99%	95%	88%	84%
Meridian	100%	100%	91%	89%	100%	98%	91%	89%	91%	95%	89%	99%	100%	95%
Molina	100%	100%	100%	100%	100%	100%	86%	89%	43%		78%	86%	90%	95%
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.10 – Measure 36D



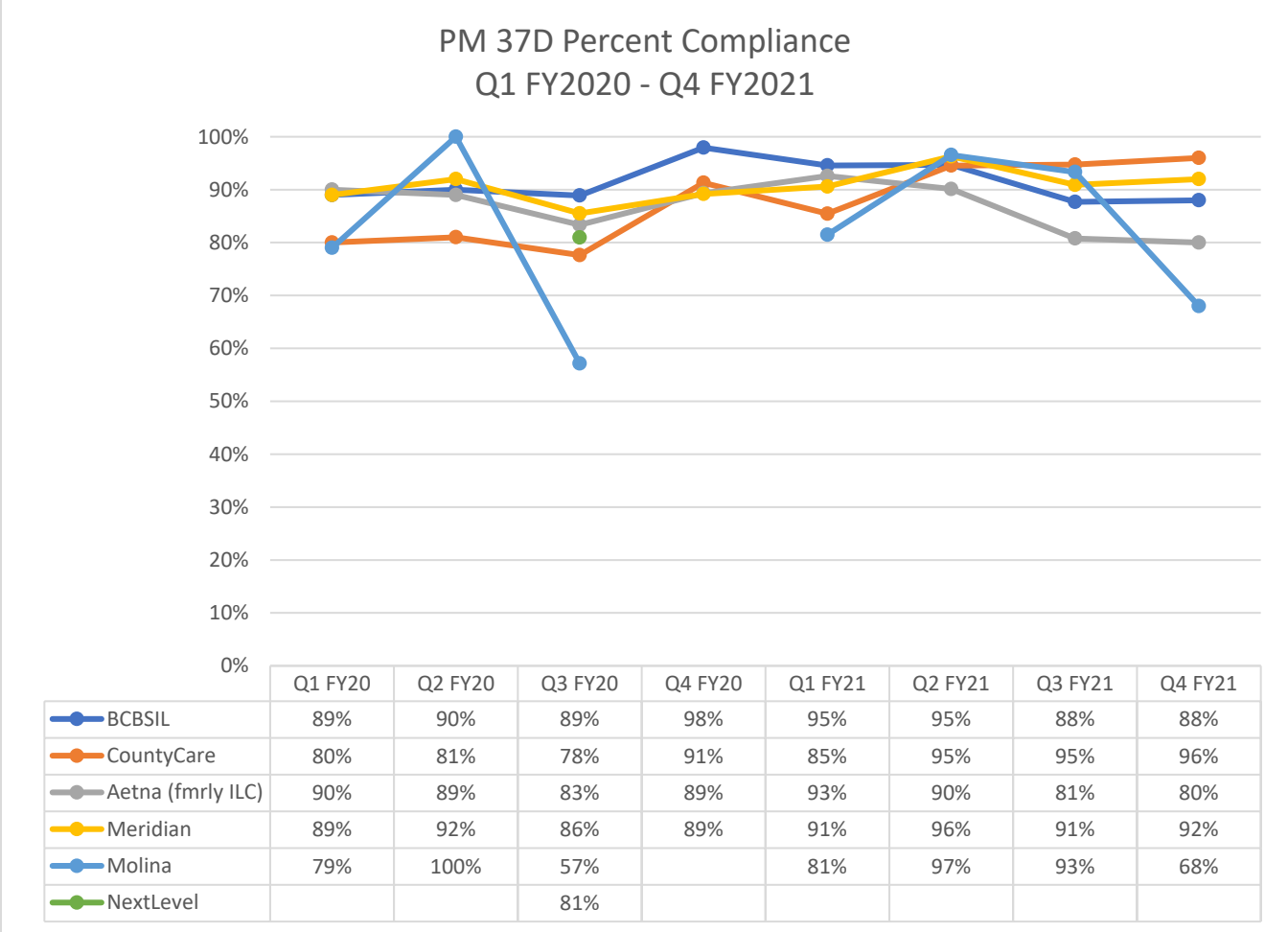
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	50%		70%	81%	77%	89%	94%	91%	89%	91%	96%	96%	98%	96%
CountyCare	80%	100%	79%			85%	65%	71%	80%	86%	84%	90%	90%	92%
Harmony		100%	50%	67%										
Aetna (fmrly ILC)			88%	80%	88%	87%	94%	94%	72%	75%	85%	84%	83%	83%
Meridian	100%	100%	65%	73%	38%	76%	78%	83%	78%	81%	75%	89%	88%	90%
Molina	100%	0%	100%		50%	0%	55%	67%	86%		77%	79%	81%	95%
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 and FY 2021 data is displayed.

Figure B.11 – Measure 37D

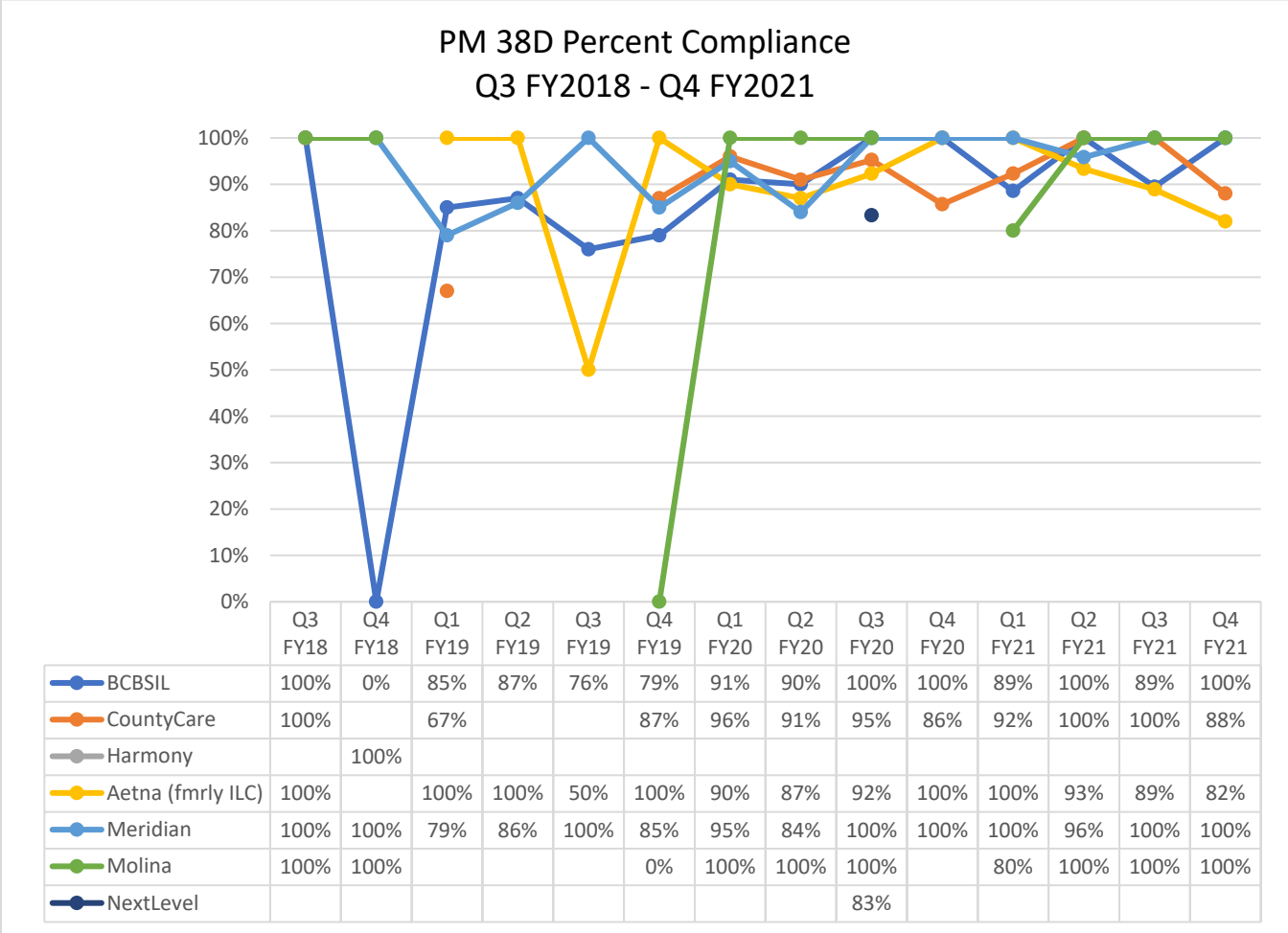


	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	89%	90%	89%	98%	95%	95%	88%	88%
CountyCare	80%	81%	78%	91%	85%	95%	95%	96%
Aetna (fmrly ILC)	90%	89%	83%	89%	93%	90%	81%	80%
Meridian	89%	92%	86%	89%	91%	96%	91%	92%
Molina	79%	100%	57%		81%	97%	93%	68%
NextLevel			81%					

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 or upon enrollee request.

Figure B.12 – Measure 38D

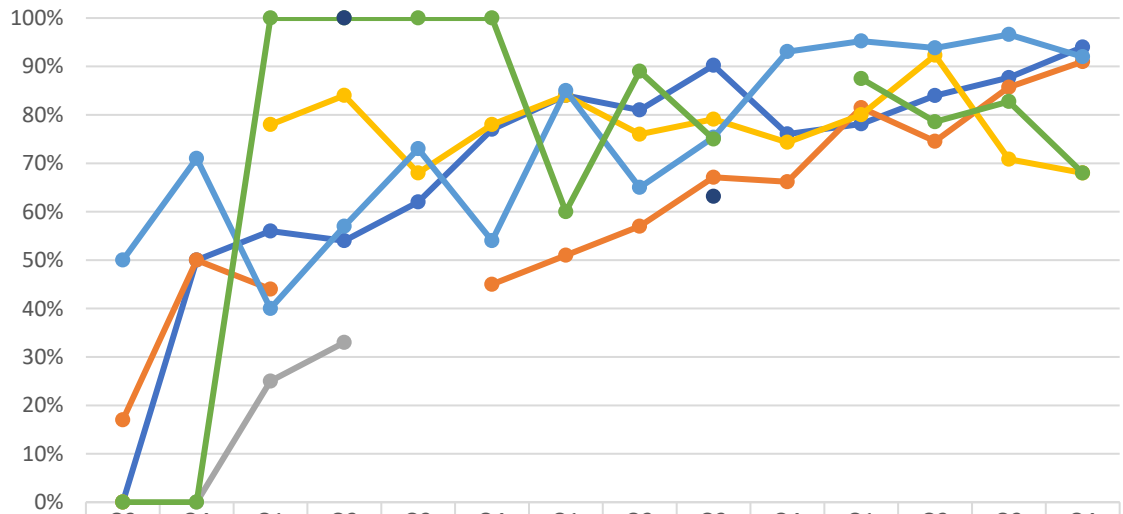


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	0%	85%	87%	76%	79%	91%	90%	100%	100%	89%	100%	89%	100%
CountyCare	100%		67%			87%	96%	91%	95%	86%	92%	100%	100%	88%
Harmony		100%												
Aetna (fmrly ILC)	100%		100%	100%	50%	100%	90%	87%	92%	100%	100%	93%	89%	82%
Meridian	100%	100%	79%	86%	100%	85%	95%	84%	100%	100%	100%	96%	100%	100%
Molina	100%	100%				0%	100%	100%	100%		80%	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.13 – Measure 39D

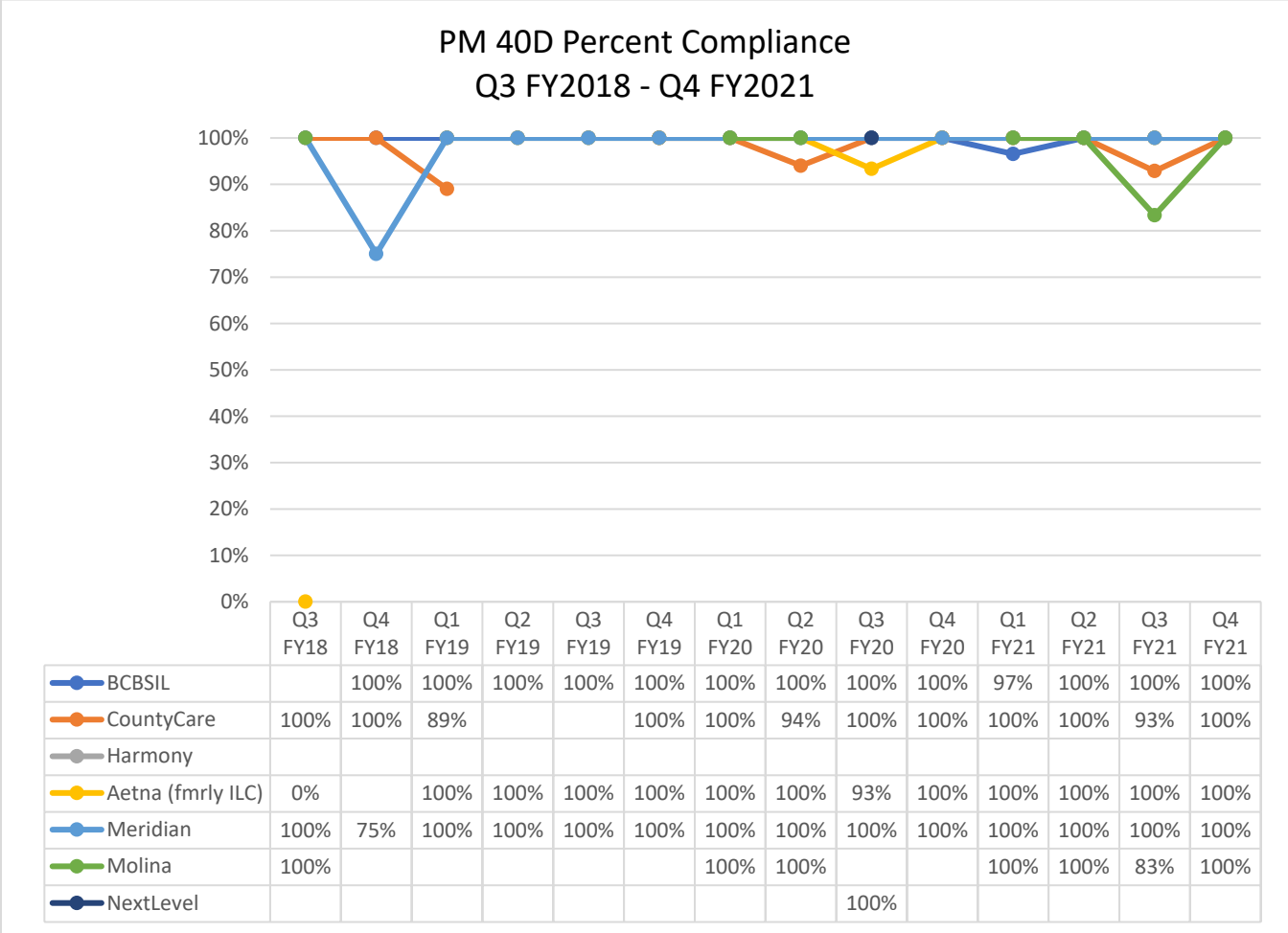


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	0%	50%	56%	54%	62%	77%	84%	81%	90%	76%	78%	84%	88%	94%
CountyCare	17%	50%	44%			45%	51%	57%	67%	66%	81%	75%	86%	91%
Harmony		0%	25%	33%										
Aetna (fmrly ILC)	0%		78%	84%	68%	78%	84%	76%	79%	74%	80%	92%	71%	68%
Meridian	50%	71%	40%	57%	73%	54%	85%	65%	75%	93%	95%	94%	97%	92%
Molina	0%	0%	100%	100%	100%	100%	60%	89%	75%		88%	79%	83%	68%
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.14 – Measure 40D

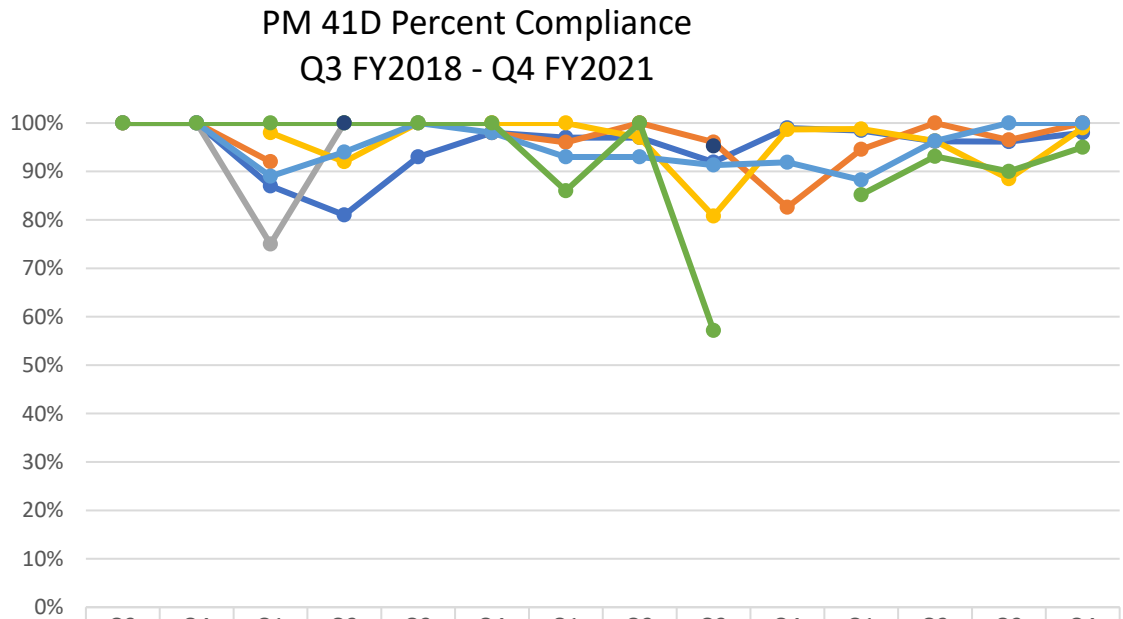


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL		100%	100%	100%	100%	100%	100%	100%	100%	100%	97%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	94%	100%	100%	100%	100%	93%	100%
Harmony														
Aetna (fmrly ILC)	0%		100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%	100%
Meridian	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%						100%	100%			100%	100%	83%	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.15 – Measure 41D

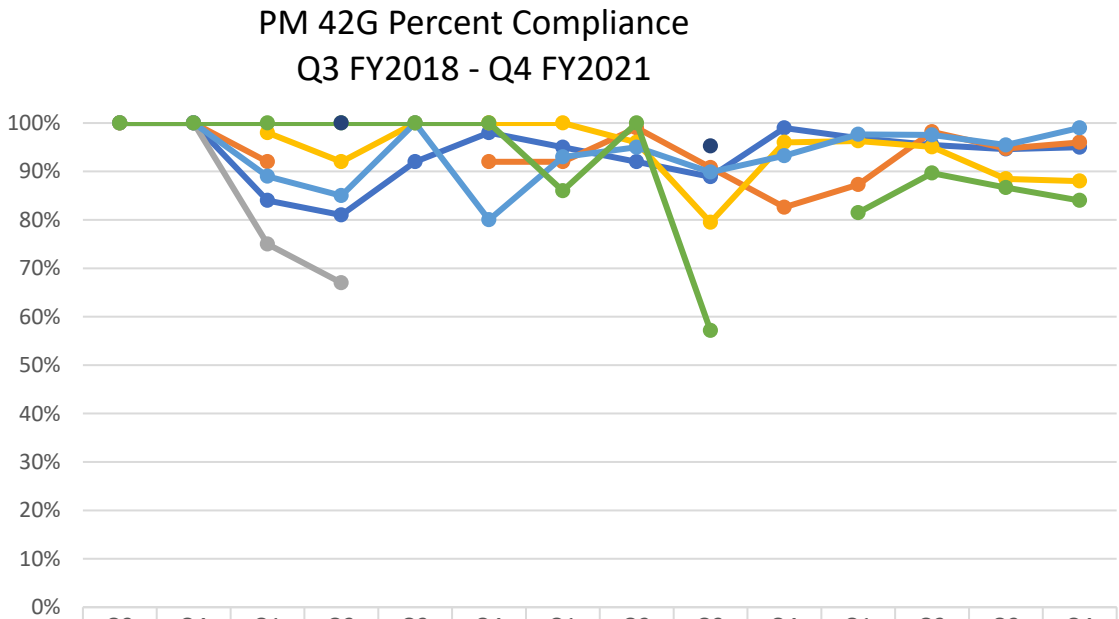


	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	87%	81%	93%	98%	97%	97%	92%	99%	98%	96%	96%	98%
CountyCare	100%	100%	92%			98%	96%	100%	96%	83%	95%	100%	96%	100%
Harmony		100%	75%	100%										
Aetna (fmrly ILC)	100%		98%	92%	100%	100%	100%	97%	81%	99%	99%	96%	88%	99%
Meridian	100%	100%	89%	94%	100%	98%	93%	93%	91%	92%	88%	96%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	86%	100%	57%		85%	93%	90%	95%
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.16 – Measure 42G



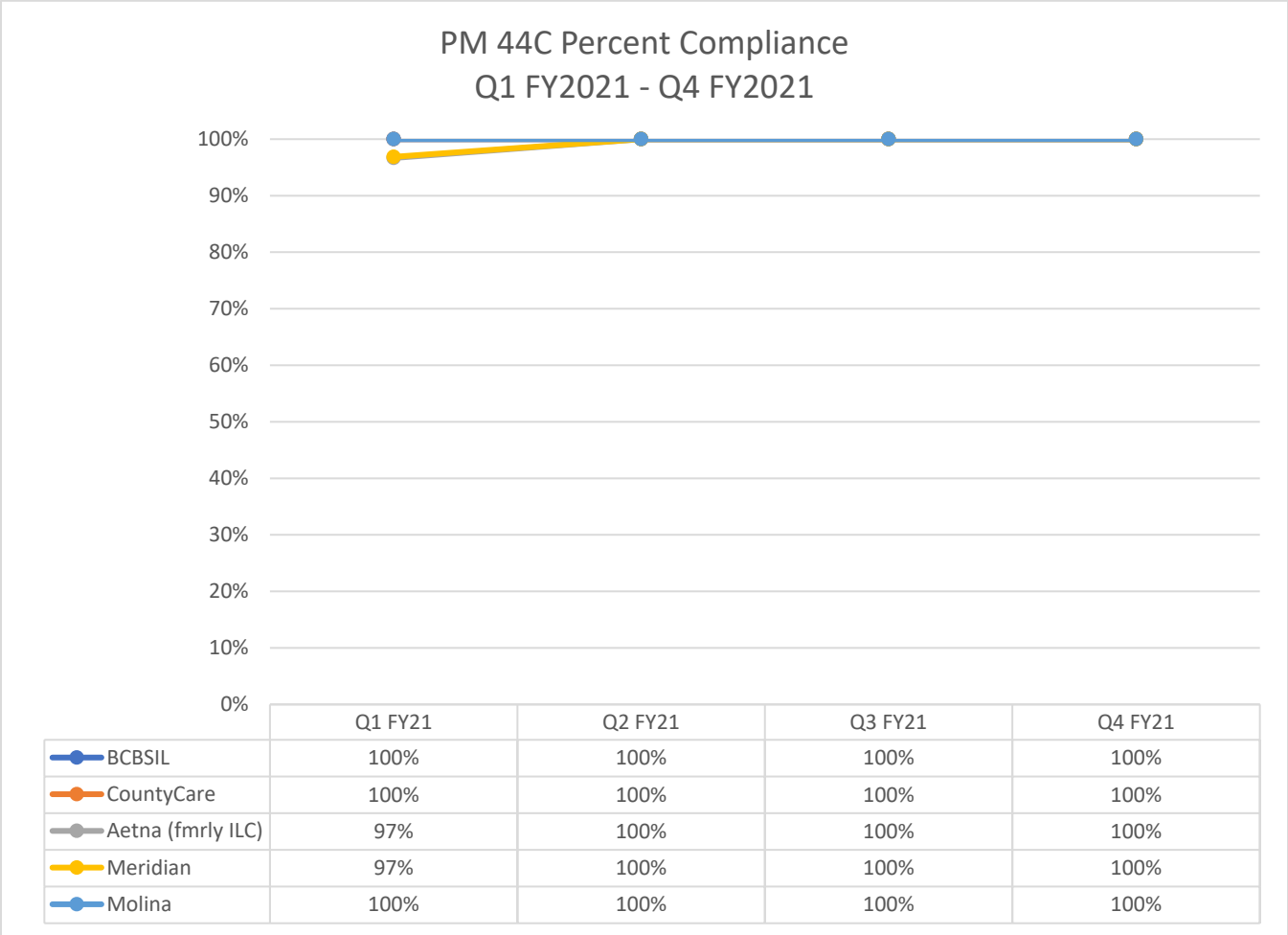
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	84%	81%	92%	98%	95%	92%	89%	99%	97%	95%	95%	95%
CountyCare	100%	100%	92%			92%	92%	99%	91%	83%	87%	98%	95%	96%
Harmony		100%	75%	67%										
Aetna (fmrly ILC)	100%		98%	92%	100%	100%	100%	96%	79%	96%	96%	95%	88%	88%
Meridian	100%	100%	89%	85%	100%	80%	93%	95%	90%	93%	98%	98%	95%	99%
Molina	100%	100%	100%	100%	100%	100%	86%	100%	57%		81%	90%	87%	84%
NextLevel				100%					95%					

Note: Blank cells represent quarters in which the health plan was not reviewed.

Measure 44C – The enrollee reported satisfaction with his/her PA.

New measure beginning FY 2021.

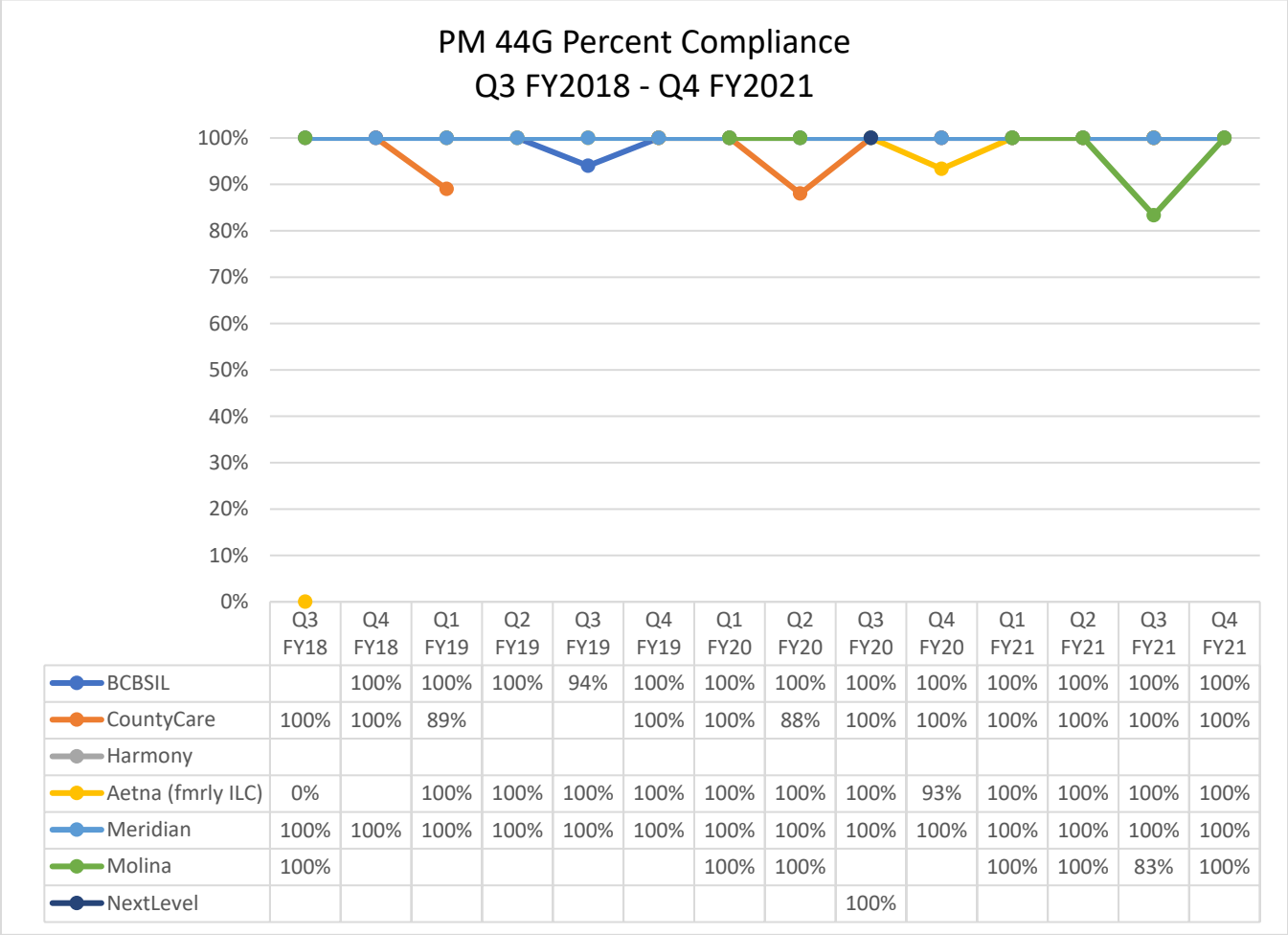
Figure B.17 – Measure 44C



	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	100%	100%	100%	100%
CountyCare	100%	100%	100%	100%
Aetna (fmrly ILC)	97%	100%	100%	100%
Meridian	97%	100%	100%	100%
Molina	100%	100%	100%	100%

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.18 – Measure 44G



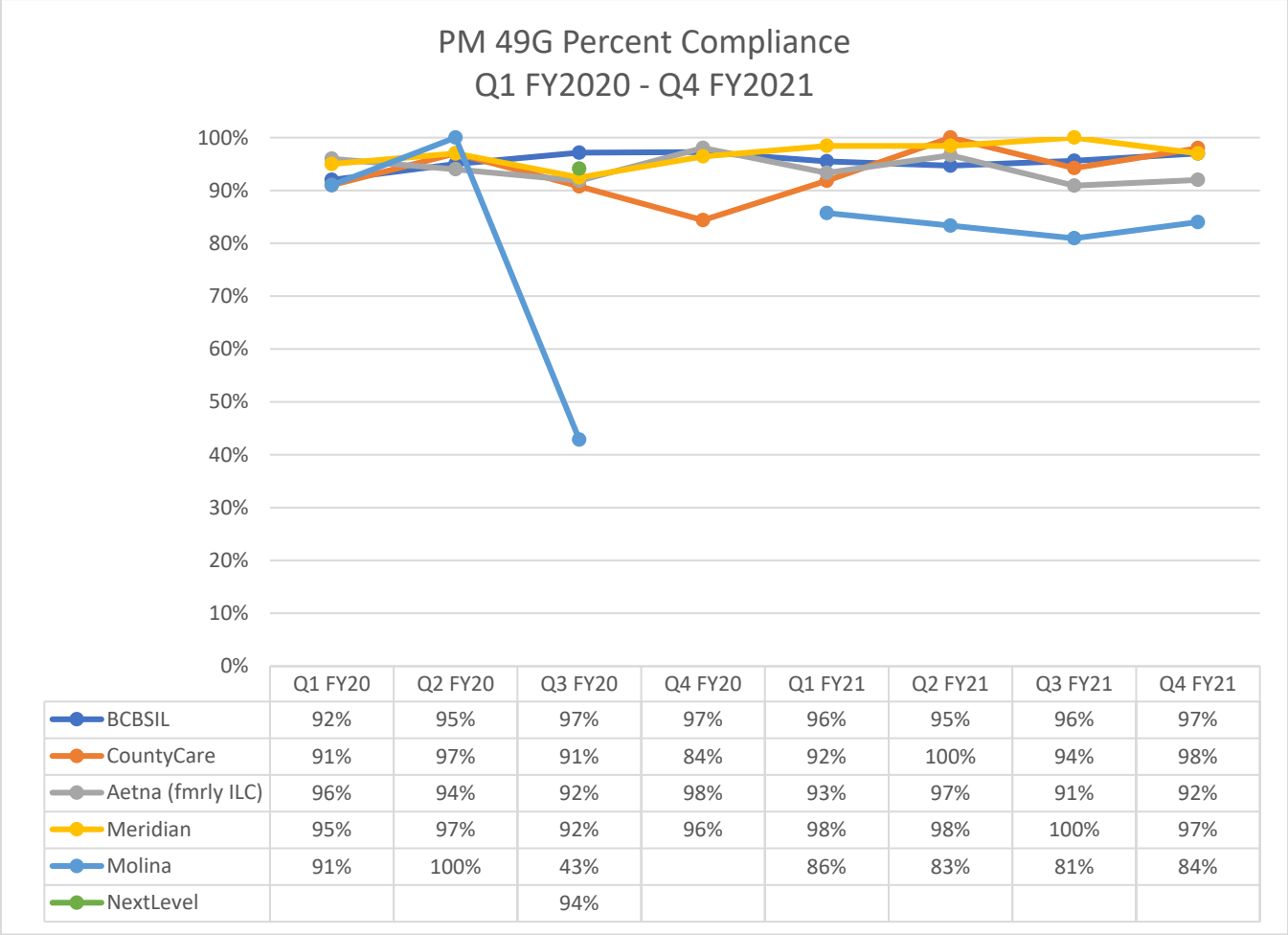
	Q3 FY18	Q4 FY18	Q1 FY19	Q2 FY19	Q3 FY19	Q4 FY19	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL		100%	100%	100%	94%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CountyCare	100%	100%	89%			100%	100%	88%	100%	100%	100%	100%	100%	100%
Harmony														
Aetna (fmrly ILC)	0%		100%	100%	100%	100%	100%	100%	100%	93%	100%	100%	100%	100%
Meridian	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%						100%	100%			100%	100%	83%	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 and FY 2021 data is displayed.

Figure B.19 – Measure 49G



	Q1 FY20	Q2 FY20	Q3 FY20	Q4 FY20	Q1 FY21	Q2 FY21	Q3 FY21	Q4 FY21
BCBSIL	92%	95%	97%	97%	96%	95%	96%	97%
CountyCare	91%	97%	91%	84%	92%	100%	94%	98%
Aetna (fmrly ILC)	96%	94%	92%	98%	93%	97%	91%	92%
Meridian	95%	97%	92%	96%	98%	98%	100%	97%
Molina	91%	100%	43%		86%	83%	81%	84%
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[1]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44C[2]**	**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%
Q1 2021	29%	0%	66%	98%	98%	99%	97%	97%	96%	95%	89%	78%	97%	98%	97%	100%	100%	96%
Q2 2021	14%	0%	77%	96%	99%	99%	100%	98%	96%	95%	100%	84%	100%	96%	95%	100%	100%	95%
Q3 2021	25%	0%	64%	99%	100%	100%	100%	93%	98%	88%	89%	88%	100%	96%	95%	100%	100%	96%
Q4 2021	45%	14%	84%	99%	99%	99%	100%	99%	96%	88%	100%	94%	100%	98%	95%	100%	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																		

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[1]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44C[2]**	**44G**	**49G**
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%
Q4 2020	0%			94%	93%	91%	100%	96%	86%	91%	86%	66%	100%	83%	83%		100%	84%
Q1 2021	13%	0%	59%	96%	93%	91%	100%	98%	84%	85%	92%	81%	100%	95%	97%	100%	100%	92%
Q2 2021	0%	0%	74%	100%	98%	100%	100%	98%	90%	95%	100%	75%	100%	100%	98%	100%	100%	100%
Q3 2021	33%	8%	59%	96%	95%	96%	100%	95%	90%	95%	100%	86%	93%	96%	95%	100%	100%	94%
Q4 2021	50%	0%	88%	100%	94%	100%	100%	91%	92%	96%	88%	91%	100%	100%	96%	100%	100%	98%
Aetna Better Health (formerly 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%
Q1 2021	50%	0%	79%	99%	99%	98%	100%	99%	85%	93%	100%	80%	100%	99%	96%	97%	100%	93%
Q2 2021	13%	17%	83%	96%	95%	96%	100%	95%	84%	90%	93%	92%	100%	96%	95%	100%	100%	97%
Q3 2021	45%	25%	85%	94%	92%	94%	100%	88%	83%	81%	89%	71%	100%	88%	88%	100%	100%	91%
Q4 2021	13%	50%	78%	98%	98%	99%	100%	84%	83%	80%	82%	68%	100%	99%	88%	100%	100%	92%
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%

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[1]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44C[2]**	**44G**	**49G**
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%
Q1 2021	38%	8%	64%	96%	99%	99%	95%	89%	75%	91%	100%	95%	100%	88%	98%	97%	100%	98%
Q2 2021	0%	8%	68%	100%	100%	100%	100%	99%	89%	96%	96%	94%	100%	96%	98%	100%	100%	98%
Q3 2021	13%	8%	66%	100%	100%	100%	100%	100%	88%	91%	100%	97%	100%	100%	95%	100%	100%	100%
Q4 2021	86%	9%	73%	99%	99%	99%	100%	95%	90%	92%	100%	92%	100%	100%	99%	100%	100%	97%
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%
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																		
Q1 2021	50%	0%	31%	89%	89%	89%	100%	78%	77%	81%	80%	88%	100%	85%	81%	100%	100%	86%
Q2 2021	0%	0%	47%	97%	90%	97%	100%	86%	79%	97%	100%	79%	100%	93%	90%	100%	100%	83%
Q3 2021	50%	0%	46%	97%	93%	90%	83%	90%	81%	93%	100%	83%	83%	90%	87%	100%	83%	81%
Q4 2021	0%	0%	10%	100%	100%	100%	100%	95%	95%	68%	100%	68%	100%	95%	84%	100%	100%	84%

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[1]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D**	**35D**	**36D**	**37D**	**38D**	**39D**	**40D**	**41D**	**42G**	**44C[2]**	**44G**	**49G**
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																		
Q3 2021																		
Q4 2021																		
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%
Q3 2021																		
Q4 2021																		

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.*

***Due to exiting HealthChoice Q4 FY2020, NextLevel's data is displayed for historic purposes through the last quarter reviewed.*

[1]*Measure modified in Q1 FY2021; historic data are not comparable.*

[2]*Measure added effective Q1 FY2021.*

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 2021																				
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%	92%	91%	94%	92%	96%	95%	94%	88%	95%	92%	92%	89%	90%	90%	89%	96%	93%	88%	95%
4A	75%		0%	50%	8%	17%	44%	30%	100%		0%	50%	38%	20%	50%	33%	33%	0%	19%	33%
12C	0%	0%	0%	0%					0%	33%	9%	0%	4%	3%	6%	22%				
20C	69%	75%	81%	88%					65%	92%	67%	77%	61%	63%	58%	68%				
31D	100%	100%	97%	100%	94%	98%	98%	98%	98%	100%	100%	100%	98%	96%	99%	99%	97%	96%	96%	99%
32D	98%	100%	97%	100%	95%	97%	97%	95%	100%	100%	100%	100%	98%	96%	98%	98%	97%	98%	96%	100%
33D	97%	100%	98%	100%	95%	98%	96%	98%	100%	100%	100%	100%	97%	99%	99%	99%	98%	98%	96%	100%
34D					98%	100%	99%	100%												
35D	100%	97%	97%	93%	91%	97%	96%	95%	95%	98%	98%	93%	92%	98%	98%	91%	96%	94%	84%	95%
36D	64%	71%	68%	79%	98%	99%	99%	99%	59%	76%	80%	73%	100%	99%	100%	99%				
37D	93%	100%	98%	97%	85%	94%	90%	88%	95%	100%	98%	95%	91%	95%	91%	80%	93%	87%	74%	83%
38D	90%	100%	100%	100%	92%	100%	93%	100%	100%	94%	100%	83%	93%	96%	88%	88%	100%	100%	100%	100%
39D	89%	84%	79%	90%	74%	78%	82%	71%	77%	89%	83%	93%	78%	82%	84%	87%	99%	99%	99%	96%
40D					99%	100%	98%	100%												
41D	100%	100%	98%	98%	90%	98%	96%	99%	98%	98%	100%	100%	90%	98%	98%	98%	99%	91%	87%	100%
42G	100%	100%	98%	98%	89%	96%	94%	94%	98%	98%	100%	100%	93%	97%	95%	88%	96%	91%	84%	94%
44C	98%	100%	100%	100%					100%	100%	100%	100%	98%	100%	100%	100%				
44G					100%	100%	99%	100%												
49G	85%	92%	92%	97%	99%	98%	99%	97%	95%	100%	100%	100%	96%	94%	89%	90%				

Table D.2—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.3—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.4—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

SFY21 Annual Report

December 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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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) 2021 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 2021 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 18 CMS waiver performance measures, and additional MMAI contract measures. During SFY 2021, 1,258 records were reviewed utilizing HSAG's web-based data collection tool. As a result, 1,118 findings of non-compliance were identified.

Although reviews in SFY 2021 occurred virtually due to pandemic restrictions, SFY 2021 performance was not impacted by pandemic emergency protocols due to the retrospective lookback period for the reviews. HSAG will report on the impact of performance in SFY 2022 reports.

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 2021.

Table 1.1—SFY 2021 MMAI Health Plans

MMAI Health Plan Name
Aetna Better Health, Inc. (Aetna)
Blue Cross Blue Shield of Illinois (BCBSIL)
Humana Health Plan, Inc. (Humana)
MeridianTotal (previously IlliniCare Health Plan [MeridianTotal])
MeridianComplete (Meridian)
Molina Healthcare of Illinois (Molina)

Successes

SFY 2021 represented the seventh year of review for the MMAI population, and several successes were identified.

☑ Twelve of the 18 CMS performance measures performed at rates over 90 percent compliance in SFY 2021.

☑ 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*, realized a statistically significant increase in performance in SFY 2021 when compared to SFY 2020.

☑ Three of the six health plans averaged greater than 90 percent compliance in SFY 2021.

☑ Compared to SFY 2020, BCBSIL realized a statistically significant increase in performance for four measures in SFY 2021.

☑ Compared to SFY 2020, Molina realized a statistically significant increase in performance for one measure in SFY 2021.

☑ Meridian maintained stable performance in SFY 2021 when compared to SFY 2020; performance reflected merging of IlliniCare and MeridianComplete data and enrolleees.

☑ Compared to SFY 2020, the ELD and PD waivers realized a statistically significant increase in one measure in SFY 2021.

Opportunities for Improvement

Review of SFY 2021 performance identified the following opportunities for improvement:

Compared to SFY 2020, Humana and Molina demonstrated a statistically significant decrease in two measures in SFY 2021.

Compared to SFY 2020, Aetna demonstrated a statistically significant decrease in one measure in SFY 2021.

Compared to SFY 2020, the PD and SLP waivers demonstrated a statistically significant decrease in two measures in SFY 2021.

Compared to SFY 2020, the BI waiver demonstrated a statistically significant decrease in one measure in SFY 2021.

Measure 4A, *overdue service plan was completed within 30 days of expected renewal,* averaged 32 percent compliance in SFY 2021. All six health plans performed at a rate of less than 50 percent in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, averaged 11 percent compliance in SFY 2021. All six health plans performed at a rate of less than 50 percent in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 20C, *a PA evaluation was completed annually*, averaged 75 percent compliance in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 35D, *the most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures,* demonstrated a statistically significant decrease in performance in SFY 2021 when compared to SFY 2020.

Measure 36D, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 74 percent and 77 percent compliance for the BI and HIV waivers, respectively, in SFY 2021. A detailed analysis is provided in Section 3 of this report.

Measure 42G, *the enrollee is informed how and to whom to report abuse, neglect, or exploitation at the time of assessment/reassessment*, demonstrated a statistically significant decrease in performance in SFY 2021 when compared to SFY 2020.

Analysis of SFY 2021 Performance on SFY 2020 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 2020 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 2020 Recommendation	SFY 2021 Analysis of Performance
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.	Aetna performed at 90 percent or greater performance for 14 of the 18 measures reviewed in SFY 2021. Performance on 10 measures reflected lower performance in SFY 2021 when compared to SFY 2020; one measure performed at a statistically significant lower rate than SFY 2020. Aetna should focus efforts on measures 4A, 12C, 20C, 35D, and 39D. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.
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.	BCBSIL realized a 17-percentage point increase in performance on measure 4A when compared to SFY 2020. BCBSIL realized a statistically significant increase in performance on measure 39D when compared to SFY 2020. BCSBIL should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

SFY 2020 Recommendation	SFY 2021 Analysis of Performance
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 demonstrated a 13-percentage point decrease in performance on measure 4A when compared to SFY 2020. Humana realized a nine-percentage point increase in performance on measure 39D when compared to SFY 2020. Humana demonstrated a statistically significant decrease in performance on measures 41D and 42D when compared to SFY 2020. Humana should focus efforts on 4A, 12C, 31D, 39D, 41D, and 42G. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.
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.	Due to Centene's acquisition of WellCare, the IlliniCare product evolved to MeridianTotal; by the end of SFY 2021, MeridianTotal and MeridianComplete enrollees and data had merged. Therefore, performance was not calculated for the entire SFY 2021. Analysis through Q2 SFY 2021 reviews demonstrated that IlliniCare (MeridianTotal) was performing at a rate of 90 percent or greater for 11 of the 18 performance measures.
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.	Due to Centene's acquisition of WellCare, by the end of SFY 2021, MeridianTotal and MeridianComplete enrollees and data had merged. Therefore, performance was not comparable between SFY 2020 and SFY 2021. However, final performance rates for SFY 2021 revealed that Meridian performed at a rate of 90 percent or greater for 14 of the 18 performance measures. Meridian should focus efforts on 4A, 12C, 20C, and 37D. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

SFY 2020 Recommendation	SFY 2021 Analysis of Performance
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 demonstrated an eight-percentage point decrease in performance on measure 4A when compared to SFY 2020. Molina realized a statistically significant increase in performance on measure 39D when compared to SFY 2020. Molina demonstrated a statistically significant decrease in performance on measures 35D and 36D when compared to SFY 2020. Molina should focus efforts on 4A, 12C, 20C, 35D, and 36D. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.
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, stable performance from SFY 2020 to SFY 2021. 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 2020 to SFY 2021; performance increased by seven percentage points. Focused efforts related to measure 36D were recommended during SFY 2020 and remain as a recommendation for SFY 2021.
Performance-measure specific	

SFY 2020 Recommendation	SFY 2021 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 32 percent in SFY 2021. 36D: Overall performance averaged 74 percent and 77 percent compliance for the BI and HIV waivers, respectively, in SFY 2021. 37D: Overall performance was 87 percent in SFY 2021. 39D: Overall performance for measure 39D was 87 percent in SFY 2021, a statistically significant increase from SFY 2020 performance. Focused efforts will continue to remain as recommendations for measures 4A, 36D.

EQRO Technical Assistance

To assist with the health plans with improvement efforts, HSAG provided ongoing technical assistance to the health plans throughout SFY 2021. 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 completion of annual reassessments, care plan and waiver service plan.
- Timely completion of PA evaluations.
- Timely completion and/or documentation of valid justification for enrollee contact.

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.

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 should focus efforts on measures 4A, 12C, 20C, 35D, and 39D. Aetna should ensure that it has a policy to obtain enrollee and SLP provider signatures on service plans. The health plan should consider review of its processes to determine any root causes related to performance on 10 measures reflecting lower performance in SFY 2021 when compared to SFY 2020. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

BCSBIL should focus efforts on 4A, 12C, and 20C. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Humana should focus efforts on 4A, 12C, 31D, 39D, 41D, and 42G. The health plan should consider review of its processes to determine any root causes related to statistically significant decreases in performance on two measures in SFY 2021 when compared to SFY 2020. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Meridian should focus efforts on 4A, 12C, 20C, and 37D. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

Molina should focus efforts on 4A, 12C, 20C, 35D, and 36D. The health plan should consider review of its processes to determine any root causes related to statistically significant decreases in performance on two measures in SFY 2021 when compared to SFY 2020. The health plan may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations.

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, 12C, 20C, and 36D. The health plans may benefit from utilizing recommendations indicated in the *Performance Measure-Specific* recommendations below.

For measure 4A, 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 measures 12C and 20C, efforts might include:

- 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 complete PA evaluations.
- Educate care manager/care coordination staff about the expectation to complete overdue PA evaluations no later than 60 days after the date of expected completion.

For measure 36D, efforts might include:

- Conduct root cause analysis to determine opportunities to affect change.
- 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.

2. Data Collection and Methodology

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 state fiscal year 2015 to monitor MMAI 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 of 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) 2021 review, HFS identified 18 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 2021, the following changes were identified from FY 2020 performance measure definitions:

- Measure 4A, overdue service plan was completed within 30 days of expected renewal, was revised for FY 2021 to include all waivers (excluded the BI and SLP waivers during FY2020).
- Measure 20C, was a PA evaluation completed annually, was added for waiver enrollees who have a personal assistant (PA).
- Measure 12C, if the PA evaluation was not completed annually, was it completed within 60 days of the expected annual date, was added for waiver enrollees who have a PA.
- Measure 44C, did the enrollee report satisfaction with his/her PA, was added for waiver enrollees who have a PA.

Other performance measures had language revisions to ensure consistency with waiver language; those changes did not result in impact to comparisons to historic data.

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 May 2020 and included waiver members enrolled as of May 1, 2020. 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	1,101	130	36	18	24	25	27
BCBSIL	5,071	537	165	58	42	132	140
Humana	1,518	130	57	14	5	30	24
IlliniCare	1,177	141	36	21	16	37	31
Meridian	1,231	140	38	19	11	41	31
Molina	1,410	181	34	20	11	60	56
Statewide Total	11,508	1,259	366	150	109	325	309

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 2021 consisted of the following:

- Quarter 1, SFY 2021: December 1, 2019 – May 31, 2020
- Quarter 2, SFY 2021: March 1, 2020 – August 31, 2020
- Quarter 3, SFY 2021: June 1, 2020 – November 30, 2020
- Quarter 4, SFY 2021: September 1, 2020 – February 28, 2021

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 care planning, waiver service provision, 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)

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 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 percent 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 percent accuracy rate standard. All members of the HSAG review team maintained a rate above 95 percent.

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 completed 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 SFY 2021

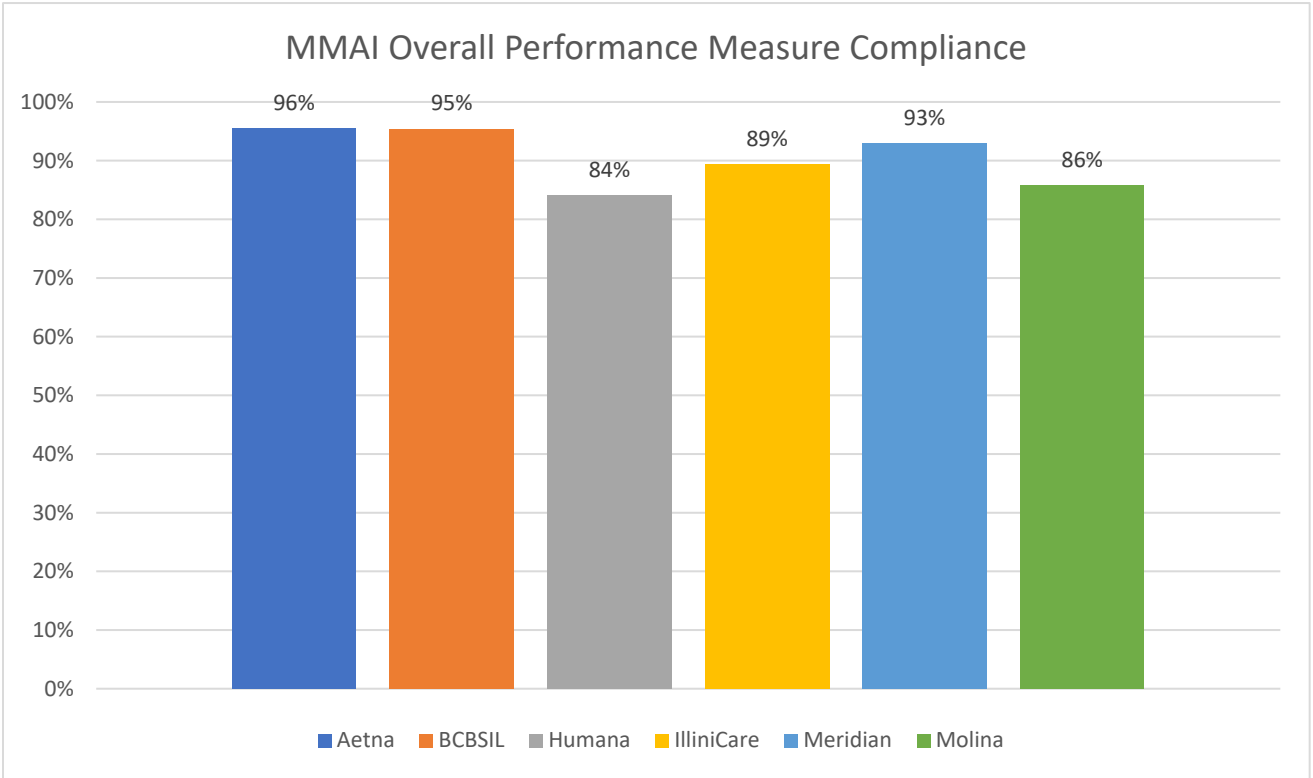
Overall Performance

Overall Health Plan Performance and Comparisons

Six health plans were reviewed during SFY 2021. Figure 3.1 displays a computed average of the total performance achieved by each health plan on all 18 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG) during SFY 2021. Displaying each health plan's overall average on the 18 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 overall compliance in SFY 2021. There was an 12-percentage point difference (84% to 96%) 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 (IlliniCare's data is representative of performance prior to merge of data with Meridian):

- Aetna performed at a statistically significant higher rate than Humana, IlliniCare, Meridian, and Molina.
- BCBSIL performed at a statistically significant higher rate than Humana, IlliniCare, Meridian, and Molina.
- Humana performed at a statistically significant lower rate than Aetna, BCBSIL, IlliniCare, and Meridian.
- IlliniCare performed at a statistically significant higher rate than Molina, but a statistically significant lower rate than Meridian.
- Meridian performed at a statistically significant higher rate than Humana, IlliniCare, and Molina.

Individual Health Plan Results

Statistical significance testing was performed to compare each health plan's overall compliance from Q1 to Q4 SFY 2021. Comparisons from SFY 2020 to SFY 2021 were not completed, as the total number of performance measures reviewed was different in each fiscal year. 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)

Analysis identified that Aetna performed at 90 percent or greater compliance in 14 of the 18 measures during SFY 2021.

Analysis identified that Aetna's greatest opportunity for improvement related to measure 20C: a PA evaluation was completed annually, which demonstrated performance of 88 percent (53 of 60 records). Aetna also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 33 percent (1 of 3 records), and 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 33 percent (2 of 6 records).

Blue Cross Blue Shield of Illinois (BCBSIL)

Analysis identified that BCBSIL performed at 90 percent or greater compliance in 15 of the 18 measures during SFY 2021.

When Q4 performance was compared to Q1 performance, BCBSIL realized a statistically significant increase in performance 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 93 percent (+7 percentage points). BCBSIL demonstrated a statistically

significant decrease in performance in measure 37D: the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 90 percent (-3 percentage points).

Analysis identified that BCBSIL's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 17 percent (5 of 30 records). BCBSIL also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 38 percent (21 of 56 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 84 percent (161 of 192 records).

Humana Health Plan, Inc. (Humana)

Analysis identified that Humana performed at 90 percent or greater compliance in nine of the 18 measures during SFY 2021. When Q4 performance is compared to Q2 performance, Humana demonstrated a statistically significant decrease in performance in measure 38D: the service plan was updated when the enrollee needs changed or upon enrollee request, which performed at a rate of 63 percent (-27 percentage points: 12 of 19 records).

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 22 percent (7 of 32 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 65 percent (79 of 121 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 63 percent (19 of 30 records).

MeridianComplete (Meridian) & MeridianTotal (formerly IlliniCare Health Plan, Inc.)

During SFY 2021, MeridianComplete and MeridianTotal merged systems and data, resulting in a combined rate after Q2. Despite the combined data, MeridianComplete demonstrated stable performance from SFY 2020 to SFY 2021, and analysis identified that Meridian performed at 90 percent or greater compliance in 14 of the 18 measures during SFY 2021.

Analysis identified that Meridian's greatest opportunity for improvement related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 9 percent (2 of 22 records). Meridian also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 33 percent (10 of 30 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 76 percent (71 of 93 records).

Molina Healthcare of Illinois, Inc. (Molina)

Analysis identified that Molina performed at 90 percent or greater compliance in 10 of the 18 measures during SFY 2021.

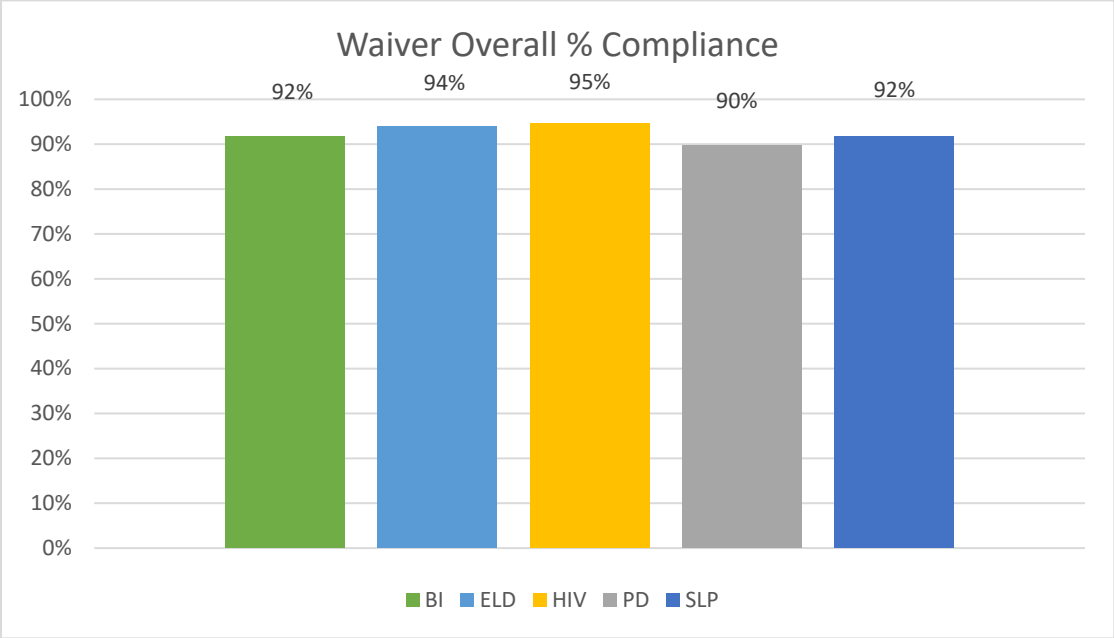
Analysis identified that Molina's greatest opportunity for improvement related to 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 4 percent (2 of 47 records). Molina also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 35 percent (11 of 31 records), and 20C: a PA evaluation was completed annually, which demonstrated performance of 36 percent (26 of 72 records).

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 90 percent or greater overall compliance in SFY 2021.

Figure 3.2—Overall Compliance Across Waiver Types



Individual Waiver Type Results

Statistical significance testing was performed to compare each waiver's overall compliance from Q1 to Q4 SFY 2021. Comparisons from SFY 2020 to SFY 2021 were not completed, as the total number of

performance measures reviewed was different in each fiscal year. Individual waiver performance analysis identified the following.

BI Waiver

Fifteen performance measures are assessed for the BI waiver. Analysis identified that the BI waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

Analysis identified that greatest opportunity for improvement for the BI waiver related to measure 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 22 percent (5 of 23 records). The BI waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 43 percent (6 of 14 records), and 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 74 percent (111 of 150 records).

ELD Waiver

Fifteen performance measures are assessed for the ELD waiver. Analysis identified that the ELD waiver performed at 90 percent or greater compliance in 11 of the 15 measures during SFY 2021.

Analysis identified that greatest opportunity for improvement for the ELD waiver related to measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 27 percent (12 of 44 records). The ELD waiver 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 performed at a rate of 80 percent (286 of 358 records).

HIV Waiver

Fifteen performance measures are assessed for the HIV waiver. Analysis identified that the HIV waiver performed at 90 percent or greater compliance in 10 of the 15 measures during SFY 2021.

Analysis identified that greatest opportunity for improvement for the HIV waiver related to measure 36D: the case manager made valid timely contact with the enrollee or valid justification is documented in the enrollee's record, which demonstrated performance of 77 percent (83 of 108 records). The HIV waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 67 percent (4 of 6 records), and 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 33 percent (4 of 12 records).

PD Waiver

Fifteen performance measures are assessed for the PD waiver. Analysis identified that the PD waiver performed at 90 percent or greater compliance in nine of the 15 measures during SFY 2021.

Analysis identified that the greatest opportunity for improvement for the PD waiver related to measure 20C: a PA evaluation was completed annually, which demonstrated performance of 67 percent (173 of 259 records). The PD waiver also had opportunity for improvement in measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 33 percent (13 of 39 records), and 12C: if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date, which demonstrated performance of 5 percent (4 of 82 records).

SLP Waiver

Ten performance measures are assessed for the SLP waiver. Analysis identified that the SLP waiver performed at 90 percent or greater compliance in seven of the 10 measures during SFY 2021.

Analysis identified that greatest opportunity for improvement for the SLP waiver related to measure 4A: overdue service plan was completed within 30 days of expected renewal, which demonstrated performance of 30 percent (18 of 61 records). The SLP waiver also had opportunity for improvement in measure 37D: the most recent service plan is in the record and completed in a timely manner, which performed at a rate of 80 percent (248 of 309 records).

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	FY2021
4A	Overdue service plan was completed within 30 days of expected renewal.	NA (0/0)	NA (0/0)	50% (1/2)
31D	The most recent service plan includes all enrollee goals as identified in the comprehensive assessment.	100% (11/11)	100% (8/8)	90% (9/10)
32D	The most recent service plan includes all enrollee needs as identified in the comprehensive assessment.	100% (11/11)	100% (8/8)	90% (9/10)
33D	The most recent service plan includes all enrollee risks as identified in the comprehensive assessment.	100% (11/11)	100% (8/8)	90% (9/10)
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)	80% (8/10)
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)	80% (26/28)
38D	The service plan was updated when the enrollee needs changed.	0% (0/1)	NA (0/0)	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)	100% (9/9)
41D	The enrollee has been given the opportunity to participate in choosing types of services and providers.	100% (11/11)	100% (8/8)	80% (8/10)

Measure	Measure Text	FY2019	FY2020	FY2021
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)	80% (8/10)

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 2021 Analysis**	**Trend Analysis (SFY 2020 & SFY 2021)**
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 one of the lowest performing, performing at a rate of 32% over SFY 2021.	Comparisons between SFY 2020 and SFY 2021 were unable to be made as the waiver types applicable to this measure changed in SFY 2021.
12C *If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.* (Captured for only enrollees with PA service)	Overall, this realized a statistically significant increase in performance from Q1 to Q4. This measure was one of the lowest performing, performing at a rate of 11% over SFY 2021.	New measure in SFY 2021.
20C *A PA evaluation was completed annually.* (Captured for only enrollees with PA service)	Overall, this measure demonstrated stable performance from Q1 to Q4. This measure was one of the lowest performing, performing at a rate of 75% over SFY 2021.	New measure in SFY 2021.
31D *The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis (SFY 2020 & SFY 2021)**
32D *The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, BCBSIL realized a statistically significant increase in this measure in SFY 2021.
33D *The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, BCBSIL realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.
35D *The most recent service plan includes signature of enrollee (or representative), Case Manager, and SLP provider (if applicable) and dates of signatures.*	Overall, this measure demonstrated a statistically significant decrease from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated a statistically significant decrease in overall performance in SFY 2021. Compared to SFY 2020, Aetna and Molina demonstrated a statistically significant decrease in this measure in SFY 2021. Compared to SFY 2020, the SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis (SFY 2020 & SFY 2021)**
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.* *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 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, Molina demonstrated a statistically significant decrease in this measure in SFY 2021.
37D *The most recent 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.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021. Compared to SFY 2020, the BI waiver demonstrated a statistically significant decrease in this measure in SFY 2021.
38D *The service plan was updated when the enrollee needs changed.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.
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.	Compared to SFY 2020, this measure realized a statistically significant increase in overall performance in SFY 2021. Compared to SFY 2020, BCBSIL and Molina realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, the ELD and PD waiver realized a statistically significant increase in this measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis (SFY 2020 & SFY 2021)**
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 2020, this measure demonstrated a statistically significant decrease in overall performance in SFY 2021. Compared to SFY 2020, BCBSIL realized a statistically significant increase in this measure in SFY 2021. Compared to SFY 2020, Humana demonstrated a statistically significant decrease in this measure in SFY 2021. Compared to SFY 2020, the PD waiver demonstrated a statistically significant decrease in this measure in SFY 2021.
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 a statistically significant decrease from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated a statistically significant decrease in overall performance in SFY 2021. Compared to SFY 2020, Humana demonstrated a statistically significant decrease in this measure in SFY 2021. Compared to SFY 2020, the PD and SLP waiver demonstrated a statistically significant decrease in this measure in SFY 2021.
44C *The enrollee reported satisfaction with his/her PA.* (Captured for only enrollees with PA service)	Overall, this measure demonstrated stable performance from Q1 to Q4.	New measure in SFY 2021.
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 2020, this measure demonstrated stable performance in SFY 2021.

CMS Performance Measure Compliance Analysis		
Measure	**SFY 2021 Analysis**	**Trend Analysis (SFY 2020 & SFY 2021)**
49G *(ELD, BI, HIV, PD Waivers) The most recent service plan includes a backup plan that includes the name of the backup.*	Overall, this measure demonstrated stable performance from Q1 to Q4.	Compared to SFY 2020, this measure demonstrated stable performance in SFY 2021.

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 performed at a rate of 32 percent compliance during SFY 2021.
- Measure 12C, *if the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date*, which performed at a rate of 11 percent compliance during SFY 2021.
- Measure 20C, *a PA evaluation was completed annually*, which performed at a rate of 75 percent compliance during SFY 2021.

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 performed at a rate of 74 percent and 77 percent compliance, respectively, during SFY 2021.

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.

Measures 12C and 20C

Measures 12C and 20C collect information related to the health plan's success in completing annual PA evaluation documentation timely. Measure 20C identifies whether the PA evaluation has been completed annually. Measure 12C measures whether the PA evaluation was completed within 60 days of that expected completion, if overdue. Performance on the measure does not indicate that a PA evaluation was never completed; the evaluation criteria limits performance only to those records that

have completion within 60 days (e.g. a PA evaluation completed on day 61 is non-compliant for the measure).

Health plans should analyze case management systems to identify that appropriate alerts are available to assist case managers in completing annual PA evaluations in a timely manner. Health plans should also make efforts to ensure that overdue PA evaluations are completed within 60 days of expected completion, if overdue. Additionally, health plans should review oversight and monitoring procedures to ensure that activities include assessment of compliance with timely PA evaluation completions.

Measure 36D

Performance on measure 36D was stable during SFY 2021 and when SFY 2021 performance is compared against SFY 2020. During SFY 2021, performance on measure 36D for the BI waiver resulted in a rate of 74 percent. Performance related to the HIV waiver resulted in a rate of 77 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 2021, 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	8/8	24/24
BCBSIL	8/8	7/7
Humana	32/32	31/32
MeridianTotal	32/32	32/32
MeridianComplete	6/6	10/10
Molina	14/14	10/10

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 averaged 99 percent. Five of the six health plans demonstrated 100 percent compliance with remediation validation. Humana's non-compliant remediation validation case demonstrated that training materials did not include topics to address the remediation action required for all performance measures. HSAG provided technical assistance regarding expectations for staff training.

Remediation validation reviews will continue in SFY 2022 and will include review of any records that were found to be not fully remediated during the SFY 2021 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

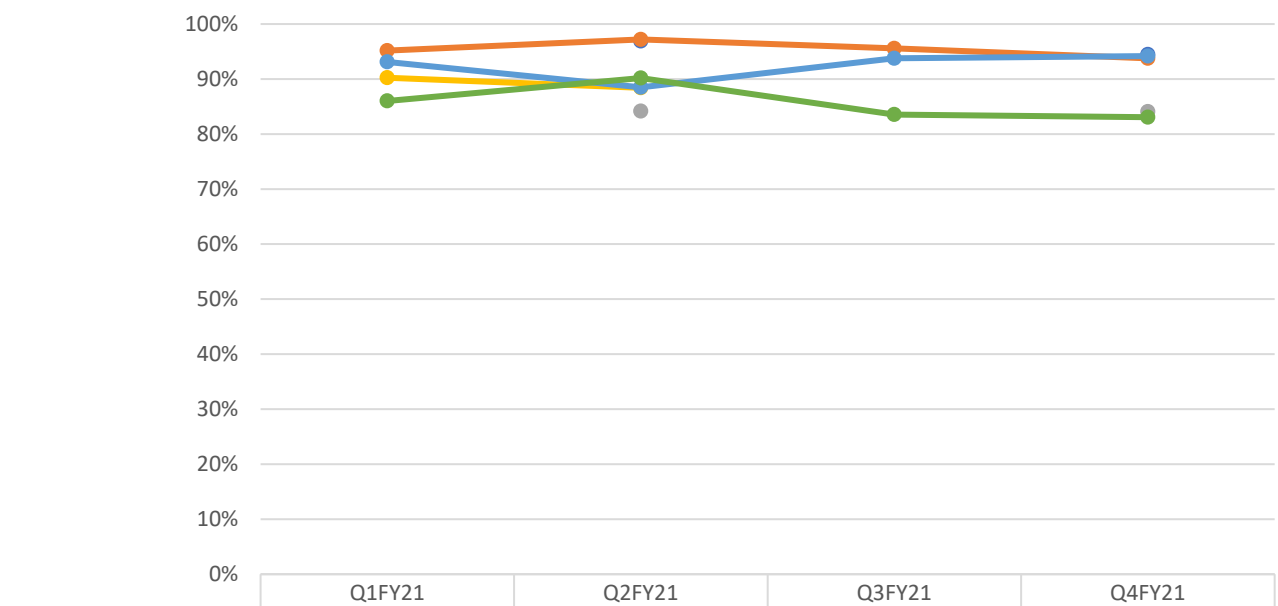
Measure #	Measure Description
4A	Overdue Service Plan was completed within 30 days of expected renewal.
12C	If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date. Captured for only enrollees with PA service
20C	A PA evaluation was completed annually. Captured for only enrollees with PA service
31D	The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.
32D	The most recent service plan includes all enrollee needs as identified in the health risk assessment including informal and formal supports responsible for addressing the need(s).
33D	The most recent service plan includes all enrollee risks as identified in the health risk assessment including issues or barriers or ways to reduce the risks.
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), Case Manager, and SLP provider (if applicable) 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 or upon enrollee request.
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.
44C	The enrollee reported satisfaction with his/her PA. Captured for only enrollees with PA service

Measure #	Measure Description
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 18 Centers for Medicare & Medicaid Services (CMS) waiver performance measures reviewed by Health Services Advisory Group, Inc. (HSAG). Due to additions to performance measures and changes in performance measure definitions in FY 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.1 – Overall Compliance



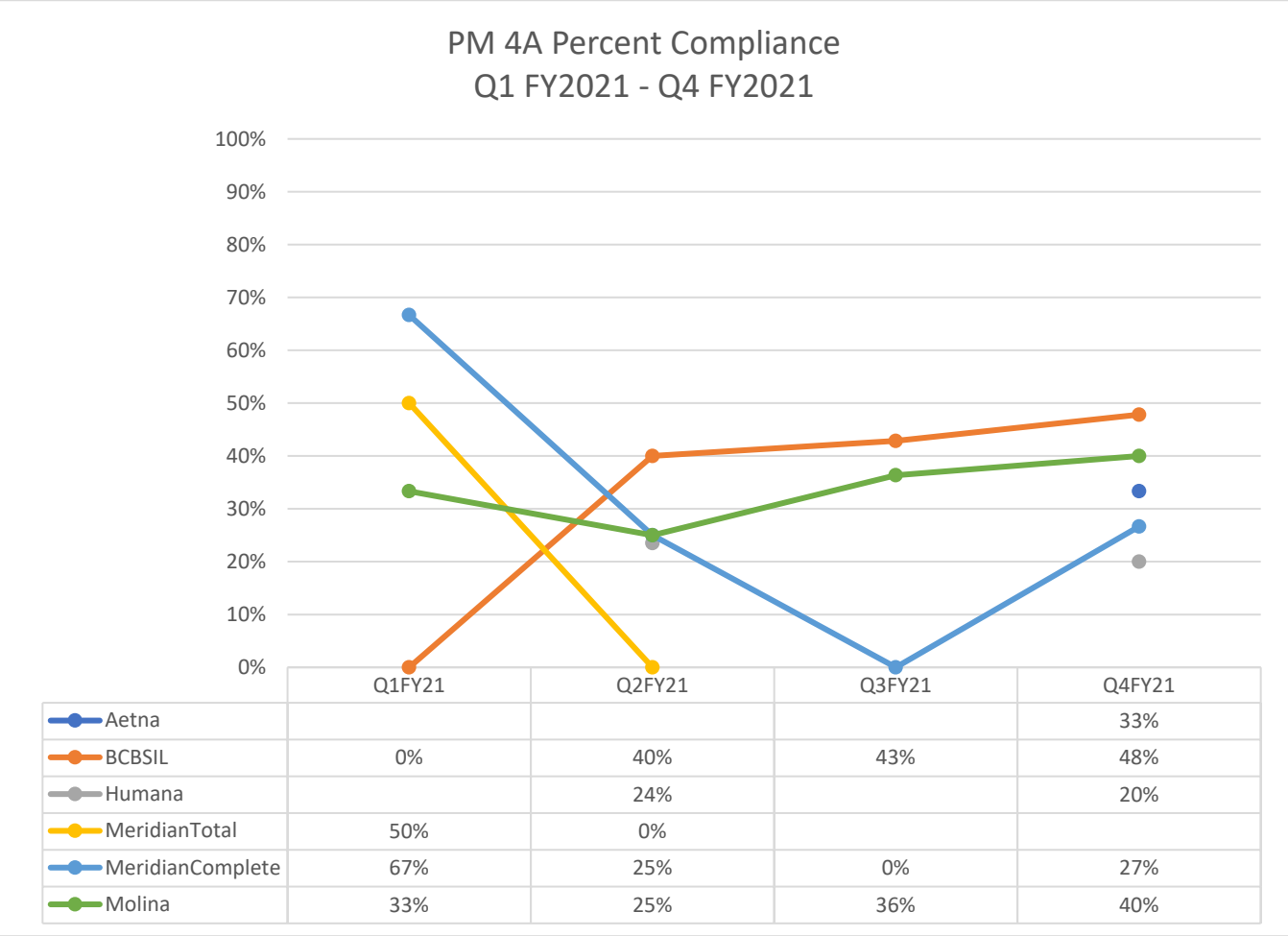
	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		97%		94%
BCBSIL	95%	97%	96%	94%
Humana		84%		84%
MeridianTotal	90%	88%		
MeridianComplete	93%	88%	94%	94%
Molina	86%	90%	84%	83%

Performance Measure Findings

Measure 4A – Overdue Service Plan was completed within 30 days of expected renewal.

Due to changes in performance measure definitions in FY 2021, historic data is not comparable and only FY 2021 data is displayed.

Figure B.2 – Measure 4A



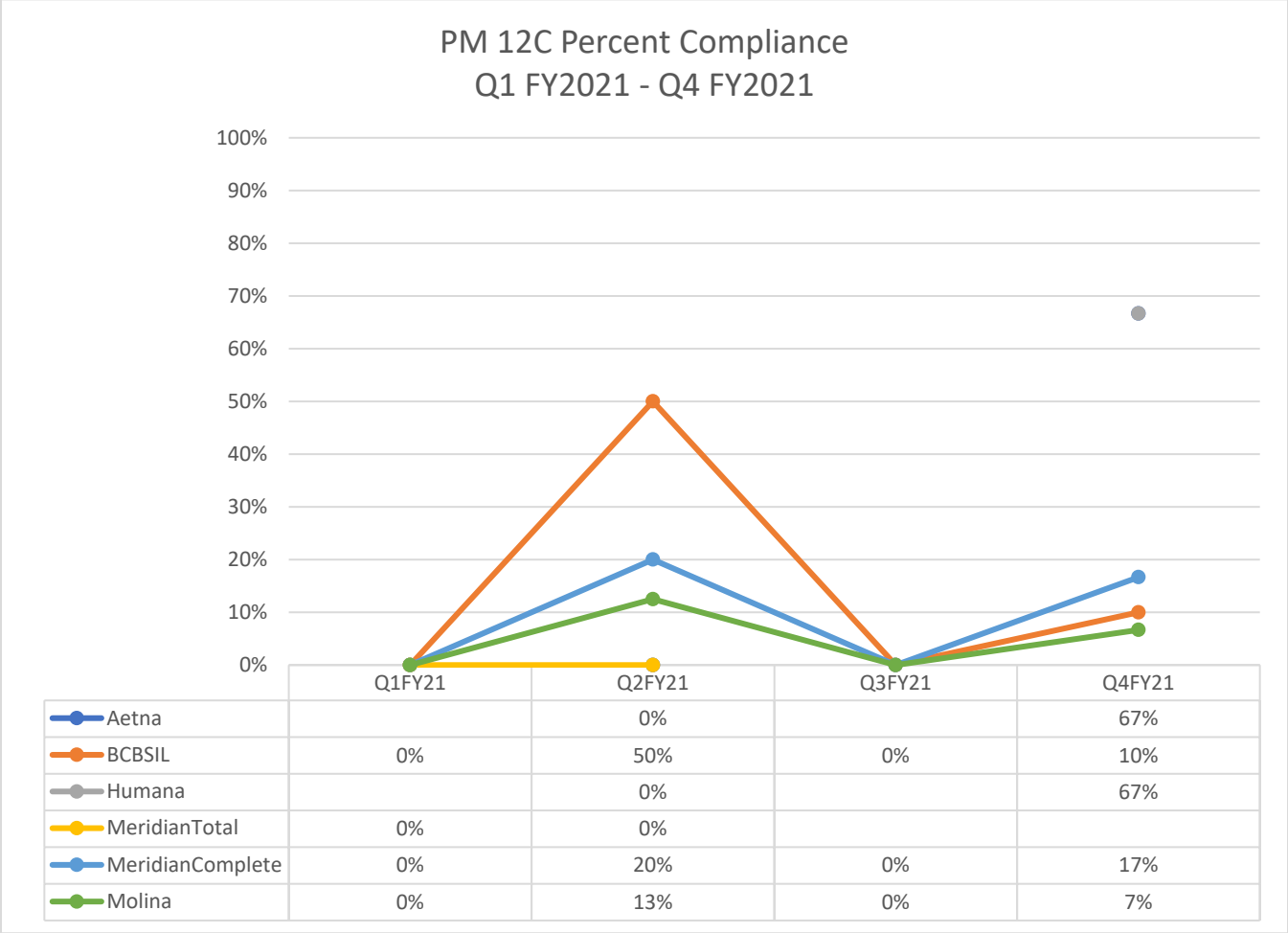
	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna				33%
BCBSIL	0%	40%	43%	48%
Humana		24%		20%
MeridianTotal	50%	0%		
MeridianComplete	67%	25%	0%	27%
Molina	33%	25%	36%	40%

Note: Blank cells represent quarters in which the health plan was not reviewed or did not have eligible records.

Measure 12C - If the PA evaluation was not completed annually, it was completed within 60 days of the expected annual date.

New measure beginning FY 2021.

Figure B.3 – Measure 12C

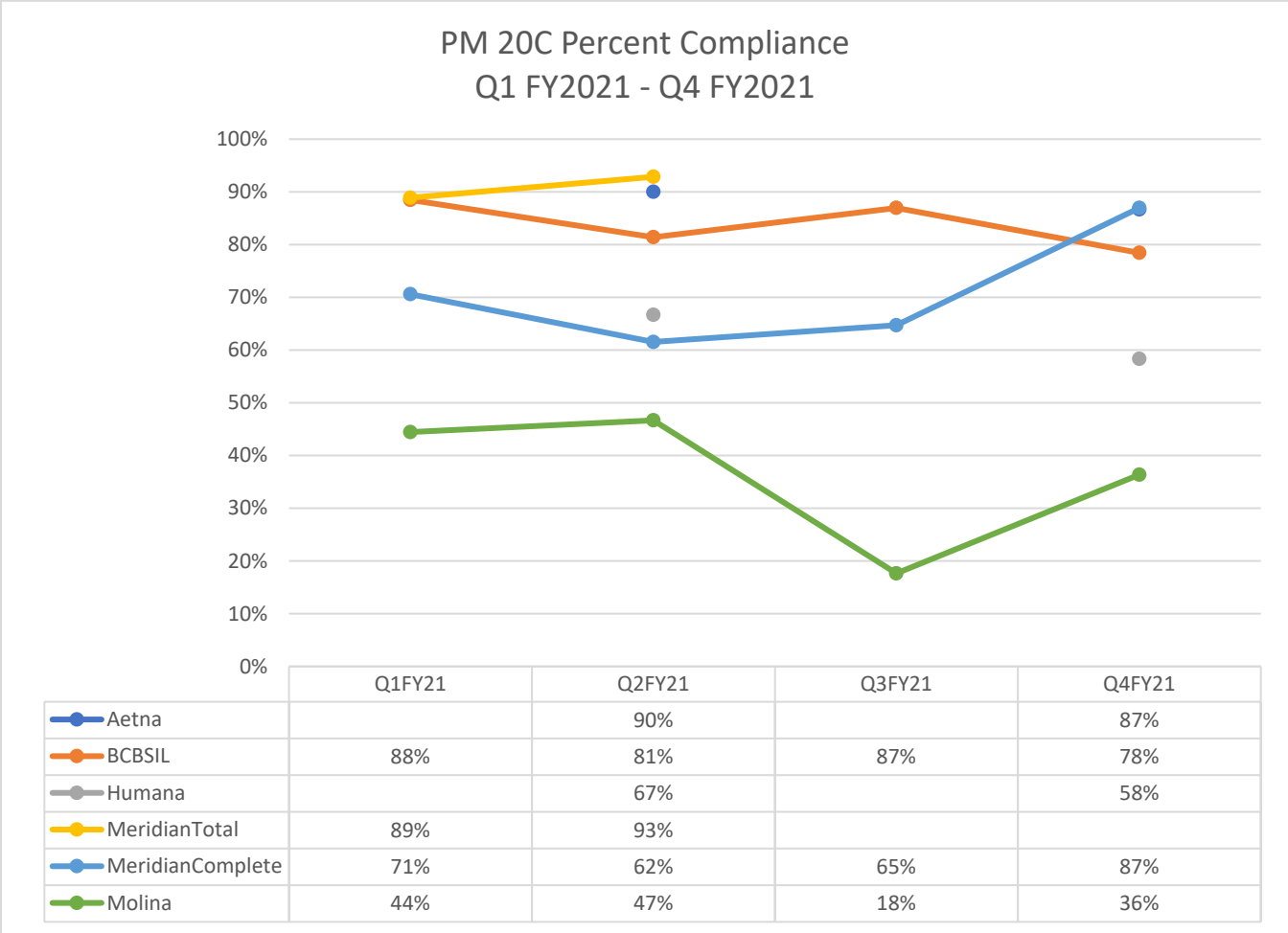


	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		0%		67%
BCBSIL	0%	50%	0%	10%
Humana		0%		67%
MeridianTotal	0%	0%		
MeridianComplete	0%	20%	0%	17%
Molina	0%	13%	0%	7%

Measure 20C - A PA evaluation was completed annually.

New measure beginning FY 2021.

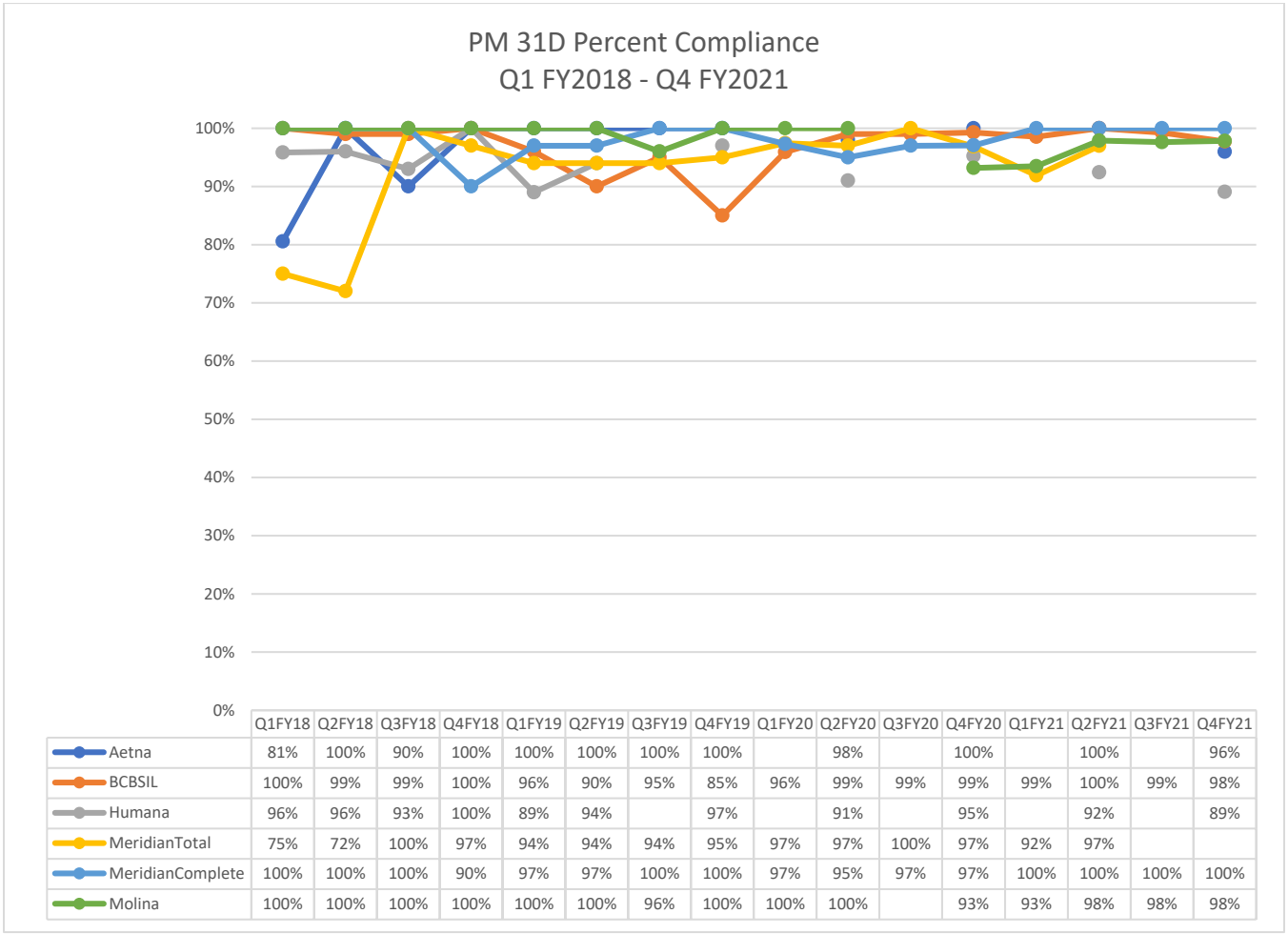
Figure B.4 – Measure 20C



	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		90%		87%
BCBSIL	88%	81%	87%	78%
Humana		67%		58%
MeridianTotal	89%	93%		
MeridianComplete	71%	62%	65%	87%
Molina	44%	47%	18%	36%

Measure 31D - The most recent service plan includes all enrollee goals as identified in the health risk assessment including enrollee choices, preferences, strengths, and any cultural considerations.

Figure B.5 – Measure 31D

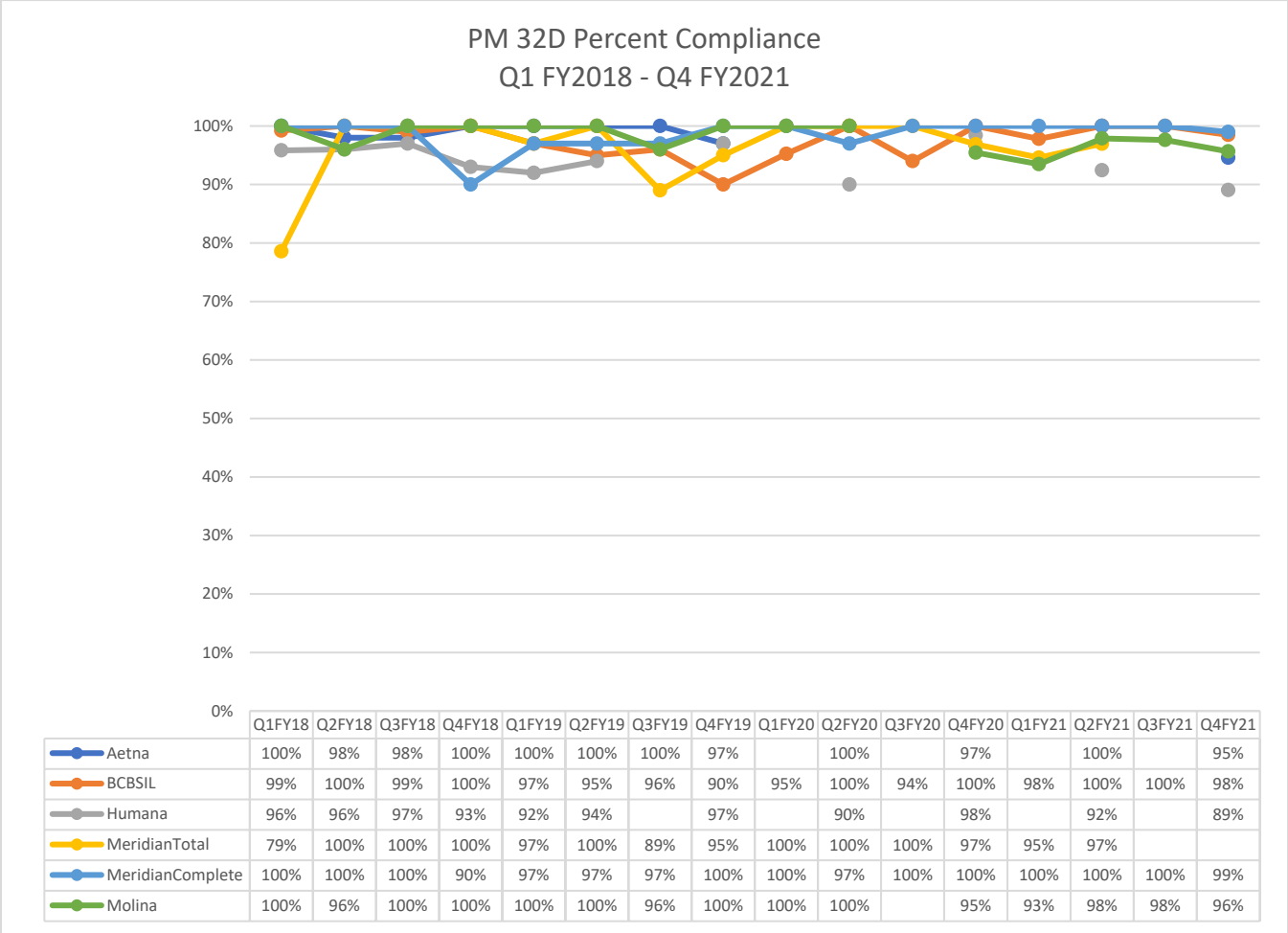


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	81%	100%	90%	100%	100%	100%	100%	100%		98%		100%		100%		96%
BCBSIL	100%	99%	99%	100%	96%	90%	95%	85%	96%	99%	99%	99%	99%	100%	99%	98%
Humana	96%	96%	93%	100%	89%	94%		97%		91%		95%		92%		89%
MeridianTotal	75%	72%	100%	97%	94%	94%	94%	95%	97%	97%	100%	97%	92%	97%		
MeridianComplete	100%	100%	100%	90%	97%	97%	100%	100%	97%	95%	97%	97%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%		93%	93%	98%	98%	98%

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 health risk assessment including informal and formal supports responsible for addressing the need(s).

Figure B.6 – Measure 32D

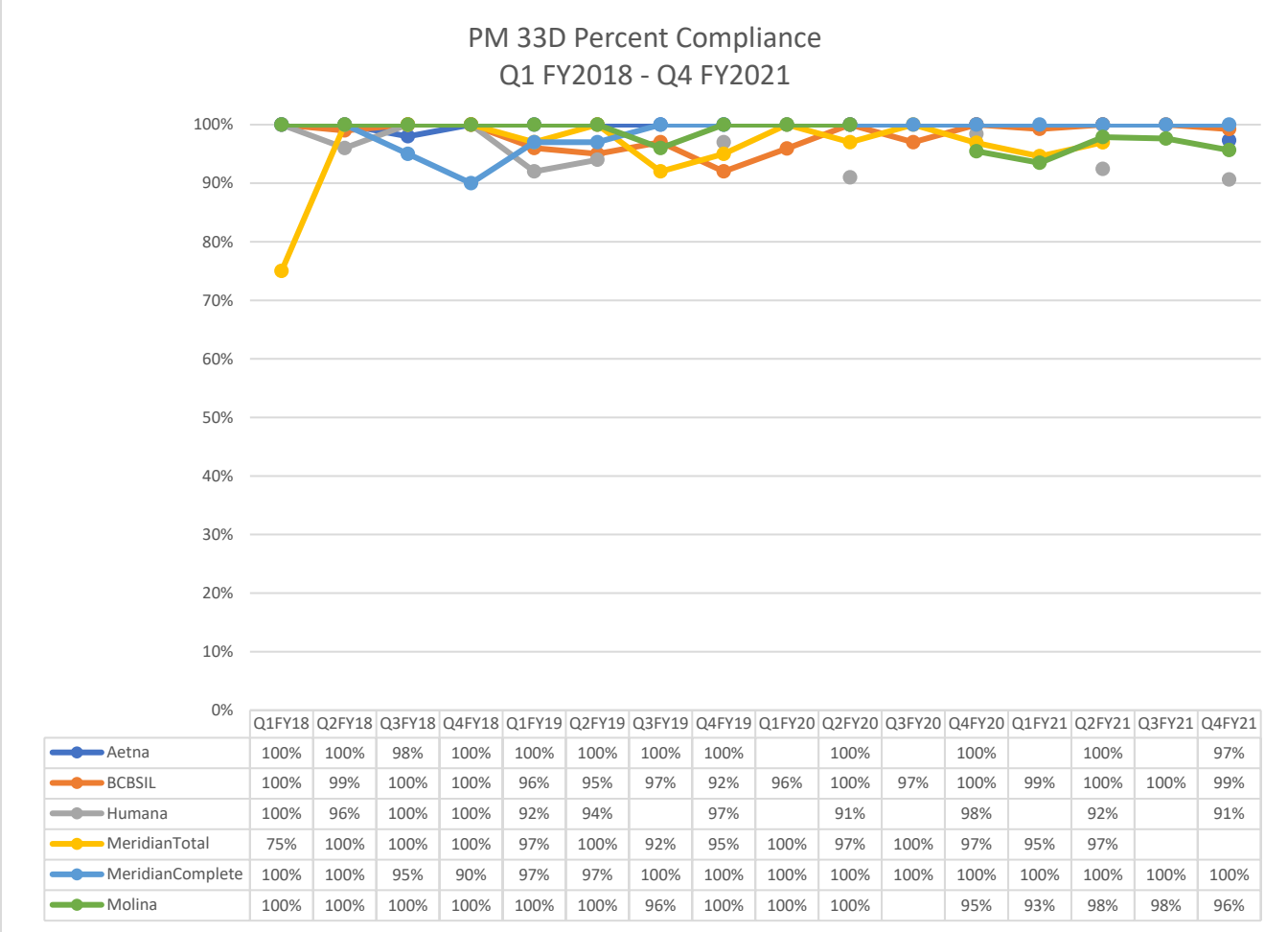


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	98%	98%	100%	100%	100%	100%	97%		100%		97%		100%		95%
BCBSIL	99%	100%	99%	100%	97%	95%	96%	90%	95%	100%	94%	100%	98%	100%	100%	98%
Humana	96%	96%	97%	93%	92%	94%		97%		90%		98%		92%		89%
MeridianTotal	79%	100%	100%	100%	97%	100%	89%	95%	100%	100%	100%	97%	95%	97%		
MeridianComplete	100%	100%	100%	90%	97%	97%	97%	100%	100%	97%	100%	100%	100%	100%	100%	99%
Molina	100%	96%	100%	100%	100%	100%	96%	100%	100%	100%		95%	93%	98%	98%	96%

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 health risk assessment including issues or barriers or ways to reduce the risks.

Figure B.7 – Measure 33D

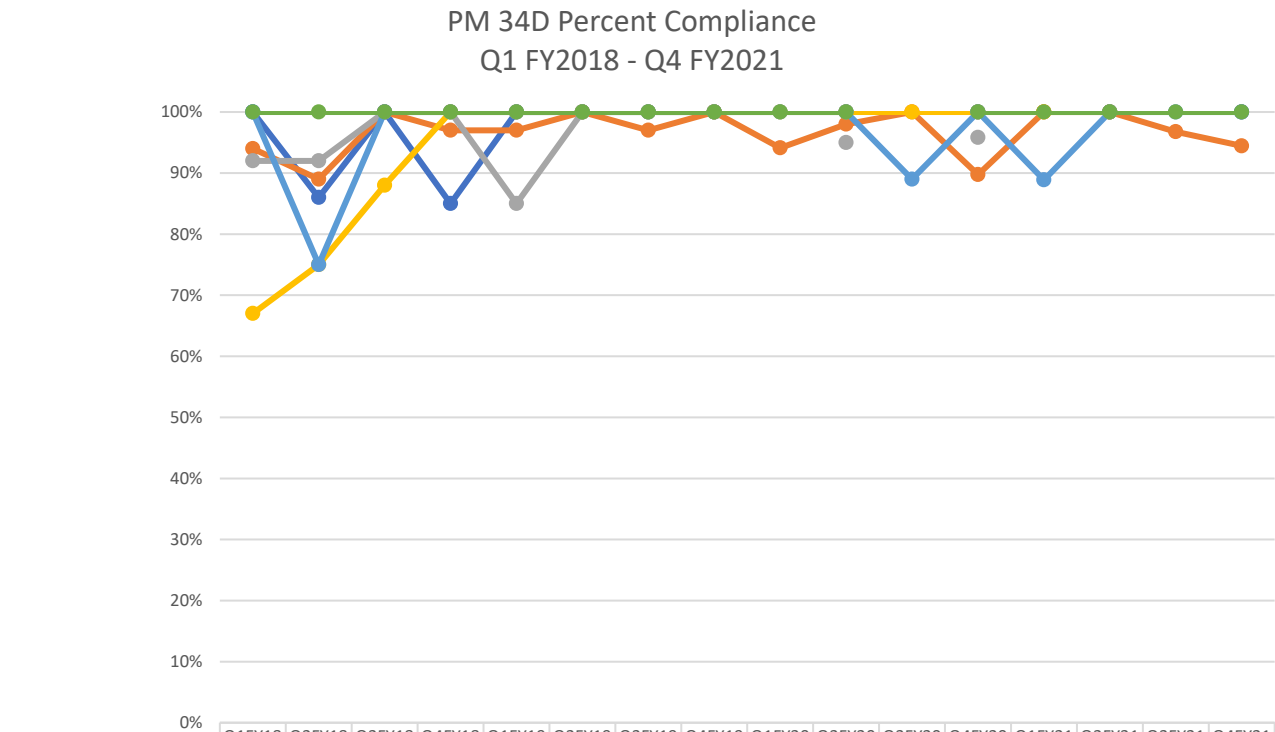


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	100%	98%	100%	100%	100%	100%	100%		100%		100%		100%		97%
BCBSIL	100%	99%	100%	100%	96%	95%	97%	92%	96%	100%	97%	100%	99%	100%	100%	99%
Humana	100%	96%	100%	100%	92%	94%		97%		91%		98%		92%		91%
MeridianTotal	75%	100%	100%	100%	97%	100%	92%	95%	100%	97%	100%	97%	95%	97%		
MeridianComplete	100%	100%	95%	90%	97%	97%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	100%	100%	96%	100%	100%	100%		95%	93%	98%	98%	96%

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.8 – Measure 34D

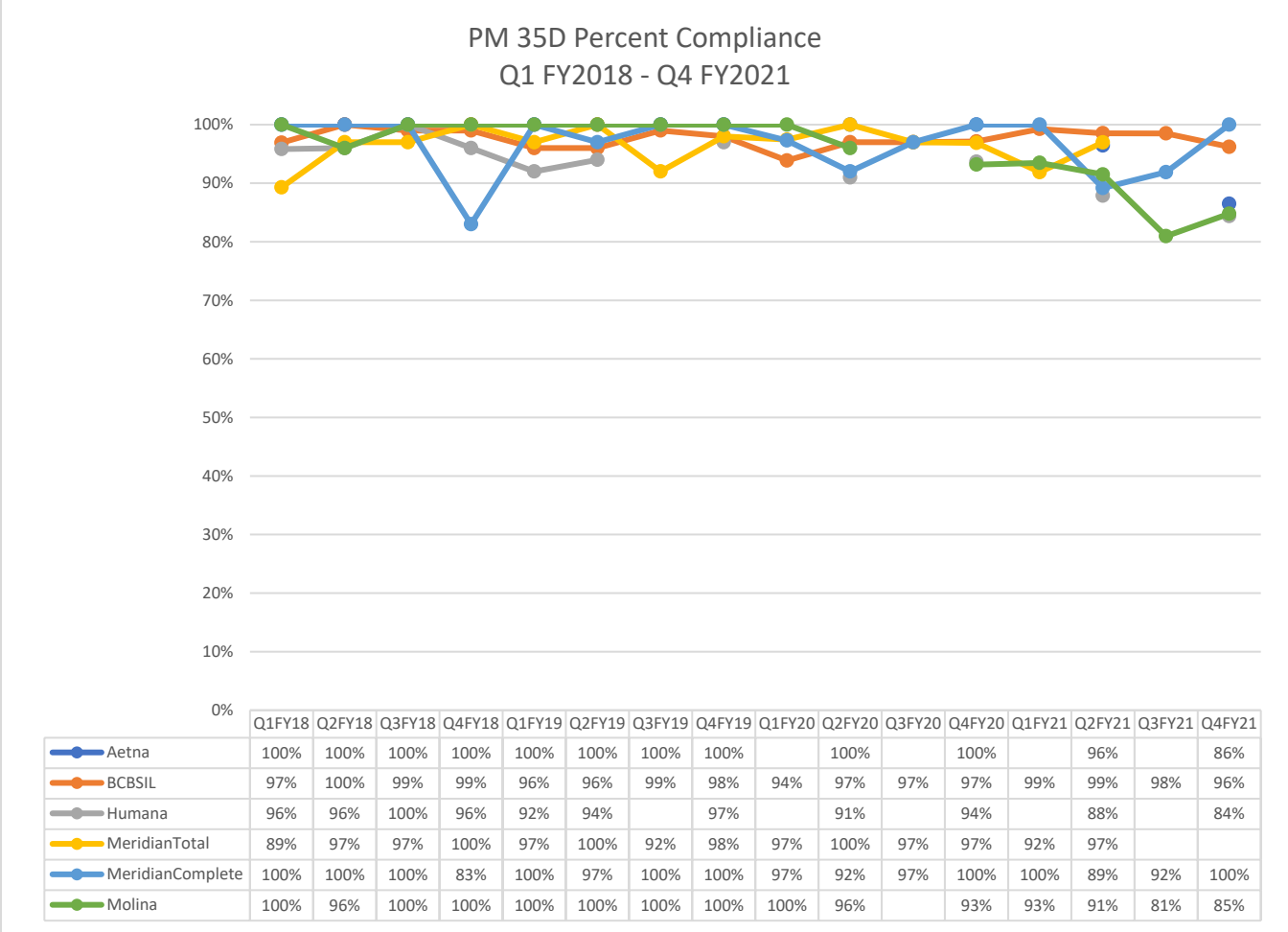


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	86%	100%	85%	100%	100%	100%	100%		100%		100%		100%		100%
BCBSIL	94%	89%	100%	97%	97%	100%	97%	100%	94%	98%	100%	90%	100%	100%	97%	94%
Humana	92%	92%	100%	100%	85%	100%		100%		95%		96%		100%		100%
MeridianTotal	67%	75%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
MeridianComplete	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	89%	100%	100%	100%
Molina	100%	100%	100%	100%	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.9 – Measure 35D



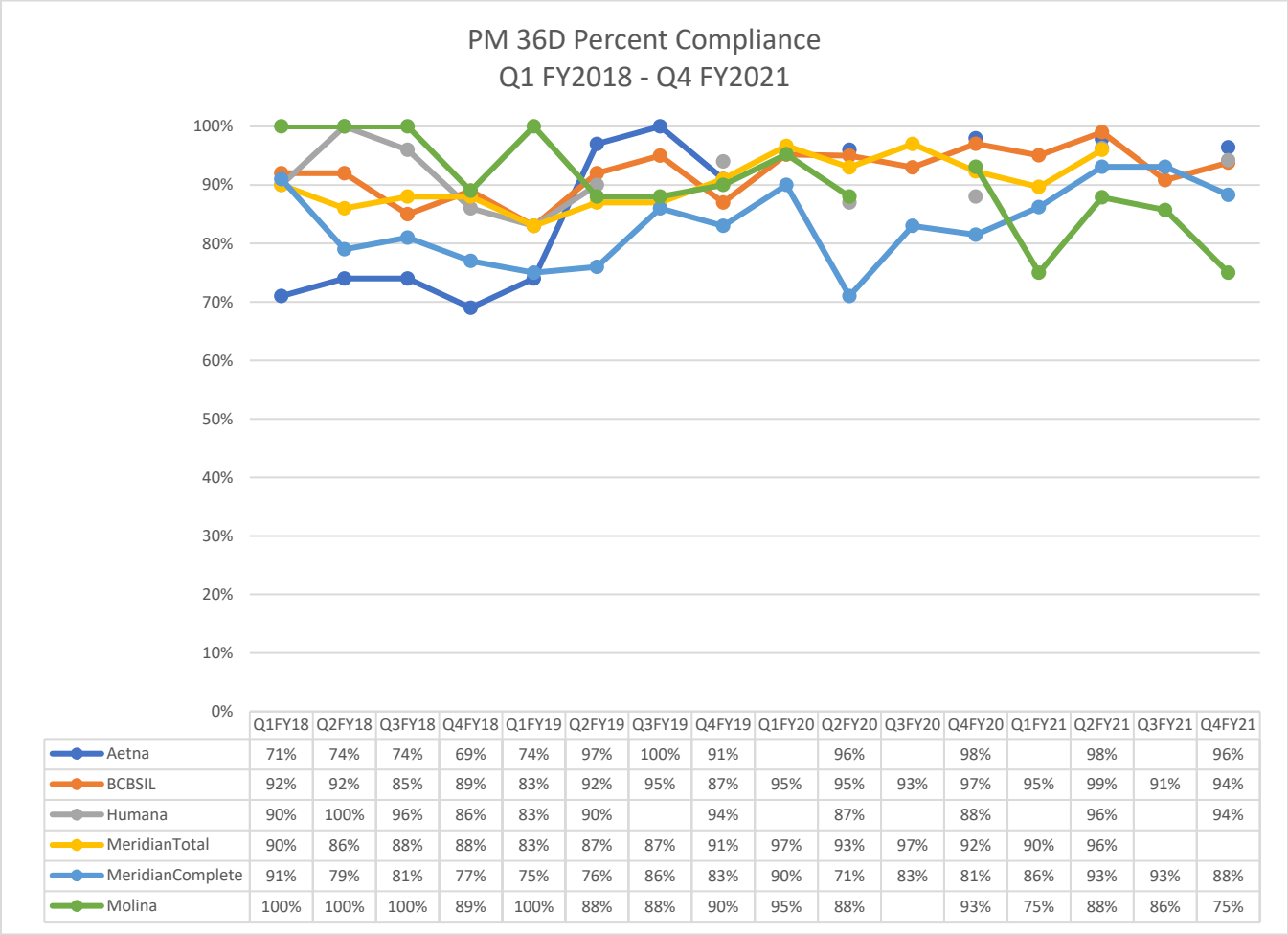
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	100%	100%	100%	100%	100%	100%	100%		100%		100%		96%		86%
BCBSIL	97%	100%	99%	99%	96%	96%	99%	98%	94%	97%	97%	97%	99%	99%	98%	96%
Humana	96%	96%	100%	96%	92%	94%		97%		91%		94%		88%		84%
MeridianTotal	89%	97%	97%	100%	97%	100%	92%	98%	97%	100%	97%	97%	92%	97%		
MeridianComplete	100%	100%	100%	83%	100%	97%	100%	100%	97%	92%	97%	100%	100%	89%	92%	100%
Molina	100%	96%	100%	100%	100%	100%	100%	100%	100%	96%		93%	93%	91%	81%	85%

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.10 – Measure 36D



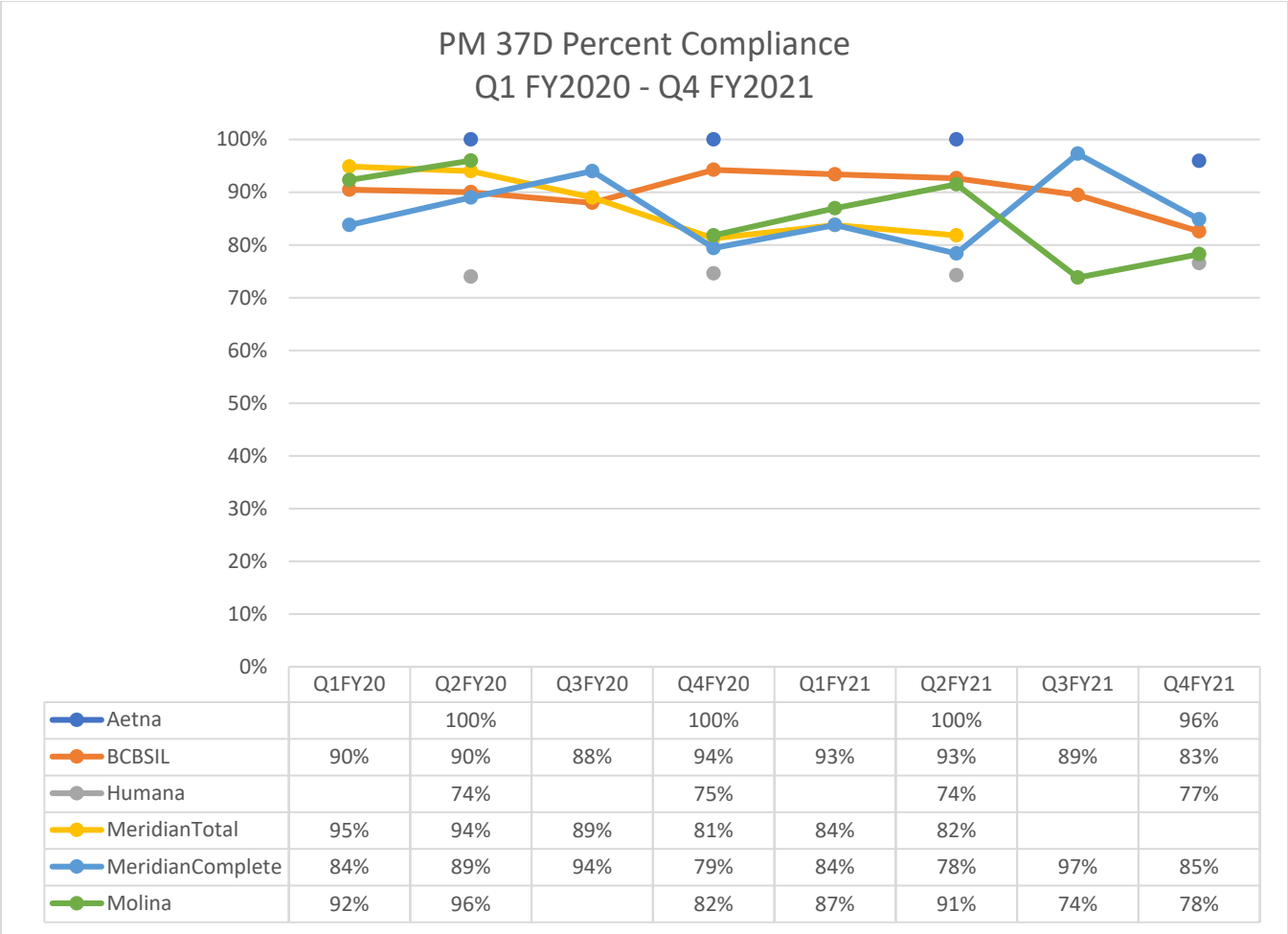
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	71%	74%	74%	69%	74%	97%	100%	91%		96%		98%		98%		96%
BCBSIL	92%	92%	85%	89%	83%	92%	95%	87%	95%	95%	93%	97%	95%	99%	91%	94%
Humana	90%	100%	96%	86%	83%	90%		94%		87%		88%		96%		94%
MeridianTotal	90%	86%	88%	88%	83%	87%	87%	91%	97%	93%	97%	92%	90%	96%		
MeridianComplete	91%	79%	81%	77%	75%	76%	86%	83%	90%	71%	83%	81%	86%	93%	93%	88%
Molina	100%	100%	100%	89%	100%	88%	88%	90%	95%	88%		93%	75%	88%	86%	75%

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 to current data is displayed.

Figure B.11 – Measure 37D

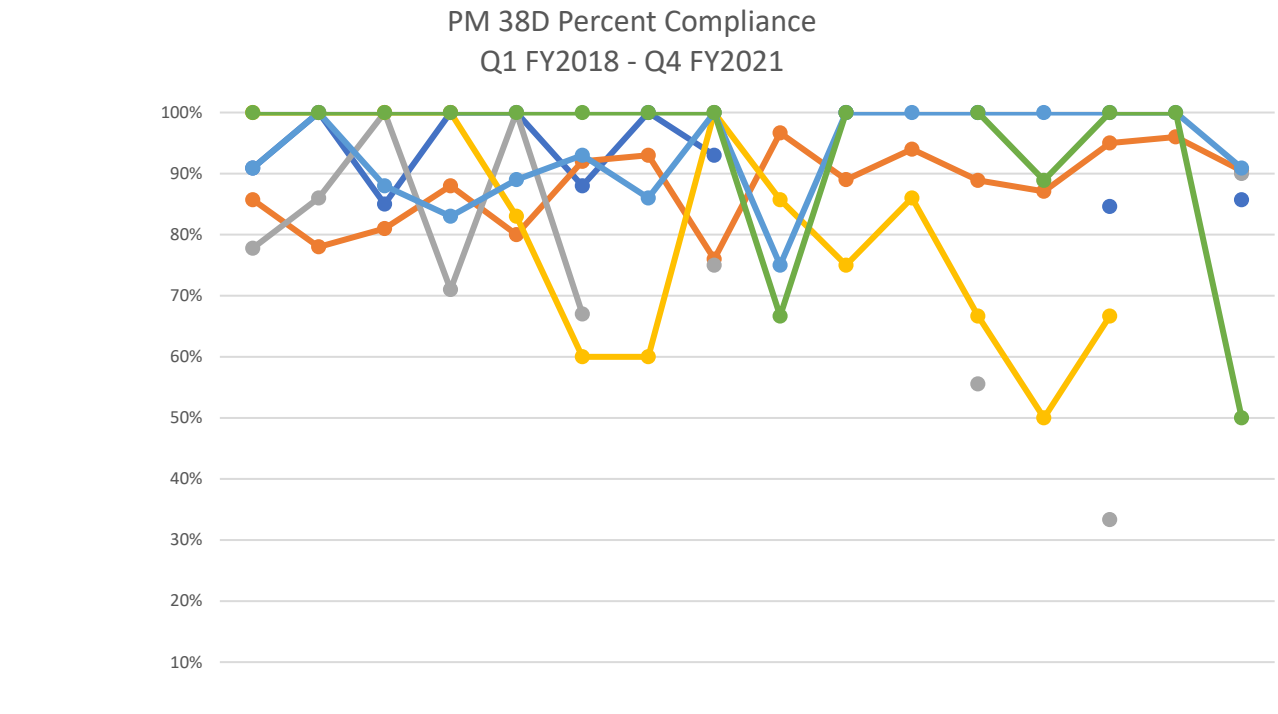


	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		100%		100%		100%		96%
BCBSIL	90%	90%	88%	94%	93%	93%	89%	83%
Humana		74%		75%		74%		77%
MeridianTotal	95%	94%	89%	81%	84%	82%		
MeridianComplete	84%	89%	94%	79%	84%	78%	97%	85%
Molina	92%	96%		82%	87%	91%	74%	78%

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 or upon enrollee request.

Figure B.12 – Measure 38D

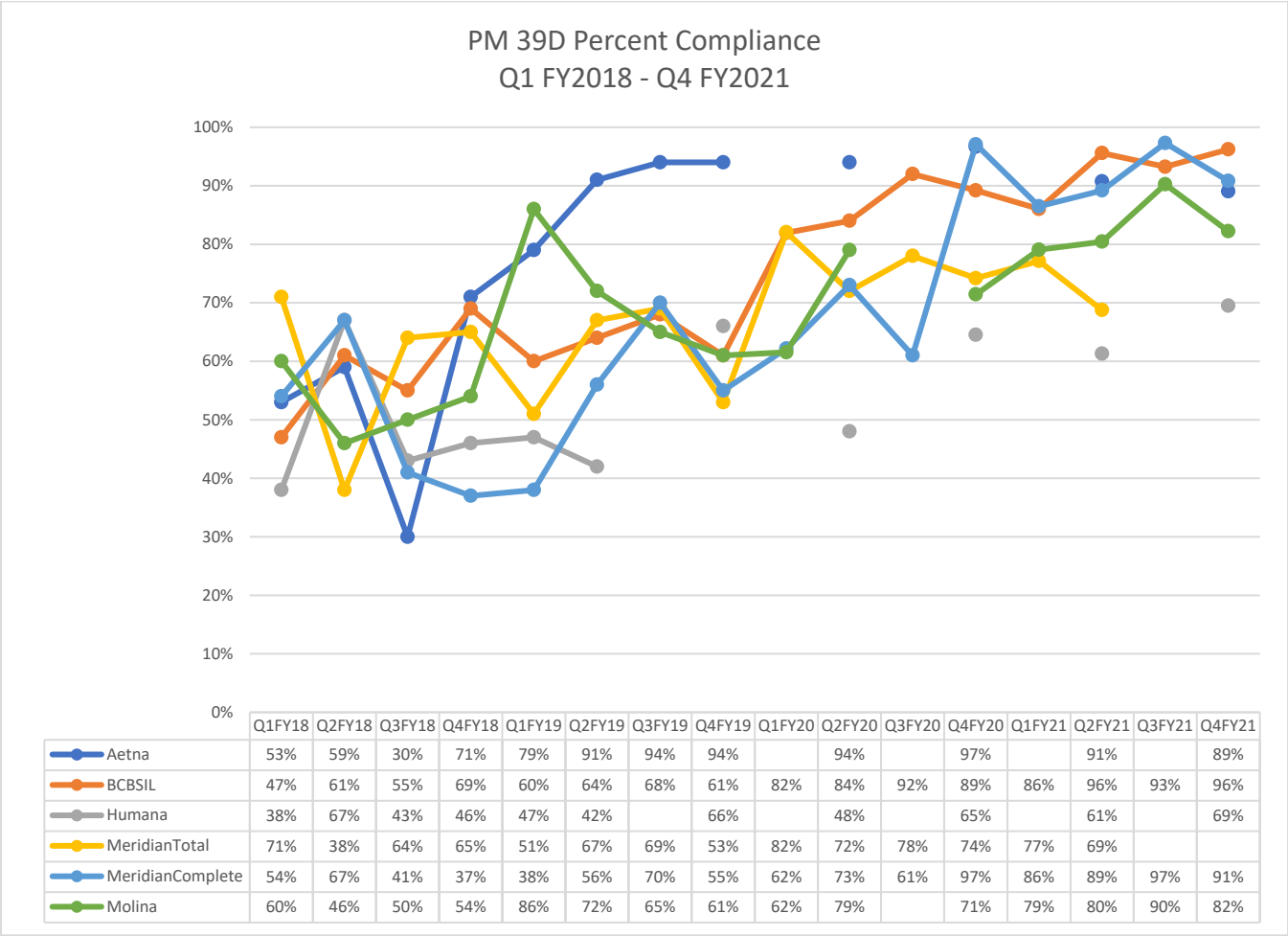


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	91%	100%	85%	100%	100%	88%	100%	93%		100%		100%		85%		86%
BCBSIL	86%	78%	81%	88%	80%	92%	93%	76%	97%	89%	94%	89%	87%	95%	96%	90%
Humana	78%	86%	100%	71%	100%	67%		75%		100%		56%		33%		90%
MeridianTotal	100%	100%	100%	100%	83%	60%	60%	100%	86%	75%	86%	67%	50%	67%		
MeridianComplete	91%	100%	88%	83%	89%	93%	86%	100%	75%	100%	100%	100%	100%	100%	100%	91%
Molina	100%	100%	100%	100%	100%	100%	100%	100%	67%	100%		100%	89%	100%	100%	50%

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.13 – Measure 39D

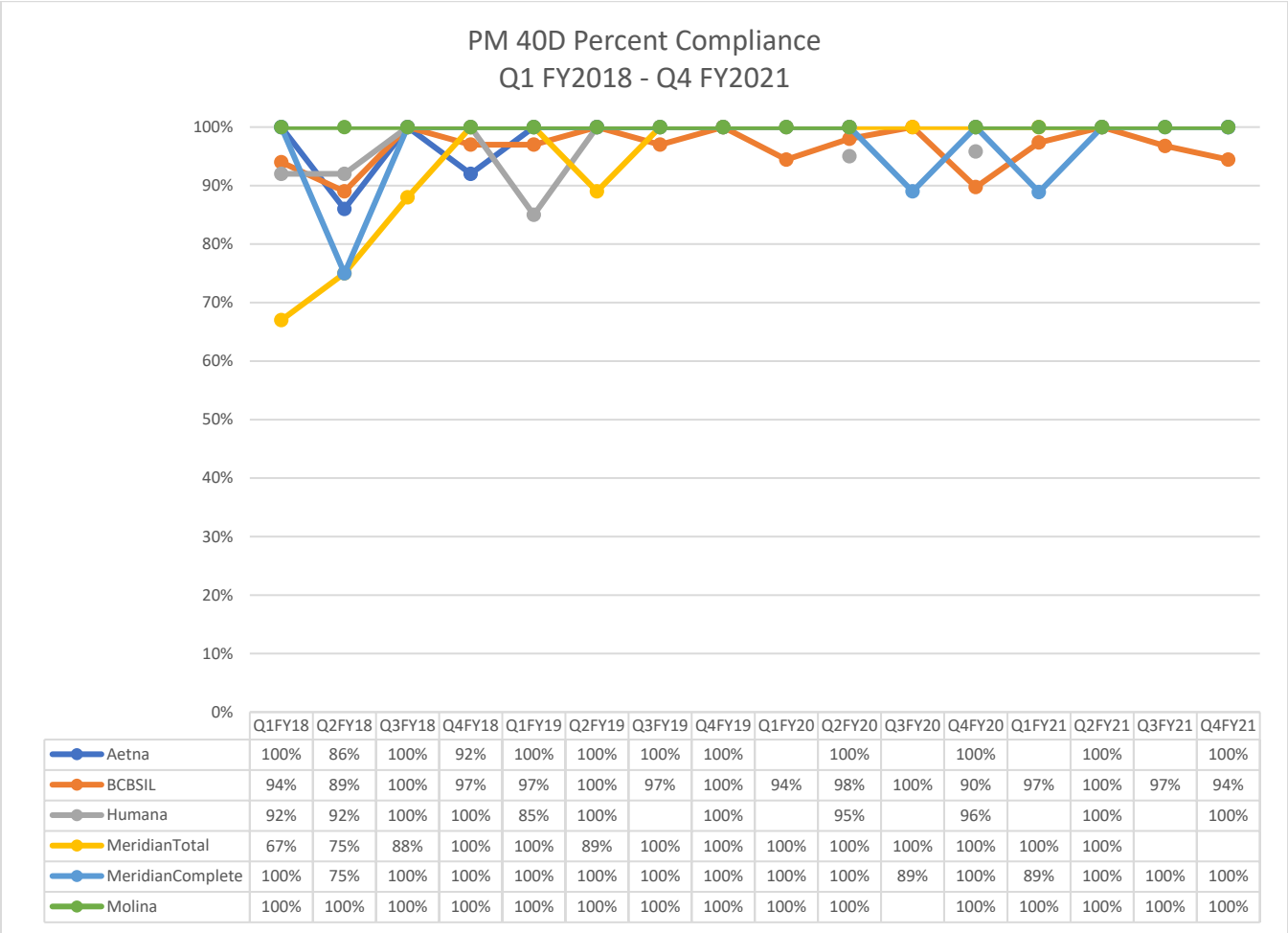


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	53%	59%	30%	71%	79%	91%	94%	94%		94%		97%		91%		89%
BCBSIL	47%	61%	55%	69%	60%	64%	68%	61%	82%	84%	92%	89%	86%	96%	93%	96%
Humana	38%	67%	43%	46%	47%	42%		66%		48%		65%		61%		69%
MeridianTotal	71%	38%	64%	65%	51%	67%	69%	53%	82%	72%	78%	74%	77%	69%		
MeridianComplete	54%	67%	41%	37%	38%	56%	70%	55%	62%	73%	61%	97%	86%	89%	97%	91%
Molina	60%	46%	50%	54%	86%	72%	65%	61%	62%	79%		71%	79%	80%	90%	82%

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.14 – Measure 40D

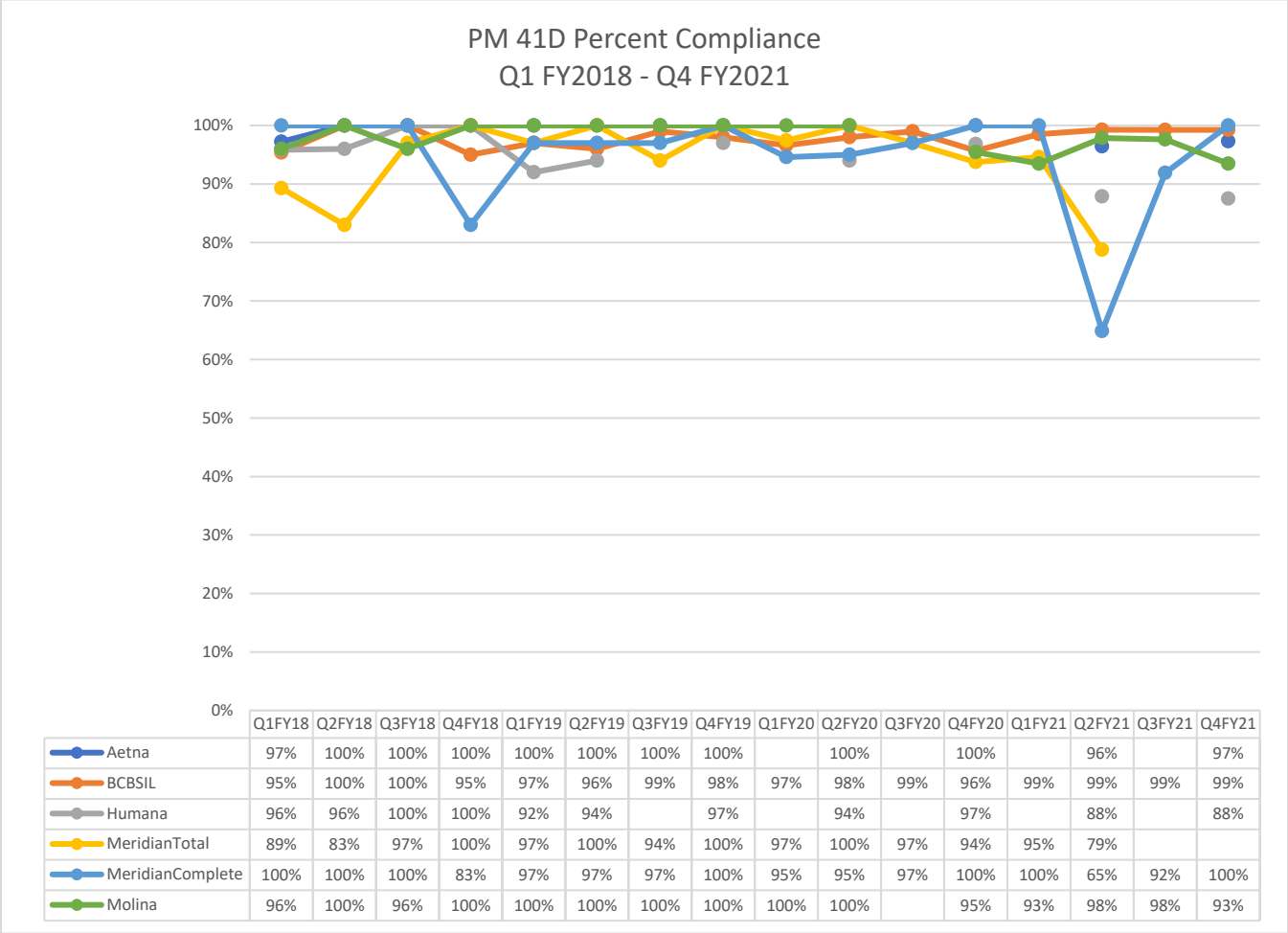


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	86%	100%	92%	100%	100%	100%	100%		100%		100%		100%		100%
BCBSIL	94%	89%	100%	97%	97%	100%	97%	100%	94%	98%	100%	90%	97%	100%	97%	94%
Humana	92%	92%	100%	100%	85%	100%		100%		95%		96%		100%		100%
MeridianTotal	67%	75%	88%	100%	100%	89%	100%	100%	100%	100%	100%	100%	100%	100%		
MeridianComplete	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	89%	100%	100%	100%
Molina	100%	100%	100%	100%	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.15 – Measure 41D

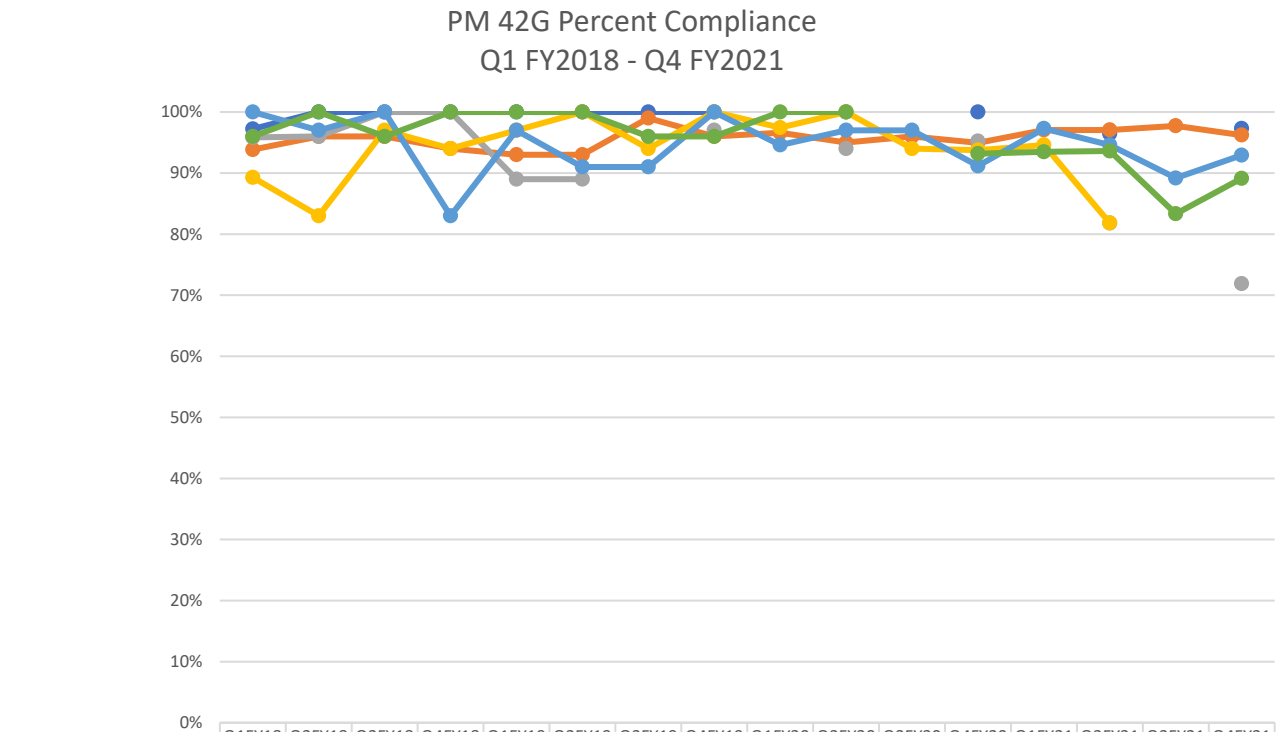


	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	97%	100%	100%	100%	100%	100%	100%	100%		100%		100%		96%		97%
BCBSIL	95%	100%	100%	95%	97%	96%	99%	98%	97%	98%	99%	96%	99%	99%	99%	99%
Humana	96%	96%	100%	100%	92%	94%		97%		94%		97%		88%		88%
MeridianTotal	89%	83%	97%	100%	97%	100%	94%	100%	97%	100%	97%	94%	95%	79%		
MeridianComplete	100%	100%	100%	83%	97%	97%	97%	100%	95%	95%	97%	100%	100%	65%	92%	100%
Molina	96%	100%	96%	100%	100%	100%	100%	100%	100%	100%		95%	93%	98%	98%	93%

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.16 – Measure 42G



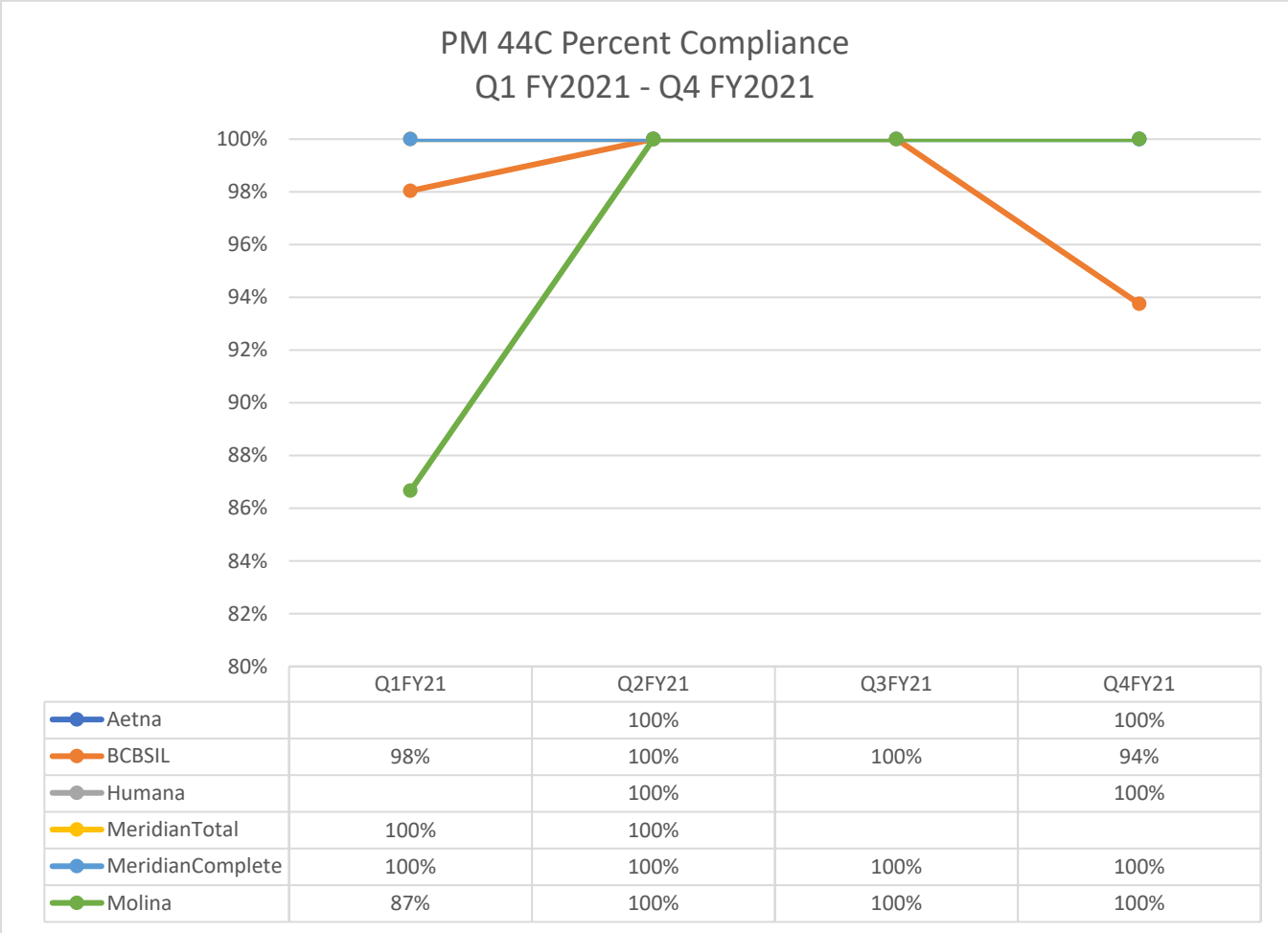
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	97%	100%	100%	100%	100%	100%	100%	100%		100%		100%		96%		97%
BCBSIL	94%	96%	96%	94%	93%	93%	99%	96%	97%	95%	96%	95%	97%	97%	98%	96%
Humana	96%	96%	100%	100%	89%	89%		97%		94%		95%		82%		72%
MeridianTotal	89%	83%	97%	94%	97%	100%	94%	100%	97%	100%	94%	94%	95%	82%		
MeridianComplete	100%	97%	100%	83%	97%	91%	91%	100%	95%	97%	97%	91%	97%	95%	89%	93%
Molina	96%	100%	96%	100%	100%	100%	96%	96%	100%	100%		93%	93%	94%	83%	89%

Note: Blank cells represent quarters in which the health plan was not reviewed.
Data prior to FY2018 available in previous years' reports.

Measure 44C – The enrollee reported satisfaction with his/her PA.

New measure beginning FY 2021.

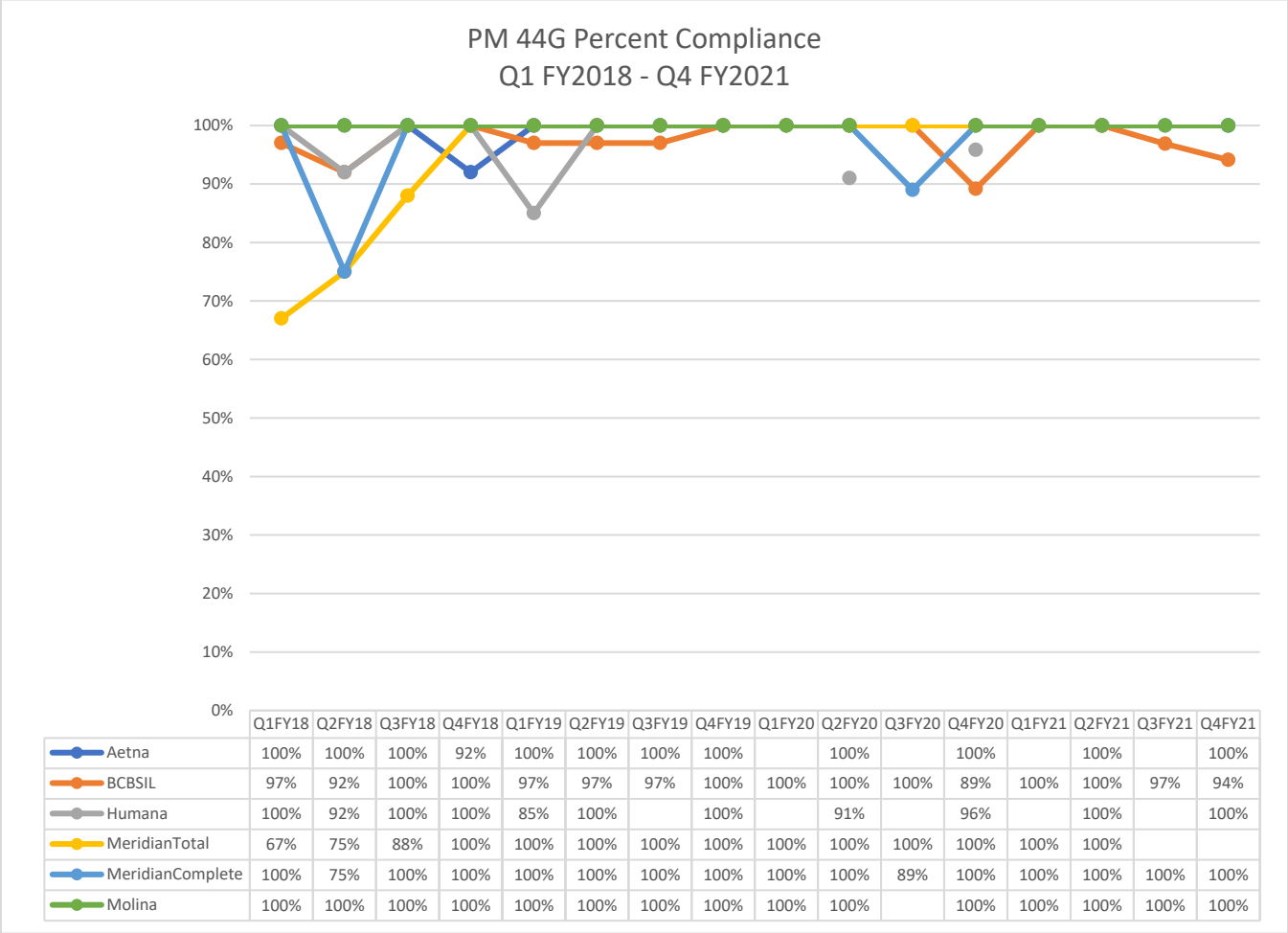
Figure B.17 – Measure 44C



	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		100%		100%
BCBSIL	98%	100%	100%	94%
Humana		100%		100%
MeridianTotal	100%	100%		
MeridianComplete	100%	100%	100%	100%
Molina	87%	100%	100%	100%

Measure 44G – The enrollee reported he/she was being treated well by direct support staff. (ELD waiver only)

Figure B.18 – Measure 44G



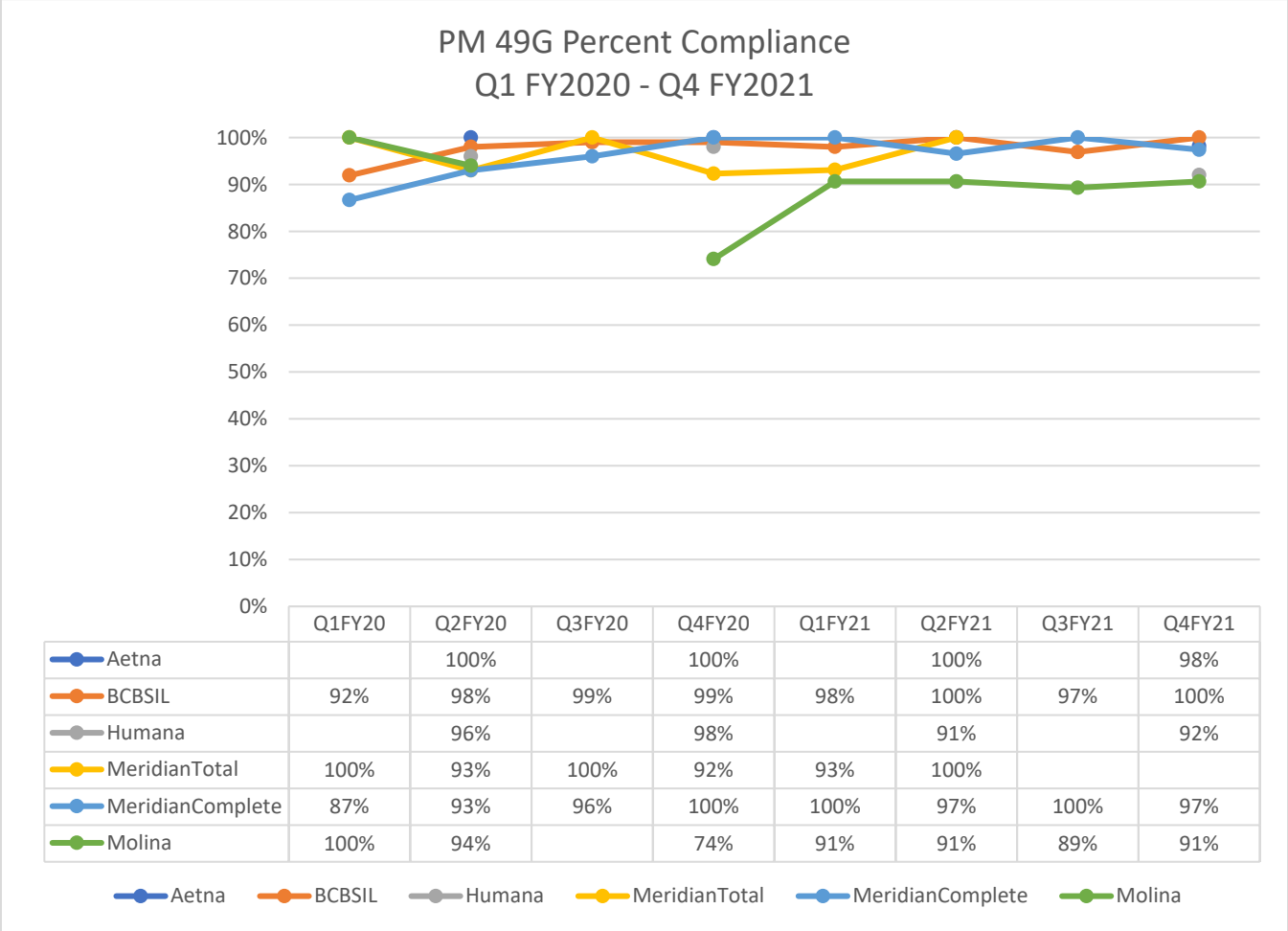
	Q1FY18	Q2FY18	Q3FY18	Q4FY18	Q1FY19	Q2FY19	Q3FY19	Q4FY19	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna	100%	100%	100%	92%	100%	100%	100%	100%		100%		100%		100%		100%
BCBSIL	97%	92%	100%	100%	97%	97%	97%	100%	100%	100%	100%	89%	100%	100%	97%	94%
Humana	100%	92%	100%	100%	85%	100%		100%		91%		96%		100%		100%
MeridianTotal	67%	75%	88%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
MeridianComplete	100%	75%	100%	100%	100%	100%	100%	100%	100%	100%	89%	100%	100%	100%	100%	100%
Molina	100%	100%	100%	100%	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 to current data is displayed.

Figure B.19 – Measure 49G



	Q1FY20	Q2FY20	Q3FY20	Q4FY20	Q1FY21	Q2FY21	Q3FY21	Q4FY21
Aetna		100%		100%		100%		98%
BCBSIL	92%	98%	99%	99%	98%	100%	97%	100%
Humana		96%		98%		91%		92%
MeridianTotal	100%	93%	100%	92%	93%	100%		
MeridianComplete	87%	93%	96%	100%	100%	97%	100%	97%
Molina	100%	94%		74%	91%	91%	89%	91%

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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
Aetna																		
Q1 2015				36%	73%	91%		9%	100%	100%	N/A			82%	82%			50%
Q2 2015				44%	58%	73%		0%	100%	100%	N/A			87%	87%			0%
Q3 2015				63%	88%	79%		92%	100%	100%	100%			88%	88%			100%
Q4 2015				70%	75%	83%		91%	100%	98%	100%			94%	92%			83%
Q1 2016				94%	87%	96%		87%	88%	96%	100%			94%	92%			96%
Q2 2016				100%	97%	100%		100%	67%	100%	N/A			100%	100%			100%
Q3 2016				92%	96%	96%		96%	90%	96%	100%			96%	96%			95%
Q4 2016				100%	100%	97%		100%	96%	100%	100%			97%	97%			100%
Q1 2017				100%	100%	100%		100%	74%	100%	100%			100%	100%			100%
Q2 2017				97%	97%	100%		100%	77%	97%	100%			97%	95%			100%
Q3 2017				97%	90%	100%		100%	81%	100%	100%			100%	100%			95%
Q4 2017				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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**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%
Q1 2021																		
Q2 2021		0%	90%	100%	100%	100%	100%	96%	98%	100%	85%	91%	100%	96%	96%	100%	100%	100%
Q3 2021																		
Q4 2021	33%	67%	87%	96%	95%	97%	100%	86%	96%	96%	86%	89%	100%	97%	97%	100%	100%	98%
BCBSIL																		
Q4 2015				91%	80%	90%		88%	85%	95%	75%			95%	93%			78%
Q1 2016				84%	84%	83%		96%	85%	95%	100%			93%	97%			94%
Q2 2016				95%	87%	91%		96%	97%	91%	100%			96%	95%			100%
Q3 2016				100%	100%	100%		99%	84%	99%	80%			97%	100%			95%
Q4 2016				95%	98%	97%		96%	76%	98%	75%			97%	99%			96%
Q1 2017				99%	96%	99%		99%	89%	97%	100%			100%	100%			100%
Q2 2017				95%	95%	96%		99%	87%	96%	33%			98%	97%			100%
Q3 2017				97%	97%	95%		100%	82%	98%	60%			96%	96%			100%
Q4 2017				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%

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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
Q1 2021	0%	0%	88%	99%	98%	99%	100%	99%	95%	93%	87%	86%	97%	99%	97%	98%	100%	98%
Q2 2021	40%	50%	81%	100%	100%	100%	100%	99%	99%	93%	95%	96%	100%	99%	97%	100%	100%	100%
Q3 2021	43%	05	87%	99%	100%	100%	97%	98%	91%	89%	96%	93%	97%	99%	98%	100%	97%	97%
Q4 2021	48%	10%	78%	98%	98%	99%	94%	96%	94%	83%	90%	96%	94%	99%	96%	94%	94%	100%
Humana																		
Q1 2015				95%	90%	75%		93%	100%	100%	N/A			93%	93%			100%
Q2 2015																		
Q3 2015				83%	95%	98%		100%	75%	100%	100%			100%	100%			75%
Q4 2015				94%	94%	94%		100%	100%	94%	N/A			100%	100%			100%
Q1 2016				100%	99%	99%		99%	100%	94%	N/A			96%	96%			100%
Q2 2016																		
Q3 2016				96%	100%	100%		96%	76%	90%	100%			93%	97%			100%
Q4 2016				100%	100%	100%		95%	79%	100%	N/A			100%	100%			100%
Q1 2017				100%	100%	100%		100%	89%	100%	50%			100%	100%			100%
Q2 2017				100%	100%	97%		93%	80%	100%	100%			100%	100%			90%
Q3 2017				100%	100%	100%		97%	100%	97%	100%			100%	100%			100%
Q4 2017				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																		

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+,1,3**	**12C2**	**20C2**	**31D**	**32D**	**33D**	**34D+**	**35D**	**36D++**	**37D1**	**38D**	**39D+**	**40D+**	**41D**	**42G**	**44C2**	**44G+**	**49G1**
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%
Q1 2021																		
Q2 2021	24%	0%	67%	92%	92%	92%	100%	88%	96%	74%	33%	61%	100%	88%	82%	100%	100%	91%
Q3 2021																		
Q4 2021	20%	67%	58%	89%	89%	91%	100%	84%	94%	77%	90%	69%	100%	88%	72%	100%	100%	92%
MeridianTotal (formerly IlliniCare)****																		
Q1 2015																		
Q2 2015																		
Q3 2015				69%	97%	100%		86%	100%	100%	N/A			100%	100%			67%
Q4 2015				83%	100%	100%		90%	100%	95%	N/A			95%	93%			100%
Q1 2016				94%	91%	86%		83%	83%	91%	N/A			91%	94%			100%
Q2 2016				100%	67%	0%		100%	100%	100%	N/A			100%	100%			100%
Q3 2016				100%	100%	100%		100%	100%	100%	N/A			100%	100%			100%
Q4 2016				100%	100%	100%		100%	100%	100%	N/A			100%	100%			100%
Q1 2017				100%	100%	100%		90%	90%	100%	N/A			95%	95%			90%
Q2 2017				80%	100%	100%		93%	100%	88%	100%			94%	94%			100%
Q3 2017				100%	92%	96%		92%	100%	92%	100%			100%	100%			100%
Q4 2017				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%

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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
Q1 2021	50%	0%	89%	92%	95%	95%	100%	92%	90%	84%	50%	77%	100%	95%	95%	100%	100%	93%
Q2 2021	0%	0%	93%	97%	97%	97%	100%	97%	96%	82%	67%	69%	100%	79%	82%	100%	100%	100%
Q3 2021																		
Q4 2021																		
MeridianComplete																		
Q1 2015				100%	100%	100%		100%	N/A	100%	N/A			100%	100%			N/A
Q2 2015				98%	90%	98%		92%	100%	100%	N/A			92%	92%			100%
Q3 2015				0%	100%	100%		100%	N/A	100%	N/A			100%	100%			N/A
Q4 2015				83%	80%	87%		80%	100%	100%	100%			83%	83%			100%
Q1 2016				99%	85%	95%		85%	72%	97%	67%			96%	91%			82%
Q2 2016				100%	63%	88%		100%	44%	88%	N/A			100%	100%			89%
Q3 2016				100%	94%	89%		94%	54%	50%	N/A			89%	72%			100%
Q4 2016				100%	100%	100%		100%	60%	87%	N/A			100%	100%			100%
Q1 2017				96%	96%	96%		100%	75%	92%	100%			100%	100%			100%
Q2 2017				100%	100%	93%		100%	100%	100%	0%			100%	93%			100%
Q3 2017				100%	100%	100%		100%	85%	97%	N/A			100%	100%			100%
Q4 2017				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%

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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
Q1 2021	67%	0%	71%	100%	100%	100%	89%	100%	86%	84%	100%	86%	89%	100%	97%	100%	100%	100%
Q2 2021	25%	20%	62%	100%	100%	100%	100%	89%	93%	78%	100%	89%	100%	65%	95%	100%	100%	97%
Q3 2021	0%	0%	65%	100%	100%	100%	100%	92%	93%	97%	100%	97%	100%	92%	89%	100%	100%	100%
Q4 2021	27%	17%	87%	100%	99%	100%	100%	100%	88%	85%	91%	91%	100%	100%	93%	100%	100%	97%
Molina																		
Q1 2015																		
Q2 2015																		
Q3 2015				64%	74%	98%		91%	100%	100%	N/A			100%	100%			100%
Q4 2015				85%	100%	100%		98%	100%	100%	100%			100%	100%			100%
Q1 2016				96%	87%	100%		96%	93%	97%	67%			100%	99%			100%
Q2 2016				100%	94%	100%		100%	93%	89%	N/A			100%	100%			93%
Q3 2016																		
Q4 2016				100%	97%	100%		97%	79%	100%	N/A			100%	100%			100%
Q1 2017				100%	100%	100%		95%	90%	100%	100%			97%	95%			100%
Q2 2017				100%	94%	100%		100%	100%	100%	NA			100%	100%			100%
Q3 2017				100%	86%	100%		100%	94%	100%	50%			100%	100%			100%
Q4 2017				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%

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[+,1,3]**	**12C[2]**	**20C[2]**	**31D**	**32D**	**33D**	**34D[+]**	**35D**	**36D[++]**	**37D[1]**	**38D**	**39D[+]**	**40D[+]**	**41D**	**42G**	**44C[2]**	**44G[+]**	**49G[1]**
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%
Q1 2021	33%	0%	44%	93%	93%	93%	100%	93%	75%	87%	89%	79%	100%	93%	93%	87%	100%	91%
Q2 2021	25%	13%	47%	98%	98%	98%	100%	91%	88%	91%	100%	80%	100%	98%	94%	100%	100%	91%
Q3 2021	36%	0%	18%	98%	98%	98%	100%	81%	86%	74%	100%	90%	100%	98%	83%	100%	100%	89%
Q4 2021	40%	7%	36%	98%	96%	96%	100%	85%	75%	78%	50%	82%	100%	93%	89%	100%	100%	91%
Cigna-HealthSpring***																		
Q1 2015				81%	66%	56%		0%	100%	100%	N/A			97%	97%			33%
Q2 2015				89%	84%	94%		89%	92%	100%	100%			89%	90%			92%
Q3 2015				60%	84%	81%		84%	100%	96%	100%			88%	88%			80%
Q4 2015				68%	82%	75%		82%	N/A	93%	N/A			93%	96%			N/A
Q1 2016				98%	94%	95%		99%	95%	99%	67%			95%	99%			95%
Q2 2016				67%	81%	85%		96%	89%	100%	N/A			100%	100%			100%
Q3 2016				100%	100%	100%		100%	75%	96%	100%			96%	96%			100%
Q4 2016				100%	100%	100%		95%	69%	95%	N/A			100%	100%			100%
Q1 2017				100%	100%	100%		100%	93%	100%	100%			100%	100%			100%
Q2 2017				97%	100%	100%		97%	82%	100%	100%			100%	100%			100%
Q3 2017				100%	100%	100%		100%	80%	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+,1,3**	**12C2**	**20C2**	**31D**	**32D**	**33D**	**34D+**	**35D**	**36D++**	**37D1**	**38D**	**39D+**	**40D+**	**41D**	**42G**	**44C2**	**44G+**	**49G1**
Q4 2017				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				84%	96%	93%		94%	100%	98%	100%			95%	96%			89%
Q4 2015				91%	99%	96%		97%	88%	100%	N/A			99%	96%			100%
Q1 2016				93%	96%	100%		96%	91%	95%	75%			99%	100%			88%
Q2 2016				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.*

*****MeridianTotal (formerly IlliniCare) merged with MeridianComplete effective Q3 FY2021. Historic data provided for information and comparison.*

+New measure effective Q1 FY2018.

++Revised measure effective Q1 FY2018.

^Measure 26C retired as of Q1 FY2018; historic data available on previous years' reports.

1Revised measure effective Q1 FY2020.

2New measure effective Q1 FY2021.

3Revised measure effective Q1 FY2021.

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 2021																				
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	94%	91%	91%	92%	94%	94%	97%	93%	94%	95%	97%	94%	89%	92%	89%	33%	94%	91%	93%	90%
4A		67%	67%	25%	25%	21%	50%	28%	100%	0%		100%	33%	36%	29%	8%	33%	13%	33%	36%
12C	0%	33%	0%	50%					0%	25%		43%	0%	11%	0%	63%				
20C	86%	76%	65%	92%					94%	85%	100%	82%	70%	74%	59%	98%				
31D	100%	98%	100%	98%	97%	97%	100%	94%	100%	100%	100%	100%	96%	100%	97%	97%	95%	97%	100%	97%
32D	100%	98%	100%	98%	97%	97%	100%	93%	100%	100%	100%	100%	96%	100%	98%	97%	95%	97%	100%	97%
33D	100%	98%	100%	100%	99%	97%	100%	96%	100%	100%	100%	100%	97%	100%	98%		95%	97%	100%	97%
34D					98%	100%	98%	98%								93%				
35D	100%	96%	96%	96%	97%	93%	97%	94%	100%	100%	100%	97%	97%	98%	93%	99%	95%	90%	89%	86%
36D	71%	87%	63%	70%	97%	100%	97%	98%	71%	86%	73%	73%	96%	100%	100%	88%				
37D	100%	93%	88%	84%	89%	88%	93%	86%	95%	94%	100%	92%	87%	89%	88%	86%	86%	83%	79%	75%
38D	86%	86%	100%	89%	89%	76%	100%	89%	75%	88%	100%	86%	94%	82%	91%	85%	75%	100%	100%	67%
39D	84%	84%	96%	86%	74%	76%	88%	83%	86%	88%	93%	95%	78%	78%	91%		100%	100%	100%	97%
40D					97%	100%	98%	98%								94%				
41D	100%	87%	100%	100%	97%	91%	100%	95%	100%	97%	100%	100%	96%	93%	97%	90%	97%	91%	95%	98%
42G	100%	91%	100%	98%	96%	92%	97%	90%	100%	100%	93%	97%	94%	94%	88%	97%	95%	88%	93%	88%
44C	100%	100%	100%	98%					94%	100%	100%	100%	96%	100%	100%					
44G					100%	100%	98%	98%								95%				
49G	97%	96%	100%	98%	97%	97%	100%	97%	100%	100%	100%	100%	94%	96%	90%	33%				

**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

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.3 – 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.4 – 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.5 – 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.6 – 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.7 – 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