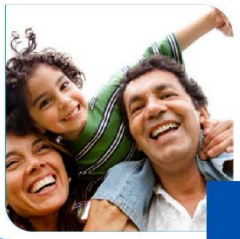





HFS

Illinois Department of
Healthcare and Family Services

EXTERNAL QUALITY REVIEW ANNUAL REPORT

April 2025

Illinois Department of Healthcare
and Family Services
Division of Medical Programs

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1. Executive Summary

Report Purpose and Overview

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

Illinois Medicaid Managed Care

HFS has worked to expand managed care statewide to deliver integrated and quality managed care to enrollees. HFS operates three distinct medical programs: HealthChoice Illinois (HealthChoice), Medicare-Medicaid Alignment Initiative (MMAI), and YouthCare Specialty Plan (YouthCare).

HealthChoice

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

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

Table 1—HealthChoice Health Plans

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Community Health Plans	BCBSIL
CountyCare (serves Cook County only)	CountyCare

Health Plan Name	Abbreviation
Meridian	Meridian
Molina Healthcare of Illinois	Molina

MMAI

MMAI is an ongoing partnership between HFS, the Centers for Medicare & Medicaid Services (CMS), and health plans, which provides coordinated care to dually eligible enrollees (seniors and persons with disabilities who have full Medicaid and Medicare benefits). HFS contracted with five Medicare-Medicaid Plans (MMPs) to administer the MMAI. Table 2 displays the MMPs.

Table 2—MMAI Health Plans

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

YouthCare

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

Quality Strategy

In 2024, in accordance with 42 CFR §438.200 et seq., HFS updated its Comprehensive Medical Programs Quality Strategy (Quality Strategy) designed to improve outcomes in the delivery of healthcare at a community level. The Quality Strategy framework includes five pillars of improvement: Adult Behavioral Health, Child Behavioral Health, Maternal and Child Health, Equity, and Improving Community and Health Promotion. To support health equity and HFS' mission, HFS strives to drive progress in the five pillars of improvement. HFS has identified six goals that fall within the five pillars, as shown in Table 3. HFS prioritizes equity across all goals by analyzing data to strategically pinpoint improvement needs and efforts.

Table 3—Quality Strategy Goals

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

Aggregating and Analyzing Statewide Data

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

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

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

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

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

Detailed information about each activity's methodology is provided in Appendix A of this report. For a comprehensive discussion of the strengths, opportunities for improvement, conclusions, and

recommendations, please refer to the results of each activity in Sections 2 and 3, as well as in Section 4 for health plan-specific analyses.

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

Performance Domains

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

Quality

as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.[1]

Timeliness

as it pertains to EQR, is described by the NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).

Access

as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance (NCQA). *2013 Standards and Guidelines for MBHOs and MCOs.*

Scope of EQR

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

Table 4—EQR Mandatory Activities

Activity	Description	CMS Protocol
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 (NAV)	This activity includes validating data to determine whether the network standards, as defined by the state, were met.	**Protocol 4.** Validation of Network Adequacy

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2025.

Program Conclusions and Recommendations

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

Table 5—Substantive Findings

Program Strengths	Domain(s)[2]
Quality Strategy Pillar: Adult Behavioral Health	
Improvements were made in follow up with adult members after they visited the hospital or emergency department (ED) for mental illness. The statewide average for all four submeasures improved at least three percentage points for the *Follow-Up After Hospitalization for Mental Illness* measure and improved to meet the next threshold. The statewide average for all submeasures demonstrated improvement in the *Follow-Up After Emergency Department Visit for Mental Illness* measure and all submeasures exceeded the 50th percentile.	
Quality Strategy Pillar: Child Behavioral Health	
Both submeasures for the *Follow-Up After Emergency Department Visit for Mental Illness* measure performed at or above the 75th percentile.	
Quality Strategy Pillar: Maternal and Child Health	
More child and adolescent members received well-child visits this year as evidenced by improvement of the statewide averages by approximately four percentage points for both submeasures of the *Well-Child Visits in the First 30 Months of Life* measure. The *Well-Child Visits in the First 15 Months—Six or More Visits* submeasure exceeded the 75th percentile and the *Well-Child Visits for Age 15 Months–30 Months—Two or More Visits* submeasure exceeded the 50th percentile. The *Child and Adolescent Well-Care Visits* measure statewide average improved by approximately three percentage points and remained above the 50th percentile.	
A majority of pregnant persons received recommended care, as demonstrated by the statewide average improving approximately five percentage points and exceeding the 75th percentile for the *Prenatal and Postpartum Care—Postpartum Care* submeasure. In addition, the *Timeliness of Prenatal Care* submeasure exceeded the 50th percentile with two of the five health plans exceeding the 75th percentile.	

[2]  = Quality,  = Timeliness,  = Access

Program Strengths	Domain(s)[2-]
Quality Strategy Pillar: Equity	
All HealthChoice health plans determined that a disparity existed for the *Improving Timeliness of Prenatal Care* PIP and implemented one or more interventions to address the disparity.	
All MMAI health plans conducted appropriate data analysis to identify a disparity for the *Improving Transportation Services* Quality Improvement Project (QIP). All MMAI health plans except one determined that a disparity existed in services and implemented at least one intervention to address the disparity.	
Quality Strategy Pillar: Community and Health Promotion	
Medicaid members with diabetes received improved levels of care, as the statewide average improved for three measures related to diabetes management (*Blood Pressure Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes,* and *Hemoglobin A1c Control for Patients With Diabetes*).	
Other Program Effectiveness Areas	
HSAG determined all health plans were fully compliant with all Healthcare Effectiveness Data and Information Set (HEDIS®)[3] Information System (IS) standards, and all data supported the elements necessary for HEDIS reporting. For the current reporting period, HSAG determined that the data collected and reported by all health plans followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.	
For the *Ambulatory Care* measure, all four health plans with reported counts reported a decrease for the *Emergency Department Visits* submeasure; for the *Outpatient Visits–Total* submeasure, three of those four health plans reported an increased count from last year, a count above the 50th percentile, and the statewide average improved to above the 50th percentile.	
All *Improving Timeliness of Prenatal Care* PIPs were found to be methodologically sound and all health plans achieved all validation criteria in Steps 7 and 8 (Implementation Stage) by accurately reporting performance indicator results and documenting methodologically sound improvement strategies for the Remeasurement 1 period.	
Four out of five HealthChoice health plans were found to have methodologically sound *Improving Transportation Services* PIPs, and all health plans except one achieved all validation criteria in Steps 7 and 8 (Implementation Stage) by accurately reporting performance indicator results and documenting methodologically sound improvement strategies for the Remeasurement 1 period.	
All MMAI health plans were found to have methodologically sound *Improving Transportation Services* QIPs, and all MMAI health plans achieved all validation criteria in Steps 7 and 8 (Implementation Stage) by accurately reporting baseline results and documenting methodologically sound improvement strategies.	

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

Program Strengths	Domain(s)[2-]
Overall, after reviewing the health plans' information system capacities, HSAG has high confidence in their ability to collect and report accurate and valid data, using appropriate methods, and produce accurate and valid results used in monitoring their network adequacy.	
The time and distance study confirmed that each of the HCI health plans has contracted with a broad network of providers with offices that are located reasonably close to the enrollees they serve.	
For most provider categories and across most parts of the state, health plan performance exceeded HFS' expectation that 90 percent of enrollees have access within these standards. In fact, with the exception of a limited number of provider categories, 99 percent to 100 percent of HealthChoice enrollees had providers located within the required time and distance from their residence.	
For the Illinois Statewide Aggregate, adult experience results for Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[4] surveys were at or between the 75th and 89th percentiles for *How Well Doctors Communicate* and *Rating of All Health Care.*	
The results of compliance reviews and additional EQRO activities demonstrated that the health plans' policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
Program Opportunities for Improvement	**Domain(s)**
Quality Strategy Pillar: Adult Behavioral Health	
The health plans struggled to engage members with opioid use disorder (OUD) and substance use disorder (SUD) in appropriate treatment. The statewide average for the *Pharmacotherapy for OUD* measure decreased by at least two percentage points and remained or dropped below the 50th percentile for all three submeasures. The statewide average for three of four submeasures in the *Initiation and Engagement of SUD Treatment* measure decreased by at least one percentage point and performed below the 50th percentile.	
Quality Strategy Pillar: Child Behavioral Health	
A majority of child members struggling with SUD did not receive follow-up after high-intensity care and/or did not engage in ongoing treatment. The statewide averages for both submeasures in the *Follow-Up After High-Intensity Care for SUD* measure decreased by at least five percentage points and dropped below the 50th percentile. The statewide averages for both submeasures in the *Initiation and Engagement of SUD Treatment—Engagement of Substance Use Treatment* submeasure decreased by nearly three percentage points; the *Engagement* submeasure performed below the 50th percentile.	

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

Program Opportunities for Improvement	Domain(s)
The results of Children's Behavioral Health (CBH) Services compliance file reviews demonstrated an opportunity for improvement related to timely follow-up appointments.	
Quality Strategy Pillar: Maternal and Child Health	
For women's health measures: • The *Cervical Cancer Screening* measure statewide average remained below the 50th percentile and decreased by 1.5 percent from MY 2022. Four of the five health plans' reported rates decreased from last year. • The *Chlamydia Screening* measure statewide average remained below the 50th percentile and relatively unchanged. • The *Breast Cancer Screening* measure statewide average and three of the five plans remained below the 50th percentile.	
Child members did not receive immunizations as recommended. The *Childhood Immunization Status* measure continued to perform below the 50th percentile.	
Adolescent members did not receive immunizations as recommended. The *Immunizations for Adolescents-Combination 2* measure continued to perform below the 50th percentile.	
Child members were not assessed for body mass index (BMI) or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure continuing to perform below the 50th percentile.	
For the Illinois Statewide Aggregate, child CAHPS survey results were below the 50th percentiles for all child measures. In addition, for the Illinois Statewide Aggregate for both the general child and children with chronic conditions (CCC) populations, experience survey results for all global ratings and composite measures, except *How Well Doctors Communicate,* were below the 50th percentiles.	
Quality Strategy Pillar: Equity	
No opportunities for improvement were identified.	
Quality Strategy Pillar: Community and Health Promotion	
In the *Adults' Access to Preventive/Ambulatory Health Services—Total* measure, all five plans improved compared to last year; however, the statewide average remained below the 50th percentile. This indicates that while there continues to be gradual improvement of use of ambulatory care, there is still greater improvements to be made.	
Other Program Effectiveness Areas	
All enrollees residing in most Illinois counties had access to pharmacies within the standard regardless of their HealthChoice health plan. However, in a few urban counties, a relatively small percentage of enrollees—from 0.1 percent to 3.0 percent—did not have the required access to a pharmacy within 15 miles or 15 minutes.	

Program Opportunities for Improvement	Domain(s)
Although each HealthChoice health plan met the standard for access to oral surgeons on a statewide basis, when results were considered at the county level it became apparent that across the southernmost counties—Alexander, Gallatin, Hardin, Johnson, Massac, Pope, Pulaski, and Saline counties—no enrollees in any health plan had access to an oral surgeon within the standard of 90 minutes or 90 miles.	
For the Illinois Statewide Aggregate, adult CAHPS experience survey results were at or between the 25th and 49th percentiles for *Getting Needed Care, Getting Care Quickly,* and *Rating of Health Plan*.	
In response to EQR recommendations, many health plans identified being unable to contact (UTC) members as a barrier to improving access and performance rates. The health plans reported barriers such as having outdated contact information or lack of success reaching members.	

Recommendations for Targeting Goals and Objectives in the Quality Strategy

Table 6—Recommendations

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	To improve treatment of OUD and SUD, HSAG recommends the health plans: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation to determine what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility. • Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment. • Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	***Pillar: Adult Behavioral Health*** **Goal 1:** Improve the health outcomes and management of behavioral health services and supports for adults. ***Pillar: Child Behavioral Health*** **Goal 2:** Improve the health outcomes and management of behavioral health services and supports for children.

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	HSAG recommends that health plans complete further analysis to understand key drivers that contribute to members with OUD never starting treatment versus members who start treatment but do not stay compliant and length of time of compliance. Upon better understanding of key drivers, the health plans should consider creating a multidisciplinary workgroup that includes the behavioral health medical director, medical directors, and quality, provider network, and care management staff to understand the eligible members' barriers and create a workplan for interventions.	***Pillar: Adult Behavioral Health*** **Goal 1:** Improve the health outcomes and management of behavioral health services and supports for adults. ***Pillar: Child Behavioral Health*** **Goal 2:** Improve the health outcomes and management of behavioral health services and supports for children.
	To address opportunities for improvement related to the *Follow-Up After High Intensity Care for SUD* and the *Initiation and Engagement of SUD Treatment* measures, HSAG recommends health plans evaluate current care coordination between facilities that provide higher levels of care and outpatient SUD providers with a focus to increase timely follow-up appointments. Creating a partnership with facilities that provide higher levels of care to ensure onsite discharge planning includes appropriate instructions and referrals to outpatient SUD providers. Health plans should expand partnerships with SUD treatment providers to ensure availability of timely appointments, receipt of referrals from discharge planners for facilities that provide higher levels of care and health plan case management, and expand telehealth options. Health plans should consider case management follow-up with eligible members to assist with appointments to initiate treatment. Health plans could consider analyzing best practices used to ensure follow-up after ED visits for mental illness to determine whether processes can be leveraged to impact follow-up after inpatient hospitalizations.	***Pillar: Child Behavioral Health*** **Goal 2:** Improve the health outcomes and management of behavioral health services and supports for children.
	To address the results of CBH compliance file reviews, each health plan should implement performance improvement strategies to ensure timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis. Health plans could consider analyzing best practices used to ensure follow-up after ED visits for mental illness to determine whether processes can be leveraged to impact follow-up after inpatient hospitalizations.	***Pillar: Child Behavioral Health*** **Goal 2:** Improve the health outcomes and management of behavioral health services and supports for children.

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	To improve women's health screening rates, HSAG recommends that the health plans: • Consider whether there are disparities/social determinants of health (SDOH) factors within the health plans' populations that contributed to lower access to care. Upon identification of root causes, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. • Address sexually transmitted infection stigma among physicians and patients. • Clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update. • Use multi-modal approaches to contact members to promote women's screenings, and incentives to providers to provide screenings, increase access, and outreach eligible members in their panels.	***Pillar: Maternal and Child Health*** **Goal 3:** Improve the health outcomes of birthing persons, babies, and children. ***Pillar: Equity*** **Goal 4:** Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
	Health plan root cause analysis indicated that the second influenza vaccine dose for infants is commonly missed. HSAG recommends health plans focus on parent education and clinic practice transformation. Health plans that already have a program for new parents should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Health plans should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in their clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules. HFS should continue requiring the health plans to analyze potential key drivers that may contribute to the observed lower performance in the *Childhood Immunization Status—Combination 10* performance measure in a particular age stratification, race/ethnicity stratification, or vaccination and to help determine why	***Pillar: Maternal and Child Health*** **Goal 3:** Improve the health outcomes of birthing persons, babies, and children.

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	their child members are inconsistently receiving immunizations. This analysis should include a drill-down to consider whether there are disparities and/or health-related social needs (HRSNs) within their populations that contribute to lower performance in a particular stratification.	
	To address adolescent immunization rates, HSAG recommends that HFS conduct a workgroup with the five health plans and other external organizations to solicit and share best practices. CountyCare exceeded the 75th percentile for this measure; HFS may want to learn about any strategies that are transferable to other health plans. Health plans should conduct further analysis to consider whether there are disparities and/or SDOH within their populations that contribute to lower performance. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	***Pillar: Maternal and Child Health*** **Goal 3:** Improve the health outcomes of birthing persons, babies, and children. ***Pillar: Equity*** **Goal 4:** Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
	Health plans should conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	***Pillar: Maternal and Child Health*** **Goal 3:** Improve the health outcomes of birthing persons, babies, and children.
	The results of the general child and CCC CAHPS survey indicates that parents/caretakers of child members perceived an overall lack of quality of care and service within their child's health plans. HSAG recommends reviewing member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling for child members. In addition, the health plans could conduct root cause analyses, focus studies, and collect members' feedback to explore their perceptions and determine what could be driving lower CAHPS scores compared to the national averages and implement appropriate interventions.	***Pillar: Maternal and Child Health*** **Goal 3:** Improve the health outcomes of birthing persons, babies, and children.

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	Results of root cause analyses completed by the health plans indicated that a high percentage of open care gaps for *Adults' Access to Preventive/ Ambulatory Health Services* measure involved younger members in the age range of 20–39. HSAG recommends health plans design and test interventions specific to the 20–39 age group to engage these members in accessing healthcare on a routine basis. Outpatient care barriers like appointment availability, wait time, and time-of-day constraints due to competing priorities can be addressed by increasing telehealth options and offering extended clinic hours. Technologies such as texting campaigns to outreach to members and telehealth options are acceptable to younger age cohorts. Strategies to increase texting opt-in rates and incentives to use convenient telehealth options may be part of a comprehensive solution to improve access to healthcare for this population that underutilizes healthcare.	***Pillar: Equity*** **Goal 4:** Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
Other Program Effectiveness Areas		
	While most health plans met the contract time and distance standards for most provider categories and showed improvement over last year's results, HFS should continue to collaborate with the health plans to monitor the status of access for all provider categories. HFS should continue to collaborate with those health plans that did not meet the access standards in specific counties and help them contract with additional providers, if available. Provider categories of concern remain pharmacy and oral surgery. HFS should continue to review provider categories for which no health plans met the access standards, with the goal of determining whether these failures are due to a lack of providers or other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid enrollees.	***Pillar: Equity*** **Goal 4:** Eliminate disparities and ensure equitable access to primary and preventive care services across the Medicaid population.
	Adult CAHPS survey results indicate a lack of quality of care. HSAG recommends that the HealthChoice Illinois health plans evaluate the process of care delivery and identify whether there are any operational issues contributing to access-to-care barriers for members. The health plans could explore ways to direct members to useful and reliable sources of information on the Internet by expanding their websites to include easily accessible health information and relevant tools, as well as links to related information. The health plans could	***Pillar: Community and Health Promotion*** **Goal 6:** Promote whole person wellness, preventive care, and management of chronic conditions.

Domain	Program Recommendations	Quality Strategy Pillar and Goal
	also consider obtaining feedback from patients on their recent office visit, such as through a follow-up call or email, to gather more specific information concerning areas for improvement and implement strategies of quality improvement to address these concerns.	
	HSAG recommends health plans review their strategies to obtain accurate member contact information, including: • Identify current providers from claims and prior authorization data and outreach providers for member contact information. • Leverage data mining to analyze unconventional sources for updated contact information (or engage data mining vendors). • Maximize community partnerships to locate members and obtain contact information. • Create flexible incentives that allow for member choice and ease of redemption. • Employ strategies to increase texting opt-in rates and incentives to use telehealth options.	***Pillar: Community and Health Promotion*** **Goal 6:** Promote whole person wellness, preventive care, and management of chronic conditions.

Mandatory EQR Activities

Validation of PIPs

Overview

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

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

As one of the mandatory EQR activities required by 42 CFR §438.358(b)(1)(i), HSAG validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS EQR Protocol 1), February 2023.[5] Please note, MMPs use the terminology QIP instead of PIP.

Objectives

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

Statewide Mandatory Topics

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

[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

Prenatal Care PIP. For the *Improving Transportation Services* PIP, the health plans and MMPs updated their submission form with Steps 7 and 8 with Remeasurement 1 data and interventions.

Technical Methods of Data Collection and Analysis

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

Description of Data Obtained

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

Table 7—Health Plan and PIP-Specific Data Source

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

Improving Timeliness of Prenatal Care PIP

PIP Validation Results

Based on its technical review, HSAG determined the overall methodological validity of the PIP. Table 8 displays the validation scores and confidence levels HSAG assigned to each health plan's *Improving Timeliness of Prenatal Care* PIP submissions.[6]

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

Health Plan Name	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met[7]	Percentage Score of Critical Elements Met[8]	Confidence Level[9]	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Confidence Level
Aetna	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
BCBSIL	100%	100%	*High Confidence*	100%	100%	*High Confidence*
CountyCare	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Meridian	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Molina	100%	100%	*High Confidence*	33%	100%	*No Confidence*

As shown in Table 8 above, for the *Timeliness of Prenatal Care* PIP, for Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable PIP methodology for all five health plans. For Validation Rating 2, HSAG assigned a *High Confidence* level that the PIP achieved significant improvement for two (BCBSIL and Meridian) of five health plans.

PIP Outcomes

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

[6] The previous year's (CY 2023) validation resulted in *Met* ratings for all health plans.

[7] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[8] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*

[9] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

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

Performance Indicator Results			
Health Plan	**Baseline (1/1/2021–12/31/2021)**	**Remeasurement 1 (1/1/2022–12/31/2022)**	**Remeasurement 2 (1/1/2023–12/31/2023)**
Aetna	78.50%	79.4% ⇔	79.1% ⇔
BCBSIL	83.32%	82.4% ↓	84.4% ↑
CountyCare	76.54%	74.4% ↓	74.4% ↓
Meridian	80.08%	80.6% ⇔	83.0% ↑
Molina	84.50%	81.8% ↓	81.1% ↓

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓Designates statistically significant decline over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 9 above, the Remeasurement 2 results ranged from 74.4 percent to 84.4 percent. Two plans, BCBSIL and Meridian, achieved statistically significant improvement over the baseline. One plan, Aetna, continued to have improvement that was not statistically significant. Lastly, two plans, CountyCare and Molina, continued to show declines in performance compared to the baseline. Sustained improvement could not be assessed at Remeasurement 2 for any health plan. Sustained improvement cannot be assessed until statistically significant improvement is achieved, and a subsequent measurement period is reported.

Improving Transportation Services PIP

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

PIP Validation Results

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

[10] The previous year's (CY 2023) validation resulted in *Met* ratings for all health plans.

Table 10—*Improving Transportation Services* PIP Validation Results

Health Plan Name	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met[11]	Percentage Score of Critical Elements Met[12]	Confidence Level[13]	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Confidence Level
Aetna						
HealthChoice	100%	100%	*High*	100%	100%	*High*
MLTSS	100%	100%	*High*	100%	100%	*High*
SNC	100%	100%	*High*	100%	100%	*High*
BCBSIL						
HealthChoice	100%	100%	*High*	100%	100%	*High*
MLTSS	100%	100%	*High*	100%	100%	*High*
SNC	100%	100%	*High*	100%	100%	*High*
CountyCare						
HealthChoice	100%	100%	*High*	100%	100%	*High*
MLTSS	100%	100%	*High*	100%	100%	*High*
SNC	100%	100%	*High*	33%	100%	*No Confidence*
Meridian (Includes YouthCare)						
HealthChoice	100%	100%	*High*	33%	100%	*No Confidence*
MLTSS	100%	100%	*High*	33%	100%	*No Confidence*
SNC	100%	100%	*High*	33%	100%	*No Confidence*
Molina						
HealthChoice	93%	89%	*Low*	100%	100%	*High*
MLTSS	93%	89%	*Low*	33%	100%	*No Confidence*
SNC	93%	89%	*Low*	33%	100%	*No Confidence*

[11] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[12] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met.*

[13] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

PIP Outcomes

Table 11 displays the baseline and Remeasurement 1 data as reported by the health plans for each line of business served.

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

Performance Indicator Results		
Health Plan	**Baseline (1/1/2022–12/31/2022)**	**Remeasurement 1 (1/1/2023–12/31/2023)**
Aetna		
HealthChoice	94.2%	95.1% ↑
MLTSS	93.9%	94.8% ↑
SNC	93.1%	97.2% ↑
BCBSIL		
HealthChoice	81.9%	90.4% ↑
MLTSS	82.7%	91.1% ↑
SNC	86.1%	93.3% ↑
CountyCare		
HealthChoice	83.5%	86.2% ↑
MLTSS	88.6%	90.4% ↑
SNC	89.4%	85.5% ↓
Meridian (includes YouthCare)		
HealthChoice	89.0%	81.2% ↓
MLTSS	89.8%	82.6% ↓
SNC	85.2%	77.8% ↓
Molina		
HealthChoice	84.7%	85.5% ↑
MLTSS	86.9%	86.1% ⇔
SNC	92.1%	91.8% ⇔

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ Designates statistically significant decline over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 11 above, the Remeasurement 1 results ranged from 77.8 percent to 97.2 percent. Nine of 15 lines of business demonstrated statistically significant improvement for Remeasurement 1. Six lines of business did not demonstrate improvement in performance.

Improving Transportation Services QIP

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

QIP Validation Results

Based on its technical review, HSAG determined the overall methodological validity of the QIP. Table 12 displays the validation scores and confidence levels HSAG assigned to each MMP's *Improving Transportation Services* QIP submissions.[14]

Table 12—*Improving Transportation Services* QIP Validation Results

MMP Name	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the QIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met[9]	Percentage Score of Critical Elements Met[10]	Confidence Level[11]	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Confidence Level
Aetna	*High*	100%	100%	*High*	100%	100%
BCBSIL	*High*	100%	100%	*High*	100%	100%
Humana	*High*	100%	100%	*High*	100%	100%
Meridian	*High*	100%	100%	*No Confidence*	33%	100%
Molina	*Low*	93%	89%	*Moderate*	67%	100%

[9] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[10] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[11] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the QIP Validation Tool.

As shown in Table 12 above, for the *Improving Transportation Services* QIP, for Validation Rating 1, HSAG assigned a *High Confidence* level for adhering to acceptable QIP methodology for four of five

[14] Calendar year (CY) 2023 validation resulted in *Met* ratings for all health plans.

MMPs. For Validation Rating 2, HSAG assigned a *High Confidence* level that the QIP achieved significant improvement for three of five MMPs.

QIP Outcomes

Below, Table 13 displays the baseline and Remeasurement 1 data as reported by the MMPs.

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

Performance Indicator Results		
MMP	**Baseline (1/1/2022–12/31/2022)**	**Remeasurement 1 (1/1/2023–12/31/2023)**
Aetna	80.3%	90.1% ↑
BCBSIL	83.3%	92.7% ↑
Humana	79.3%	80.6% ↑
Meridian	90.0%	82.1% ↓
Molina	89.9%	90.0% ⇔

↑ Designates statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ Designates statistically significant decline over the baseline measurement period (p value < 0.05).
HSAG rounded percentages to the first decimal place.

As shown in Table 13 above, the Remeasurement 1 results ranged from 80.6 percent to 92.7 percent. Three of five QIPs (Aetna, BCBSIL and Humana) demonstrated statistically significant improvement for Remeasurement 1. One plan, (Molina), demonstrated non-significant improvement and one plan, (Meridian), had a decline in performance.

Aim Statements and Interventions

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

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

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

PIP Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to PIPs/QIPs were included in Table 5 and recommendations for improvement were included in Table 6. Health plan/MMP-specific strengths, opportunities for improvement, and recommendations are included in Section 3.

PMV

Objectives

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

HealthChoice Compliance Audit

HFS required that an NCQA-licensed audit organization conduct an independent audit of each HealthChoice health plan's MY 2023 data. HFS also contracted with HSAG to conduct a MY 2023 NCQA HEDIS Compliance Audit of the HealthChoice health plans' data collection and reporting processes. Health plan specific PMV reports were produced. Table 14 displays the health plans included in the PMV.

Table 14—HealthChoice Health Plans Included in PMV

Health Plan
Aetna
BCBSIL
CountyCare
Meridian
Molina

Technical Methods of Data Collection and Analysis

HFS selected a specific set of HEDIS measures for HSAG's validation based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. HSAG adhered to NCQA's *HEDIS Measurement Year 2023, 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. Additional details about the methodology and measure selection for PMV are in Appendix A—Methodology.

Results

As shown in Table 15 below, HSAG determined all HealthChoice health plans were fully compliant with all HEDIS IS standards, and all data supported the elements necessary for HEDIS reporting. Several aspects involved in the calculation of performance measure data were crucial to the validation process. These included data integration, data control, and documentation of performance measure calculations. For the current reporting period, HSAG determined that the data collected and reported by all health plans followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

Table 15—MY 2023 NCQA HEDIS Compliance Audit Results for All HealthChoice Health Plans

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

Table 16 below shows the summary of validation results for the HealthChoice measure rates selected for validation during the CY 2024 PMV activity. All measure calculations resulted in rates that were not significantly biased, and all performance measures required by HFS received an R (i.e., *Reportable*) designation for all HealthChoice health plans.

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

Performance Measure	Specifications	Validation Rating
Cervical Cancer Screening	HEDIS	R
Controlling High Blood Pressure	HEDIS	R
Follow-Up After Emergency Department Visit for Substance Use	HEDIS	R
Initiation and Engagement of SUD Treatment	HEDIS	R

HealthChoice Pay-for-Reporting (P4R)

As part of the MY 2023 NCQA HEDIS Compliance Audit, HSAG also validated the HealthChoice P4R performance measure rates. The 2024 validation measure sets included HEDIS, CMS Core Set, CMS MLTSS, and HFS custom measures. Table 17 displays the health plans included in the PMV.

Table 17—HealthChoice Health Plans Included in PMV

Health Plan
Aetna
BCBSIL
CountyCare
Meridian
Molina

Technical Methods of Data Collection and Analysis

HSAG conducted PMV for the HFS' P4R Program in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023*. Additional details about the methodology for PMV are in Appendix A—Methodology.

Results

Table 18 displays the indicator-specific review findings and designations for the HealthChoice health plans on the P4R performance measures.

Table 18—Review Designations by Measure for all HealthChoice Health Plans

Performance Measure	Specifications	Validation Rating
Adult Behavioral Health		
Follow-Up After High-Intensity Care for SUD—7-Day Follow-Up—Total	HEDIS	R
Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	HEDIS	R
Pharmacotherapy for OUD	HEDIS	R
Child Behavioral Health		
Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents	HFS Custom	R
Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents	HFS Custom	R
Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Inpatient Behavioral Health Utilization	HFS Custom	R
Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Average Length of Stay	HFS Custom	R
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat Hospitalizations Per Member	HFS Custom	R
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percentage of Repeat Hospitalizations Per Member	HFS Custom	R
Equity		
Human Immunodeficiency Virus (HIV) Viral Load Suppression—Percentage of Members with a Viral Load Less Than 200 Copies/mL	HFS Custom	R
HIV Viral Load Suppression—Percentage of Members with a Valid Lab Result and a Viral Load Less Than 200 Copies/mL	HFS Custom	R
Gap in HIV Medical Visits—Total	HFS Custom	R
Prescription of HIV Antiretroviral Therapy—Total	HFS Custom	R

Performance Measure	Specifications	Validation Rating
Maternal and Child Health		
Annual Dental Visits—Total	HEDIS	R
Child and Adolescent Well-Care Visits—Total	HEDIS	R
Childhood Immunization Status—Combination 10	HEDIS	R
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	HEDIS	R
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	HEDIS	R
Community and Health Promotion		
MLTSS Comprehensive Care Plan and Update—Care Plan with Core Elements	CMS MLTSS	R
MLTSS Comprehensive Care Plan and Update—Care Plan with Supplemental Elements	CMS MLTSS	R
MLTSS Successful Transition After Long-Term Facility Stay—Observed Transition Rate	CMS MLTSS	R
MLTSS Successful Transition After Long-Term Facility Stay—Expected Transition Rate	CMS MLTSS	R

YouthCare Performance Measures

HSAG requested the performance measure report and the final audit reports generated by the HEDIS Compliance Audit licensed organization for YouthCare. These documents, which were used and/or generated by the health plan and its auditors during the NCQA HEDIS Compliance Audit, were reviewed by HSAG.

MMAI PMV

Technical Methods of Data Collection and Analysis

HFS contracted with HSAG to conduct an audit for Humana. HFS selected a specific set of MMAI measures for HSAG's validation based on factors such as HFS-required measures, data availability, previously audited measures, and past performance. HSAG conducted PMV in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, February 2023.*[15] Additional details about the methodology and measure selection for PMV are in Appendix A—Methodology.

[15] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

Results

As shown in Table 19 below, HSAG determined Humana was fully compliant with all IS standards and that all data supported the elements necessary for performance measure reporting. Several aspects involved in the calculation of performance measure data were crucial to the validation process. These included data integration and documentation of performance measure calculations. For the current reporting period, HSAG determined that the data collected and reported by Humana followed State specifications and reporting requirements, and the rates were valid, reliable, and accurate.

Table 19—MY 2023 PMV Audit Results for Humana

IS Capabilities Assessment				
Medical Services Data	**Enrollment Data**	**Practitioner Data**	**Data Preproduction Processing**	**Data Integration and Reporting**
Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant	Fully Compliant

Below, Table 20 shows the summary of validation results for the MMAI measure rates selected for validation during the CY 2024 PMV activity. All measure calculations resulted in rates that were not significantly biased, and all performance measures required by HFS received an R designation for Humana.

Table 20—Review Designations by Measure for Humana

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

MMAI IL 3.6

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

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

HSAG validated the data collection and reporting processes used by the MMPs to report the quality withhold performance measure data for Demonstration Year 9 (January 1, 2023, through December 31, 2023) in accordance with the CMS publication, *Protocol 2. Validation of Performance Measures: A*

Mandatory EQR-Related Activity, February 2023 (CMS Protocol 2).[16] Table 21 displays HSAG's validation finding for all MMPs.

Table 21—MMAI IL 3.6 PMV Audit Results

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

PMV Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to PMV were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 3.

Performance Measure Results

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

Compliance Monitoring

Compliance Review

This section presents a description of the activities HSAG conducted to comply with 42 CFR Part 438 Subpart E, which requires that specific review activities be performed by an EQRO related to required EQRs of a health plan's compliance with state and federal standards. One mandatory EQR requirement is a review, conducted within the previous three-year period, to determine the health plan's compliance with the standards set forth in Subpart D of 42 CFR §438.358 and the QAPI requirements described in 42 CFR §438.330.

In state fiscal year (SFY) 2024, the second year of a new three-year review cycle, HSAG conducted an Evaluation of Administrative Processes and Compliance Review (Compliance Review) in accordance with §438.358 by evaluating a subset of standards selected by HFS for the health plans serving HealthChoice and the MMPs serving MMAI.

[16] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: http://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

Objectives

The Compliance Review assessed each health plan's and MMP's compliance with the federal standards and the State contract requirements found in HFS Model Contract 2018-24-001, the MMAI three-way contract, the YouthCare contract, and the subsequent amendments to all three contracts. In SFY 2024, the Compliance Review covered the remaining standards, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. HSAG used information and data derived from Compliance Reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care of Medicaid services provided to Medicaid enrollees.

Technical Methods of Data Collection and Analysis

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

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

Standards

The SFY 2024 Compliance Review included a subset of requirements that address federal Medicaid managed care regulations and State standards. For HealthChoice and MMAI, a total of seven standards were assessed in SFY 2023, and the remaining standards were covered in SFY 2024, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. Table 22 displays the standards reviewed for each health plan in the three-year cycle.

Table 22—Review Standards for the Three-Year Period: SFY 2023–SFY 2025

			All HealthChoice and MMAI Health Plans		
#	CFR	Standard Name	SFY 2023	SFY 2024	SFY 2025
I	438.206	Availability of Services[17]		✓	
II	438.207	Assurances of Adequate Capacity and Services		✓	
III	438.208	Coordination and Continuity of Care (including Transitions of Care)	✓		
IV	438.210	Coverage and Authorization of Services	✓		
V	438.214	Credentialing and Recredentialing	✓		
VIII[18]	438.100	Enrollee Information/Enrollee Rights		✓	
IX	438.224	Confidentiality		✓	
X	438.56	Enrollment and Disenrollment		✓	
XI	438.228	Grievance and Appeal Systems	✓		
XII	N/A	Organization and Governance	✓		
XIII	N/A	Fraud, Waste, and Abuse		✓	
XIV	438.242	Health ISs		✓	
XV	438.230	Subcontractual Relationships and Delegation	✓		
XVI	N/A	Critical Incidents		✓	
XVII	438.236	Practice Guidelines and Minimum Standards of Care		✓	
XVIII	438.330	QAPI Program	✓		

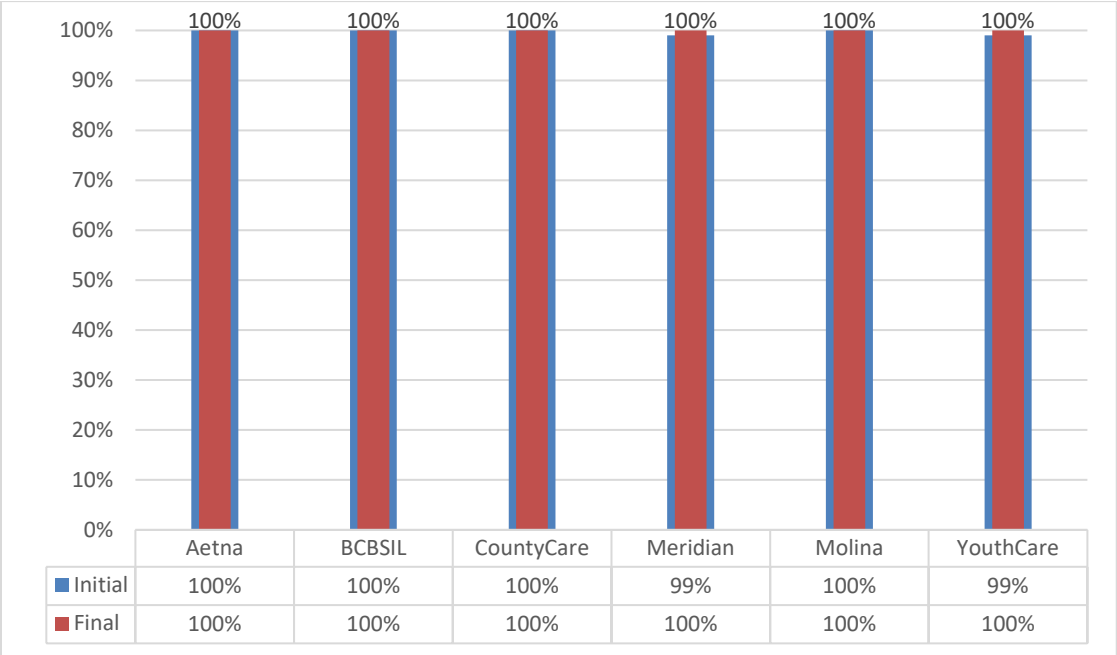
[17] Standard I included Emergency and Poststabilization Services.

[18] In previous compliance review cycles, HSAG and HFS designated Standard VI for CBH and Standard VII for YouthCare. In SFY 2023, standards VI and VII were removed because YouthCare-specific review tools were created to ensure evaluation of specific contact requirements. In SFY 2024, HSAG conducted a CBH post-implementation review with HCI health plans to follow up on previous findings.

Results for Compliance Review

The SFY 2024 Compliance Review included a subset of requirements that address federal Medicaid managed-care regulations and State standards. For HealthChoice and MMAI, a total of nine standards were assessed in SFY 2024, and the remaining standards were covered in SFY 2023, thereby completing the required evaluation of the administrative and compliance process once in a three-year period. Figure 1 displays the overall initial and final HealthChoice health plan-specific compliance scores for all nine standards reviewed during the SFY 2024 Compliance Review.

Figure 1—Overall Compliance Ratings by HealthChoice Health Plan

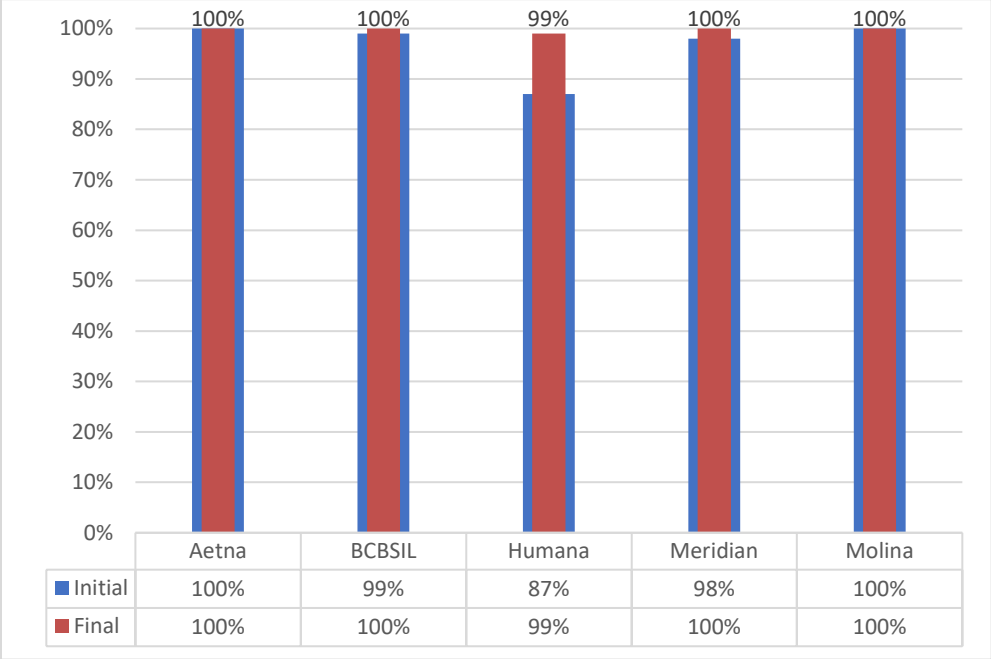


	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare
Initial	100%	100%	100%	99%	100%	99%
Final	100%	100%	100%	100%	100%	100%

As shown in Figure 1, all HealthChoice health plans achieved an initial overall compliance score of 99 percent or 100 percent. The health plans were generally compliant with policies and procedures as well as file reviews. The health plans were provided an opportunity to remediate elements for each standard that did not achieve 100 percent on initial review; final scores were 100 percent for all health plans.

Figure 2 displays the overall initial and final MMAI health plan-specific compliance scores for all nine standards reviewed during the SFY 2024 Compliance Review.

Figure 2—Overall Compliance Ratings by MMAI Health Plan



	Aetna	BCBSIL	Humana	Meridian	Molina
Initial	100%	99%	87%	98%	100%
Final	100%	100%	99%	100%	100%

As shown in Figure 2, all MMPs achieved an initial overall compliance score at or between 87 percent and 100 percent. Generally, the MMPs were compliant with policies and procedures as well as file reviews. The MMPs were provided with an opportunity to remediate elements for each standard that did not achieve 100 percent on the initial review; final scores ranged from 99 percent to 100 percent for all MMPs.

CBH Services Post-Implementation Review

As part of the Compliance Review, HSAG conducted a post-implementation review to follow up on implementation of CBH Services after a revised contract amendment was implemented on July 1, 2022. All health plans demonstrated an opportunity for improvement in ensuring compliance with the CBH Services requirements.

Health Benefits for Immigrant Adults (HBIA) and Health Benefits for Immigrant Seniors (HBIS) Readiness Review

HFS requested HSAG conduct a focused readiness review to assess the HealthChoice health plans' readiness to receive enrollees in the HBIA and HBIS program, which launched under managed care on January 1, 2024. HSAG conducted the HBIA and HBIS readiness review to assess the HCI health plans' structural and operational capacity to perform the managed care functions described in the Illinois

HealthChoice Model Contract and subsequent amendments. All health plans demonstrated compliance with no critical findings impacting the ability to receive HBIA and HBIS enrollees.

Compliance Review Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to compliance review were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 3.

NAV

Objectives

Title 42 of the CFR §438.350(a) requires that the State develop and enforce network adequacy standards, and have a qualified EQRO perform an annual EQR of each plan that includes NAV.[19] The purpose of the NAV is to assess the health plans' compliance with the State-defined network adequacy standards by evaluating their collection of provider data, the reliability and validity of their network adequacy data, and the methods, systems, and processes they use to monitor their network adequacy. The EQRO is required to determine a validation rating that reflects its overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by the State.

Technical Methods of Data Collection and Analysis

HSAG used the methodologies approved by HFS to conduct the NAV for SFY 2024. There were two main components to the activity: an ISCA for all health plans and an independent time and distance study of the HealthChoice health plans and YouthCare.

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

The health plans also submitted their own time and distance data and results to HSAG for review. HSAG conducted an independent time and distance study of the health plans' provider network data to confirm compliance with the access standards incorporated in the health plan contracts, calculating the percentage of each health plan's enrollees who had a provider located within the required access

[19] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

standards. HSAG compared its results to those submitted by the health plans and considered the similarity in assigning validation scores.

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

Results

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

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

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

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

- **Statewide:** Overall, 99 percent to 100 percent of HealthChoice enrollees, whatever their choice of health plan, had necessary providers located within the required time and distance from their residence. The percentage of enrollees with the required access to adult and pediatric oral surgeons was lower, but still exceeded the 90 percent standard when viewed on a statewide level.
- **Health equity**: There was little indication of disparities in access for enrollees related to race, ethnicity, age, sex, and Disproportionately Impacted Area (DIA) status. Deficits in access were similar across urbanicity, age, sex, race, and ethnicity. Enrollees residing in DIA ZIP Codes were more likely to have access to care within standards than those residing in non-DIA ZIP Codes, but this may be due to a correspondence between DIA status and urbanicity, and may or may not be a function of disparity. Where standards were not met for a provider in a county or region, all enrollees who lived there were impacted, regardless of race, ethnicity, or any of the other factors examined.

- **Provider networks**: All health plans met standards for all enrollees and counties in all provider categories assessed except pharmacies and oral surgeons.
- **Pharmacies**: HFS holds access to pharmacies to a higher standard than other provider categories, requiring that 100 percent of enrollees have access within 15 minutes or 15 miles in urban counties, or within 60 minutes or 60 miles in rural counties. All health plans met this standard in all rural counties, but in some urban counties, between 97.3 and 99.9 percent of enrollees had access within the standard.
- **Oral surgeons**: Access to oral surgeons for the adult and pediatric populations requires that 90 percent of enrollees have access within 60 minutes or 60 miles in urban counties, or within 90 minutes or 90 miles in rural counties. When results were analyzed by county and region, each of the health plans that served statewide (i.e. all but CountyCare) failed to provide the required access to oral surgeons for adult and pediatric enrollees in some areas, predominantly in rural counties located in regions 1, 2, or 3. These findings are consistent with prior years, but showed year over year improvement. The health plans have attributed this finding to the lack of provider availability in certain areas of the state and/or provider unwillingness to accept Medicaid rates.
- **Nursing facilities**: HFS requires that MMAI enrollees have access to two nursing facilities within 15 miles or 30 minutes from enrollees' ZIP Code of residence within each county. All of the MMAI plans met the standard for above 99 percent of enrollees in each region and for more than 91 percent of counties in each region. However, county-specific analysis identified that in one rural county, Alexander, four of the five MMAI plans did not meet the HFS standard. In several additional counties, one or two health plans did not meet the standard.

HSAG also noted the following study limitations:

- Time and distance results summarize the geographic distribution of a provider network relative to enrollee residences and may not fully reflect the availability of providers (or appointments) at given office locations. These general statistics do not take into account other issues known to impact access, such as whether a specific provider is accepting new Medicaid patients at a specific location, or how active the provider is in the Medicaid program.
- The analyses were based on reported average drive times and may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of providers relative to Medicaid enrollees; the shorter the average drive time, the more similar the distribution of providers is relative to enrollees.
- When evaluating the results presented, note that provider data supplied by the health plans may not include providers contracted with the health plans under limited use contracts or single case agreements.

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

Statewide strengths and opportunities for improvement related to network adequacy were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 3.

Optional EQR Activities

Beneficiary Experience With Care

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

Objectives

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

Technical Methods of Data Collection and Analysis

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

CAHPS Measures

CAHPS survey questions were categorized into 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. Member experience is assessed through the evaluation of eight performance measures.

HSAG performed three separate analyses on the survey results: top-box score calculations, national comparisons, and a trend analysis. HSAG performed a trend analysis that compared the 2024 top-box scores to the corresponding 2023 top-box scores. Top-box score results that were statistically significantly higher in 2024 than in 2023 are noted with upward (▲) triangles. Top-box scores that were statistically significantly lower in 2024 than in 2023 are noted with downward (▼) triangles. Top-box scores in 2024 that were not statistically significantly higher or lower than scores in 2023 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 23 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 23—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

Adult CAHPS Medicaid Results

HFS requires health plans to use a NCQA-certified CAHPS survey vendor to administer CAHPS surveys to a sample of their adult enrollees. The 2023 and 2024 adult Medicaid CAHPS top-box scores, trend analysis, and overall member experience ratings (i.e., star ratings) are presented in Table 24 and Table 25 below for each health plan and the statewide aggregate.

Table 24—2023 and 2024 Adult Health Plan-Specific Results: Composite Measures

Plan Name	Year	*Getting Needed Care*	*Getting Care Quickly*	*How Well Doctors Communicate*	*Customer Service*
Aetna	2023	80.73% ★★	77.82% ★★	92.00% ★★	87.04% ★★
	2024	75.52% ★	77.42% ★★	92.38% ★★	87.49% ★
BCBSIL	2023	82.58% ★★	80.25% ★★	93.00% ★★★	89.12% ★★
	2024	82.41% ★★★	81.63% ★★★	93.65% ★★★	91.16% ★★★★
CountyCare	2023	76.16% ★	77.73% ★★	92.58% ★★	91.11% ★★★★
	2024	80.02% ★★	78.17% ★★	91.23% ★	90.15% ★★★
Meridian	2023	84.12% ★★★	83.78% ★★★	90.68% ★	92.67%+ ★★★★★
	2024	83.71% ★★★	82.61% ★★★	95.90%▲ ★★★★★	92.08% ★★★★★

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Molina	2023	81.43% ★★	82.38% ★★★	92.89% ★★	86.74%+ ★★
	2024	86.12% ★★★★	78.62% ★★	95.32% ★★★★★	87.07%+ ★
Illinois Statewide Aggregate	2023	81.36% ★★	81.04% ★★★	91.71% ★★	90.22% ★★★
	2024	81.61% ★★	79.90% ★★	94.04% ★★★★	89.85% ★★★

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

Table 25—2023 and 2024 Adult Health Plan-Specific Results: Global Ratings

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Aetna	2023	47.90% ★	64.12% ★	61.87% ★	51.11% ★
	2024	50.84% ★	65.70% ★★	64.68% ★★	49.83% ★
BCBSIL	2023	54.75% ★★	71.10% ★★★	69.73% ★★★	66.24% ★★★★
	2024	56.06% ★★★	74.78% ★★★★★	67.77% ★★★	67.76% ★★★★
CountyCare	2023	61.26% ★★★★	73.87% ★★★★	63.83% ★	67.83% ★★★★
	2024	61.14% ★★★★	70.82% ★★★	73.55% ★★★★★	68.15% ★★★★
Meridian	2023	56.77% ★★★	64.40% ★★	62.50%+ ★	55.98% ★
	2024	60.32% ★★★★	70.99% ★★★	66.91% ★★★	62.26% ★★★
Molina	2023	57.58% ★★★	67.01% ★★	72.55% ★★★	58.66% ★★
	2024	69.50%▲ ★★★★★	76.22%▲ ★★★★★	70.10%+ ★★★★	63.64% ★★★

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Illinois Statewide Aggregate	2023	55.94% ★★	66.79% ★★	64.29% ★	57.98% ★
	2024	59.99% ★★★★	70.81% ★★★	68.41% ★★★	61.26% ★★

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

As shown in Table 24 and Table 25 above, Meridian's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *How Well Doctors Communicate*. Molina's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *Rating of All Health Care* and *Rating of Personal Doctor*. Aetna was the lowest performing health plan, with all 2024 results at or below the 49th percentile.

Child CAHPS Medicaid Results

HFS requires health plans to use a NCQA-certified CAHPS survey vendor to administer CAHPS surveys to a sample of their child enrollees. The 2023 and 2024 child Medicaid CAHPS top-box scores, trend analysis, and overall member experience ratings (i.e., star ratings) are presented in Table 26 and Table 27 below for each child health plan and the statewide aggregate.

Table 26—2023 and 2024 Child Health Plan-Specific Results: Composite Measures

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Aetna	2023	83.44% ★★	81.51% ★	94.83% ★★★	81.20% ★
	2024	81.82% ★★	84.50% ★★	93.73% ★★	90.09%▲ ★★★★
BCBSIL	2023	73.05% ★	78.99% ★	92.58% ★★	87.72% ★★★
	2024	73.32% ★	75.28% ★	92.38% ★★	84.80% ★
CountyCare	2023	74.35% ★	82.34% ★	94.50% ★★	86.17% ★
	2024	79.36% ★★	82.03% ★	93.00% ★★	87.87% ★★★

Plan Name	Year	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service
Meridian	2023	86.49% ★★★	86.02%+ ★★	93.03% ★★	86.69%+ ★★
	2024	83.06% ★★★	85.93% ★★	94.05% ★★★	84.07%+ ★
Molina	2023	82.06% ★★	85.76% ★★	94.06% ★★	87.76% ★★★
	2024	81.41% ★★	79.83%▼ ★	94.21% ★★★	84.41% ★
Illinois Statewide Aggregate	2023	80.45% ★	83.11% ★	93.49% ★★	86.27% ★★
	2024	79.71% ★★	81.78% ★	93.45% ★★	85.60% ★

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

Table 27—2023 and 2024 Child Health Plan-Specific Results: Global Ratings

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Aetna	2023	63.25% ★	73.77% ★	72.34%+ ★★★+	58.10% ★
	2024	67.12% ★★	70.57% ★	68.53% ★★	61.39% ★
BCBSIL	2023	66.00% ★	72.47% ★	60.56%+ ★	72.14% ★★
	2024	67.97% ★★	74.35% ★★	63.16%+ ★	73.50% ★★★
CountyCare	2023	68.80% ★★	77.10% ★★	68.60%+ ★	75.47% ★★★
	2024	77.16%▲ ★★★★★	75.59% ★★	75.26%+ ★★★★	78.56% ★★★★★
Meridian	2023	71.23% ★★★	75.88% ★★	76.19%+ ★★★	71.36% ★★
	2024	65.98% ★★	75.89% ★★★	69.44%+ ★★	67.21% ★

Plan Name	Year	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often	Rating of Health Plan
Molina	2023	70.00% ★★	78.09% ★★★	73.58% ★★★	63.81% ★
	2024	63.21% ★	75.00% ★★	75.47% ★★★★	61.31% ★
Illinois Statewide Aggregate	2023	68.38% ★★	75.20% ★★	70.39% ★★	69.55% ★★
	2024	67.95% ★★	74.70% ★★	69.29% ★★	69.08% ★★

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

As shown in Table 26 and Table 27 above, Aetna's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *Customer Service*. CountyCare's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *Rating of All Health Care*. Conversely, Molina's experience survey results showed a statistically significant decline in 2024 compared to 2023 for *Getting Care Quickly*. Aetna and BCBSIL were the lowest performing health plans, with all 2024 results at or below the 49th percentile, except for one composite measure for Aetna and one global rating for BCBSIL.

Statewide CAHPS Child Medicaid Survey

HSAG administers a CAHPS survey on behalf of HFS for child members of the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/CHIP) programs. The standardized survey instrument selected was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set. Results were calculated for the general child population and for the population of children identified as having a chronic condition.

General Child Population

Table 28 shows the 2023 and 2024 general child populations' CAHPS top-box scores and overall member experience ratings (i.e., star ratings) for Illinois statewide program aggregate, All Kids, and Illinois Medicaid.

Table 28—2023 and 2024 Statewide Survey General Child Population Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2023	81.50% ★★	81.83% ★★	81.09% ★
	2024	81.64% ★★	82.03% ★★	81.14% ★★
Getting Care Quickly	2023	82.42% ★	81.44% ★	83.55% ★
	2024	84.18% ★★	83.63% ★★	84.91% ★★
How Well Doctors Communicate	2023	94.70% ★★★	94.90% ★★★	94.45% ★★
	2024	94.01% ★★★	93.68% ★★	94.44% ★★★
Customer Service	2023	86.85% ★★	87.11% ★★	86.54% ★★
	2024	83.41% ★	82.36%+ ★	84.67%+ ★
Global Ratings				
Rating of All Health Care	2023	67.09% ★	70.00% ★★	63.60% ★
	2024	66.76% ★★	67.68% ★★	65.56% ★★
Rating of Personal Doctor	2023	74.60% ★	74.75% ★★	74.41% ★
	2024	71.09% ★	72.30% ★	69.44% ★
Rating of Specialist Seen Most Often	2023	75.38% ★★★	77.88% ★★★★	72.09%+ ★★
	2024	69.72% ★★	72.13%+ ★★★	66.67%+ ★★
Rating of Health Plan	2023	62.41% ★	62.62% ★	62.11% ★
	2024	63.47% ★	63.93% ★	62.88% ★

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

As shown in Table 28 above, none of the experience survey results for the general child population showed a statistically significant improvement or decline in 2024 compared to 2023. All program results for *Getting Needed Care, Getting Care Quickly, Customer Service, Rating of All Health Care, Rating of Personal Doctor,* and *Rating of Health Plan* were below the 50th percentile, which indicates that parents/caretakers of child members perceived a lack of access to getting the care, tests, or treatments their child needed; a lack of timeliness of care and encountered difficulty scheduling with a provider or facility; felt that customer service staff did not provide the information or assistance that parents/caretakers needed; may have received poor communication and service from their child's personal doctor; and felt there is an overall lack of quality of care and service in their child's health plans.

CCC Population

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

Below, Table 29 shows the 2023 and 2024 CCC populations' CAHPS top-box scores, trend analysis, and overall member experience ratings (i.e., star ratings) for Illinois statewide program aggregate, All Kids, and Illinois Medicaid.

Table 29—2023 and 2024 Statewide Survey CCC Child Results

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Composite Measures				
Getting Needed Care	2023	82.26% ★	83.89%+ ★	80.63%+ ★
	2024	82.30% ★★	84.79% ★★	79.40% ★
Getting Care Quickly	2023	87.99% ★★	85.70%+ ★	90.17%+ ★★
	2024	88.17% ★★	89.21% ★★	87.00% ★

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
How Well Doctors Communicate	2023	95.07% ★★★	95.96%+ ★★★	94.23% ★★
	2024	93.25% ★★★	95.17% ★★★	91.22% ★
Customer Service	2023	86.31%+ NA	82.93%+ NA	89.53%+ NA
	2024	83.33% ★	80.99%+ ★	85.62%+ ★
Global Ratings				
Rating of All Health Care	2023	63.47% ★★	65.14% ★★	61.82% ★
	2024	62.57% ★★	64.06% ★★	60.84% ★★
Rating of Personal Doctor	2023	74.03% ★★	73.23% ★★	74.81% ★★
	2024	73.27% ★★	74.46% ★★	71.92% ★★
Rating of Specialist Seen Most Often	2023	75.65% ★★★	79.69%+ ★★★★★	70.59%+ ★
	2024	71.11% ★★	74.60% ★★★	66.67%+ ★★
Rating of Health Plan	2023	55.28% ★	54.61% ★	55.94% ★
	2024	57.30% ★	56.28% ★	58.45% ★
CCC Composites and Items				
Access to Specialized Services	2023	65.33%+ ★	71.21%+ ★★★	59.88%+ ★
	2024	62.93% ★	63.92%+ ★	61.84%+ ★
FCC: Personal Doctor Who Knows Child	2023	90.79% ★	93.48%+ ★★★★★	88.37%+ ★
	2024	91.48% ★★★	92.14% ★★★	90.73% ★★

	Year	Illinois Statewide Aggregate	All Kids	Illinois Medicaid
Coordination of Care for Children with Chronic Conditions	2023	81.58%+ ★★★★★	83.87%+ ★★★★★	78.87%+ ★★★★
	2024	76.08% ★★	78.70%+ ★★★	73.26%+ ★
Access to Prescription Medicines	2023	91.83% ★★★	92.45% ★★★	91.18% ★★★
	2024	88.15% ★★	89.34% ★★	86.75% ★
FCC: Getting Needed Information	2023	94.98% ★★★★★	96.33% ★★★★★	93.64% ★★★
	2024	91.34% ★★★	93.75% ★★★★	88.55% ★

▲ Indicates the 2024 score is statistically significantly higher than the 2023 score.
▼ Indicates the 2024 score is statistically significantly lower than the 2023 score.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA indicates NCQA's 2023 Quality Compass Benchmark and Compare Quality Data were not available; therefore, star results are not available.

As shown in Table 29 above, none of the experience survey results for the CCC population showed a statistically significant improvement or decline in 2024 compared to 2023. All program results for *Getting Needed Care, Getting Care Quickly, Customer Service, Rating of All Health Care, Rating of Personal Doctor, Rating of Health Plan, Access to Specialized Services,* and *Access to Prescription Medicines* were below the 50th percentile, which indicates that parents/caretakers of child members with chronic conditions perceived a lack of access to getting the care, tests, or treatments their child needed; a lack of timeliness of care and encountered difficulty scheduling with a provider or facility; felt that customer service staff did not provide the information or assistance that parents/caretakers needed; may have received poor communication and service from their child's personal doctor; felt there is an overall lack of quality of care and service in their child's health plans; and poor access to medical equipment/prescription medicines or treatment needed for their child with chronic conditions.

Special Needs Children (SNC) Survey

HSAG administered a CAHPS survey on behalf of HFS for Illinois' SNC health plans and the FYiC population. Results were calculated for the general child population and for the population of children identified as having a chronic condition. The standardized survey instrument selected was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the CCC measurement set.

SNC General Population

Table 30 shows the 2023 and 2024 general child populations' CAHPS top-box scores, trend analysis, and overall member experience ratings (i.e., star ratings) for the SNC health plans and FYiC.

Table 30—SNC and FYiC General Child Population Results

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
Composite Measures								
Getting Needed Care	2023	82.51% ★★	83.02% ★★	83.10% ★★	87.32% ★★★	85.21% ★★★	75.59% ★	84.64% ★★
	2024	84.60% ★★★	77.59% ★	78.90% ★	84.37% ★★★	89.18% ★★★★	89.22%+▲ ★★★★	81.48% ★★
Getting Care Quickly	2023	88.10% ★★★	87.30% ★★	83.88% ★	86.69% ★★	86.97% ★★	92.68% ★★★★★	91.04% ★★★★
	2024	87.06% ★★★	80.71%▼ ★	84.58% ★★	87.16% ★★★	91.01%+ ★★★★★	93.16% ★★★★★	90.15% ★★★★
How Well Doctors Communicate	2023	90.94% ★	92.12% ★	92.65% ★★	94.17% ★★	93.05% ★★	96.69% ★★★★	97.59% ★★★★★
	2024	89.75% ★	93.09% ★★	88.92% ★	92.04% ★★	91.37% ★	96.70% ★★★★★	96.68% ★★★★★
Customer Service	2023	90.25% ★★★★	90.98% ★★★★	87.56% ★★	90.83% ★★★★	84.99% ★	89.63% ★★★	89.35% ★★★
	2024	90.22%+ ★★★★	86.81% ★★	85.44% ★	89.84% ★★★	88.19%+ ★★★	85.34%+ ★	87.88%+ ★★★
Global Ratings								
Rating of All Health Care	2023	66.39% ★	66.04% ★	66.97% ★	68.27% ★★	62.83% ★	71.11% ★★★	66.29% ★
	2024	66.47% ★★	65.63% ★★	65.84% ★★	63.64% ★	69.57% ★★★	70.37% ★★★	67.25% ★★
Rating of Personal Doctor	2023	75.50% ★★	76.84% ★★	78.24% ★★★	80.00% ★★★	70.46% ★	79.80% ★★★	77.64% ★★★
	2024	68.61% ★	76.12% ★★★	75.28% ★★	74.90% ★★	74.37% ★★	76.70% ★★★	80.27% ★★★★★
Rating of Specialist Seen Most Often	2023	74.83% ★★★	81.17% ★★★★★	83.41% ★★★★★	75.20% ★★★	70.24% ★★	68.70% ★	69.68% ★★
	2024	75.21% ★★★★	78.79% ★★★★★	77.60% ★★★★★	81.36% ★★★★★	80.00%+ ★★★★★	76.79%+ ★★★★	66.32%+ ★
Rating of Health Plan	2023	60.15% ★	67.31% ★	69.96% ★★	63.95% ★	57.42% ★	53.66% ★	53.15% ★
	2024	59.76% ★	65.45% ★	69.58% ★★	62.73% ★	59.45% ★	59.90% ★	54.49% ★

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

As shown in Table 30 above, YouthCare's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *Getting Needed Care.* Conversely, BCBSIL's experience survey results showed a statistically significant decline in 2024 compared to 2023 for *Getting Care Quickly.*

SNC CCC

Table 31 shows the 2023 and 2024 CCC populations' CAHPS top-box scores, trend analysis, and overall member experience ratings (i.e., star ratings) for the SNC health plans and FYiC population.

Table 31—SNC CCC NCQA Comparisons

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
Composite Measures								
Getting Needed Care	2023	83.19% ★	83.20% ★	83.34% ★	87.42% ★★	85.47% ★★	72.82% ★	83.14% ★
	2024	86.01% ★★	79.14% ★	81.40% ★★	83.90% ★★	87.35% ★★★	83.11%▲ ★★	81.57% ★★
Getting Care Quickly	2023	89.75% ★★	88.15% ★★	85.46% ★	87.35% ★★	87.52% ★★	91.99% ★★★	90.65% ★★
	2024	87.74% ★★	81.80%▼ ★	84.05% ★	86.66% ★	89.99% ★★★	92.29% ★★★★	90.80% ★★★
How Well Doctors Communicate	2023	91.03% ★	92.82% ★	92.48% ★	94.10% ★★	92.93% ★	96.22% ★★★	97.23% ★★★★★
	2024	91.54% ★	92.23% ★★	89.76% ★	91.18% ★	92.11% ★	96.24% ★★★★	96.80% ★★★★★
Customer Service	2023	91.04% NA	91.72% NA	89.05% NA	91.63% NA	85.95% NA	90.00%+ NA	88.21% NA
	2024	90.71% ★★★	87.72% ★★	86.83% ★★	90.49% ★★★	89.20%+ ★★	83.94% ★	85.77% ★
Global Ratings								
Rating of All Health Care	2023	64.42% ★★	65.85% ★★	65.80% ★★	66.46% ★★	62.01% ★	66.48% ★★	63.57% ★★
	2024	65.92% ★★★	67.76% ★★★	68.86% ★★★	61.84% ★★	65.19% ★★★	60.62% ★	61.18% ★★
Rating of Personal Doctor	2023	75.09% ★★	77.42% ★★	77.47% ★★	78.39% ★★★	69.31% ★	77.27% ★★	76.41% ★★
	2024	69.34% ★	76.26% ★★★	73.85% ★★	71.40%▼ ★★	72.76% ★★	74.14% ★★	81.03% ★★★★★

	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	YouthCare	FYiC
Rating of Specialist Seen Most Often	2023	73.76% ★★★	80.66% ★★★★★	83.43% ★★★★★	73.89% ★★★	69.08% ★	65.88%+ ★	68.59% ★
	2024	74.34% ★★★	81.53% ★★★★★	78.41% ★★★★	74.23% ★★★	76.39% ★★★★	64.49% ★	64.35% ★
Rating of Health Plan	2023	56.87% ★	66.99% ★★	68.78% ★★★	61.81% ★	56.10% ★	48.68% ★	47.94% ★
	2024	60.27% ★	66.53% ★★	67.73% ★★★	60.12% ★	56.60% ★	54.09% ★	47.38% ★
CCC Composites and Items								
Access to Specialized Services	2023	68.24%+ ★	66.35% ★	69.33% ★	69.16% ★	64.97%+ ★	62.23%+ ★	66.35% ★
	2024	68.49% ★★	62.95% ★	63.93% ★	64.32% ★	71.13%+ ★★	68.21% ★★	62.60% ★
FCC: Personal Doctor Who Knows Child	2023	89.78% ★	90.65% ★	91.31% ★★	92.45% ★★★	90.96% ★★	88.47% ★	88.50% ★
	2024	89.20% ★	91.49% ★★★	91.36% ★★★	89.21% ★	88.80% ★	89.71% ★	91.25% ★★★
Coordination of Care for Children with Chronic Conditions	2023	81.19%+ ★★★★★	77.61% ★★★	80.67%+ ★★★★★	79.53% ★★★★	77.84% ★★★	70.01%+ ★	68.34% ★
	2024	84.67% ★★★★★	80.02% ★★★★	87.16% ★★★★★	78.84% ★★★	84.65%+ ★★★★★	72.27% ★	71.94% ★
Access to Prescription Medicines	2023	88.55% ★	87.63% ★	92.56% ★★★	89.25% ★★	88.62% ★	80.37% ★	82.80% ★
	2024	90.74% ★★★	85.42% ★	89.31% ★★	86.85% ★	89.29% ★★	77.68% ★	83.79% ★
FCC: Getting Needed Information	2023	89.52% ★	88.42% ★	87.04% ★	89.84% ★	86.46% ★	90.06% ★★	94.14% ★★★★
	2024	89.73% ★★	89.05% ★★	89.42% ★★	90.28% ★★	92.27% ★★★	90.79% ★★	92.01% ★★★

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

As shown in Table 31 above, YouthCare's experience survey results showed a statistically significant improvement in 2024 compared to 2023 for *Getting Needed Care*. Conversely, BCBSIL's experience survey results showed a statistically significant decline in 2024 compared to 2023 for *Getting Care Quickly* and Meridian's experience survey results showed a statistically significant decline in 2024 compared to 2023 for *Rating of Personal Doctor*.

CAHPS Statewide Strengths, Opportunities for Improvement, and Recommendations

Statewide strengths and opportunities for improvement related to CAHPS were included in Table 5 and recommendations for improvement were included in Table 6. Health plan-specific strengths, opportunities for improvement, and recommendations are included in Section 3.

Quality Rating System

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

In CY 2024, 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.

Health plan performance was evaluated in six separate reporting categories, identified as important to consumers.[20] 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.
- **Living With Illness**: Includes HEDIS measures that assess how well health plans take care of people who have chronic conditions, such as diabetes and hypertension.
- **Behavioral Health**: Includes HEDIS measures that assess if members with behavioral health conditions received appropriate follow-up after hospitalization, ED visit, or high intensity care, as well as measures that assess pharmacotherapy for OUD and the initiation and engagement of SUD

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

treatment. In addition, this category includes a HEDIS measure that assesses if children and adolescents using antipsychotic prescriptions receive appropriate metabolic testing.

- **Women's and Children's Health**: Includes HEDIS measures that assess how often women-specific and child and adolescent services are provided (e.g., breast cancer, cervical cancer, and chlamydia screenings, as well as prenatal and postpartum care; and child and adolescent immunizations, well-child visits, and weight assessment and counseling for children/adolescents).

HFS, in collaboration with HSAG, chose measures for the 2024 (MY 2023) Report Card based on a number of factors, such as measures that best approximate the reporting categories that are useful to consumers; using data that are available; and using nationally recognized, standardized measures of Medicaid and/or managed care. Weights were applied when calculating the category summary scores and the confidence intervals to ensure that all measures contributed equally to the derivation of the final results.

HSAG presented measure-level ratings on the selected HEDIS and CAHPS measures based on comparisons to national Medicaid benchmarks. A five-level rating scale was used to report how HEDIS and CAHPS measures compared to the 2023 Quality Compass national Medicaid benchmarks. In addition, HSAG provided consumers with category-level trending information for the selected categories (Doctor's Communication, Access to Care, Living With Illness, Behavioral Health, and Women's and Children's Health) to indicate whether the health plans' average rating in each category improved, declined, or stayed the same from 2023 to 2024 based on comparisons to national Medicaid benchmarks. HSAG computed five reporting category summary scores for each health plan. HSAG compared each measure to national benchmarks and assigned star ratings for each measure.

3. Additional EQR Activities

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

Network Monitoring

Objectives and Technical Methods of Data Collection and Analysis

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

Network Adequacy Monitoring Results

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

Analyses and monitoring of the HealthChoice, MLTSS, and MMAI provider network throughout SFY 2024 and CY 2024 verified that the health plans contracted with a sufficient number of required provider types within each service region.

Access and Availability Telephone Survey

Introduction

As part of its provider network adequacy monitoring activities, HFS requested that HSAG conduct an access and availability survey to evaluate the accuracy of provider information and appointment availability for Illinois Medicaid enrollees with a behavioral health or prenatal care provider. To support HFS' goal to identify and prioritize reducing health disparities, the focus of the study was on providers in DIAs.[21] DIAs are defined as ZIP Codes that meet the following criteria:[22]

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

[21] The list of DIA ZIP Codes can be found at: Illinois Department of Commerce and Economic Opportunity. *Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program.* https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: Feb 4, 2025.

[22] Illinois Department of Commerce and Economic Opportunity. *QCT –DIA Map*. Illinois workNet Center. Available at: https://www.illinoisworknet.com/qctdiamap. Accessed on: Feb 4, 2025.

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

According to the managed care plans' contracts with HFS, each health plan is required to maintain provider network capacity to ensure that behavioral health appointments for follow-up after an ED visit are available within seven calendar days and 30 calendar days of an ED visit and prenatal care appointments are available within two weeks (i.e., 14 calendar days) for first trimester appointments, one week (i.e., seven calendar days) for second trimester appointments, and three calendar days for a third trimester appointments.

Objectives

The goal of the survey was to evaluate Illinois' Medicaid managed care network of behavioral health and prenatal care locations. Specific survey objectives included the following:

- Determine whether provider locations accept patients enrolled with a Medicaid health plan
- Determine whether provider locations accept new patients
- Determine appointment availability with the sampled specialty locations for routine behavioral health or prenatal care services

Methodology

To address the study objectives described above, HSAG used an HFS-approved methodology and script to conduct a non-secret (i.e., "revealed caller") telephone survey of behavioral health and prenatal care providers' offices to collect information on enrollees' access to providers. The health plans assessed in this analysis included the following: Aetna, BCBSIL, CountyCare, Meridian, Molina, and YouthCare.

Study Limitations

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

Key Findings

Overall, the provider information maintained and provided by the plans is poor, which impacts access to care due to the ability of members to find a provider that delivers the requested services. Table 32 below provides a summary of the findings from the study.

Table 32—Summary of Findings

Concerns	Findings
Contact information was inaccurate.	Overall, 58.5 percent of locations could be contacted. Of the sampled telephone numbers, 7.4 percent were disconnected, 12.0 percent reached a location that was not a medical facility, and 0.8 percent reached a fax machine. Additionally, among cases reached, 38.4 percent reached a number that was not a scheduling line.
Acceptance of new patients was low.	Among cases that could be reached, 20.6 percent of locations accepted new patients; however, only providers listed as accepting new patients in the provider data were selected for the survey sample.
Acceptance of the health plan was low.	Among cases that could be reached, 21.8 percent of locations reported accepting the requested health plan.
Acceptance of Illinois Medicaid was low.	Among cases that could be reached, 23.4 percent of locations reported accepting Illinois Medicaid.
Provider's specialty in the provider data file was inaccurate.	Among cases that could be reached, 26.4 percent of locations confirmed the provider specialty listed in the provider data was accurate.
Appointment availability was low.	Among cases that could be reached, 12.2 percent of the provider locations offered an appointment.

Concerns with data accuracy need to be addressed, as this is preventing most interviewers from reaching a provider office or an appointment line. Overall, accuracy of acceptance of the health plan, Medicaid, and new patients, and of offering the service was low. Among similar studies, the Illinois health plans generally performed lower than other plans in other states for the overall accuracy of acceptance of the health plan, Medicaid, new patients, offering the requested services, and appointment availability. Among prenatal care cases that could be contacted, YouthCare had the lowest acceptance rates for the following indicators: offering requested services, accepting Illinois Medicaid and the plan, accepting new patients, and appointment availability. CountyCare and BCBSIL first trimester appointments for existing patients met the wait time standard at 12 and 13 calendar days, respectively. Additionally, 100 percent of the BCBSIL and CountyCare existing patient appointments for a 30-day follow up after an ED visit met the compliance standard.

When compared to the 2023 Access and Availability Survey of dental and primary care locations in a DIA ZIP Code, the behavioral health and prenatal care group performed worse than the dental and primary care population for most study indicators. The poor quality of the provider information

contributed to these findings and may result in a decreased ability for enrollees in DIAs to access behavioral health and prenatal care services. Additionally, when compared to similar studies in other states, the DIA response rates were lower across comparable surveys. Moreover, compared to similar studies, providers in DIA ZIP Codes had a higher number of bad phone numbers or offices that were unable to be reached. Overall, the quality of the provider data for the DIA population is generally worse than in other surveys HSAG has conducted.

Recommendations

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

- **The provider's contact information provided by the plans was incorrect—**HSAG was unable to reach 41.5 percent of sampled cases across all health plans. Of cases reached, 38.4 percent indicated the telephone number did not connect to a patient scheduling line. Of sampled cases, 12.0 percent reached a nonmedical facility, and 7.4 percent reached a disconnected number. Overall, the behavioral health provider data resulted in a higher number of inaccurate phone numbers (i.e., disconnected number, fax number, personal number, or nonmedical facility).
  - Since the health plans supplied HSAG with the provider data used for this survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls (e.g., disconnected telephone numbers or telephone numbers and addresses that do not correspond to the sampled provider location).
  - To further evaluate data inconsistencies, HFS could consider conducting a network validation survey (NVS) to evaluate the health plans' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the health plans' provider directory, and if key indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) match between the plan-submitted data and the online provider directory, a call would be placed to the provider location to verbally confirm the directory information and request appointment availability.
- **Members are experiencing limited appointment availability—**Of the cases reached, HSAG was only able to obtain an appointment date with 12.2 percent of the sampled locations, with 11.1 percent of behavioral health respondents offering an appointment and 13.4 percent of prenatal care respondents offering an appointment. The survey identified several barriers to obtaining appointment dates, including pre-registration or requiring personal information before scheduling and the schedule/calendar being unavailable. While some barriers pose unique limitations since the interviewer cannot provide the office personal information, other limitations may pose barriers to all Medicaid enrollees trying to schedule appointments.
  - HFS and the health plans should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment.

  - The health plans should provide insurance acceptance education to provider office staff members.
- **Members are experiencing wait times beyond the appointment compliance standards—** Appointment availability compliance rates were low, with 39.0 percent of new and 56.7 percent of existing behavioral health appointment dates meeting the 7-day ED follow-up compliance standard; however, 79.2 percent of new and 94.8 percent of existing appointment dates met the 30-day ED follow-up compliance standard. For prenatal care, 61.0 percent of new and 70.5 percent of existing appointment dates met the first trimester compliance standard; 41.0 percent of new and 53.3 percent of existing appointment dates met the second trimester standard; and 23.3 percent of new and 32.8 percent of existing appointment dates met the third trimester appointment standard.
  - The health plans should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, health plans should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.
  - In coordination with ongoing outreach and network management activities, the health plans should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.
  - HFS should continue to monitor the health plans' compliance with existing State standards for appointment availability. Additionally, HFS should evaluate whether additional access standards or access assessments are needed to address gaps in provider availability.

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

Time and Distance Analysis

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

Evaluation of Quality Strategy

Due to program changes, such as incorporating SNC 1915(b) waiver populations in HealthChoice Illinois and the statewide expansion of the MLTSS 1915(b) waiver, HFS revised its Quality Strategy, published in March 2021.

Regulations at 42 CFR §438.340(c)(2), (c)(2)(i), and (c)(2)(ii) require states to review and update their quality strategy as needed, but no less than every three years. A state's review of the quality strategy must include an evaluation of the effectiveness of the quality strategy conducted within the previous three years. HSAG assisted HFS with its Quality Strategy evaluation in accordance with CMS' *Quality Strategy Toolkit for States*.[23] The Quality Strategy evaluation was included in the state's 2024–2026 Quality Strategy.

Case Management (CM) Staffing and Training Reviews

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

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

HSAG analyzed contractually required elements of CM 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 2023 biannual staffing and training reviews.

The first biannual review of 2024 included assessment of internal health plan staff as well as any delegated entities performing CM services,[24] and included health plan data for staff members with hire dates on or before April 1, 2024. HSAG noted that training is completed each CY; therefore, training completion was assessed only during the second biannual review, which was conducted in the fall of 2024 and included health plan data for staff members with hire dates on or before November 1, 2024. Results of training analyses are included but should be reviewed with caution as health plans may not have scheduled or completed training as of November 1, 2024. HSAG will reassess training completion during the first biannual review of CY 2025 to ensure that all required 2024 training was completed.

[23] 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: Feb 4, 2025.

[24] A delegate is an entity that provides case management on behalf of the health plan. Delegates are separate companies from the health plan, but the health plan is responsible for making sure that they meet the same requirements as the health plan's own employees.

HealthChoice Illinois

HSAG analyzed health plan compliance with 19 contractually required elements of CM staffing and training in the HealthChoice Illinois contract. The strengths, opportunities for improvement, and recommendations are described below.

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

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

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

- Some health plans did not meet qualification/education requirements for case managers with SNC or HCBS waiver caseloads. The health plans should review the qualification/education requirements for the SNC and HCBS waivers to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plans may consider submitting exemption requests to HFS for consideration.
- The health plans should ensure that all case managers, internal and delegated, receive required trainings by the end of CY 2024.

MMAI

HSAG analyzed MMP compliance with 25 contractually required elements of CM staffing and training in the MMAI contract. The strengths, opportunities for improvement, and recommendations are described below.

For the MMPs statewide, the following conclusions were made:

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

For the MMPs statewide, the following recommendations were identified:

- Some MMPs did not meet qualification/education requirements for case managers with HCBS waiver caseloads. The MMPs should review the qualification/education requirements for the HCBS

waivers to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The MMPs may consider submitting exemption requests to HFS for consideration.

- Some MMPs' MMAI case management enrollment represented less than 100 percent of the total enrollment for the MMP. The MMAI contract requires that all MMAI enrollees be offered case management; however, enrollees can decline case management. The MMPs should review their data to ensure that all enrollees engaged in case management are accurately reflected in their staffing submissions.
- The MMPs should ensure that all case managers receive required trainings by the end of CY 2024. Only Aetna had evidence of compliance for all required trainings by the November 2024 submission.

YouthCare

HSAG analyzed YouthCare's compliance with eight contractually required elements of CM staffing and training in the YouthCare contract. The strengths, opportunities for improvement, and recommendations are described below.

For YouthCare, the following conclusions were made:

- Caseload weighting is a way to balance a case manager's workload based on the intensity of management expected to support a customer. HFS requires the health plans to manage the number of customers on each case manager's caseload to ensure that customers receive the attention they need. The health plan was compliant with all caseload requirements.
- YouthCare achieved 100 percent compliance for case management supervisor and case manager qualifications and credentials.

For YouthCare, the following recommendations were identified:

- The health plan should continue to implement its oversight processes to ensure that it is tracking all required trainings and has a process to address outstanding trainings to be completed prior to the end of each CY.

HFS

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

- Most health plans and MMPs achieved significant compliance with staffing and training requirements. HSAG recommends that HFS continue biannual reviews to ensure continued compliance. For health plans/MMPs demonstrating year-to-year noncompliance, HSAG recommends that HFS provide direction or corrective actions to address findings.

Critical Incident Monitoring Review

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

The health plans that were included in the CY 2024 review are displayed in Table 33.

Table 33—Health Plans in CI Monitoring Review

Health Plan	Population(s) Reviewed
Aetna	HealthChoice, MMAI
BCBSIL	HealthChoice, MMAI
CountyCare	HealthChoice
Humana	MMAI
Meridian	HealthChoice, MMAI
Molina	HealthChoice, MMAI
YouthCare	YouthCare

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. A detailed description of the sampling methodology and data collection processes is provided in health plan-specific reports. 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 assessed compliance in each of the following domains:

- Reporting of Incident
- Communication With Investigating Authorities
- Compliance With Investigating Authority Decisions
- CM Activities
- Case Closure and Resolution

HSAG also reviewed the following information to assess the health plans' CI system effectiveness:

- Remediation of recommendations from quarterly reviews.
- Oversight processes and procedures.
- CI closure processes.
- Reporting, monitoring, and resolution of behavioral health CI events.
- Collaboration with waiver agencies.

System Effectiveness and File Review Findings

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

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

- File reviews demonstrated that the health plans were compliant with ensuring the health, safety, and welfare (HSW) of the enrollee after the CI occurred. The enrollee was contacted (or the health plan completed attempts to contact the enrollee), and the health plan mitigated the enrollee's needs, risks, and/or situation.
- File reviews demonstrated that the health plans effectively identified and reported CIs to the appropriate investigating authority.
- File reviews demonstrated that the health plans consistently complied with the Adult Protective Services (APS) Report of Substantiation (ROS) Process Policy after the receipt of an APS ROS form.
- File reviews demonstrated that the health plans have a thorough CI oversight process that aims to resolve the initial CI and prevent subsequent CI events.
- YouthCare demonstrated significant coordination of care with the enrollee's assigned DCFS caseworker to address post-discharge needs.
- When opportunities for improvement were identified, the health plans demonstrated actions to remediate those findings.

For the health plans statewide, the following recommendation was identified:

- Although the health plans demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. The health plans should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.

CMS HCBS Waiver Performance Measures Record Review

CMS requires HFS to provide quality oversight of state health plans and employ strategies to discover successes and opportunities for improvement within the HCBS waiver program. To provide feedback and analysis on the health plans' compliance with waiver care management program requirements, HFS requested that HSAG conduct quarterly reviews of waiver beneficiary records. 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.

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

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

This summary of findings for the CY 2024 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 were provided in quarterly and annual reports.

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 Record Reviews

Table 34 displays the five HealthChoice health plans reviewed in CY 2024.

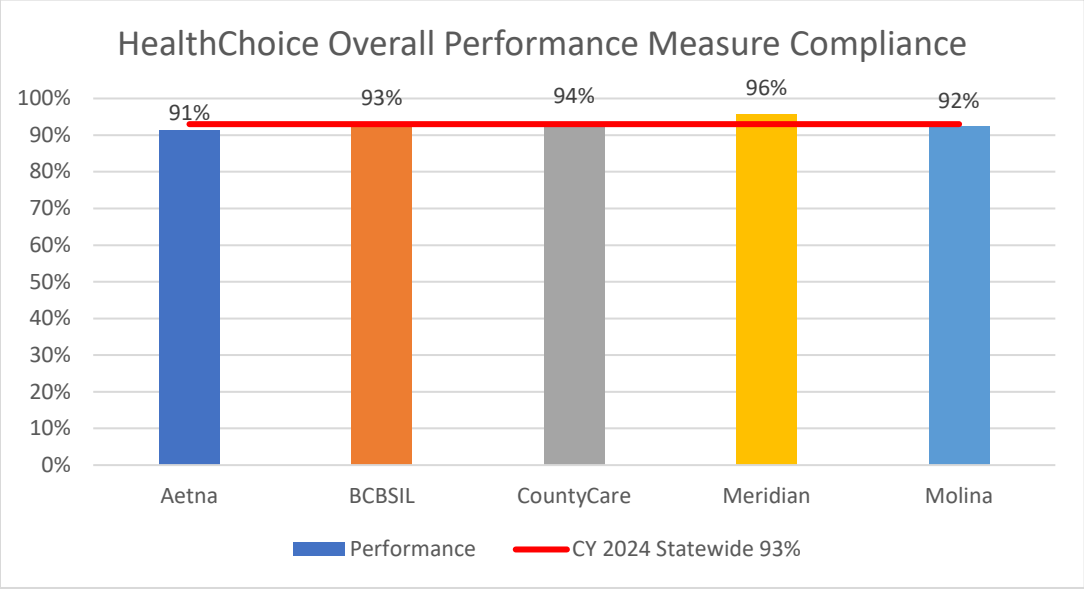
Table 34—HealthChoice Plans Reviewed in CY 2024

Health Plan Name	Abbreviation
Aetna Better Health	Aetna
Blue Cross Blue Shield of Illinois	BCBSIL
CountyCare Health Plan	CountyCare
MeridianHealth	Meridian
Molina Healthcare of Illinois	Molina

During CY 2024, 1,482 HealthChoice and 1,516 MLTSS records were reviewed using HSAG's web-based data collection tool.[25] As a result, 1,032 HealthChoice and 1,094 MLTSS findings of noncompliance were identified. The CY 2024 reviews assessed performance during a lookback period of June 1, 2023, through August 31, 2024.

Figure 3 displays a computed average of the total performance achieved by each health plan on the 15 CMS waiver performance measures reviewed by HSAG.[26] Displaying each health plan's overall average on the 15 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans. All five health plans averaged greater than 90 percent overall compliance in CY 2024. Three of the five health plans performed at rates equal to or greater than the CY 2024 statewide average (aggregate across all health plans) of 93 percent.

Figure 3—CY 2024 Overall HealthChoice Compliance



[25] MLTSS enrollees are managed through HealthChoice and included in HealthChoice results. MLTSS-specific results are available upon request.

[26] The figure reflects comparisons across all 15 performance measures reviewed throughout the CY.

The strengths, opportunities for improvement, and recommendations are described below.

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

- Twelve of the 15 CMS performance measures averaged 90 percent or greater compliance.
- Ten of the 15 CMS performance measures achieved a statistically significant increase in performance when compared to CY 2023.
- All five waivers averaged greater than 90 percent compliance and achieved a statistically significant increase in overall performance when compared to CY 2023.
- All five health plans averaged greater than 90 percent compliance and achieved a statistically significant increase in performance in more than one performance measure.
- Four of the five health plans achieved a statistically significant increase in overall performance when compared to CY 2023.

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

- Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 70 percent compliance. To impact performance on Measure D6, HSAG recommended the following efforts:
  - Conduct root cause analysis to determine opportunities to effect change.
  - Conduct staff training to ensure understanding of contact requirements for all waiver types. Training should include expectations for completion of face-to-face and telephone contacts.
  - Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
  - Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
  - Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
  - Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.
- Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*, averaged 83 percent compliance. To impact performance on Measure G1, HSAG recommended the following efforts:
  - 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.
  - Evaluate current documentation templates to ensure that all historic versions have been archived and that staff members have access to and are using only the current version of each template.
  - Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.

MMAI Record Reviews

Table 35 displays the five MMAI health plans reviewed during CY 2024.

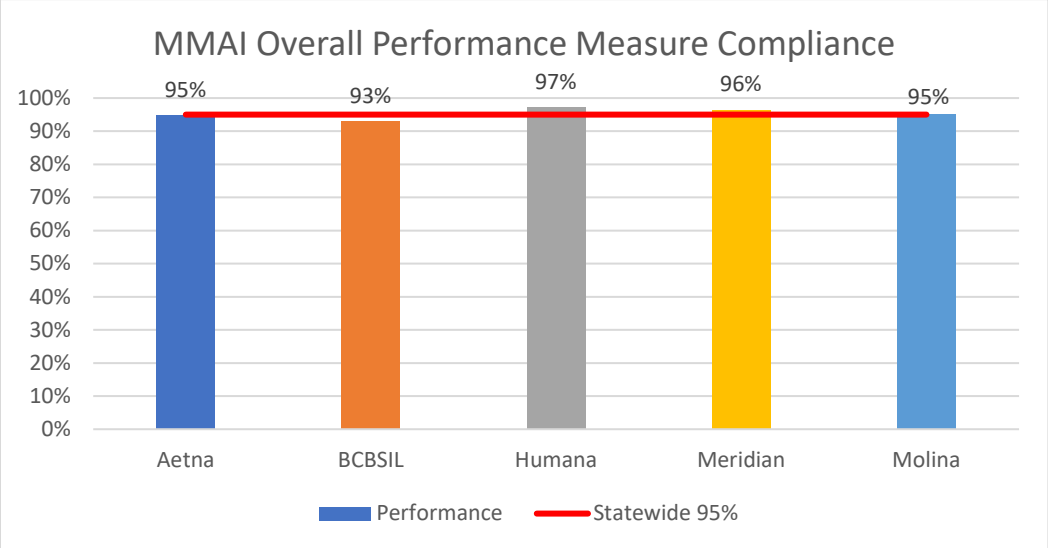
Table 35—MMAI Health Plans Reviewed in CY 2024

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

During CY 2024, 1,305 records were reviewed using HSAG's web-based data collection tool. As a result, 716 findings of noncompliance were identified. The CY 2024 reviews assessed performance during a lookback period of June 1, 2023, through August 31, 2024.

Figure 4 displays a computed average of the total performance achieved by each health plan on the 15 CMS waiver performance measures reviewed by HSAG.[27] Displaying each health plan's overall average on the 15 HCBS CMS waiver performance measures is used as a comparison of overall compliance for each health plan and as a compliance comparison across health plans. All five health plans averaged greater than 90 percent overall compliance in CY 2024. Four of the five health plans performed at rates equal to or greater than the CY 2024 statewide average (aggregate across all health plans) of 95 percent.

Figure 4—CY 2024 Overall MMAI Compliance



[27] The figure reflects comparisons across all 15 performance measures reviewed throughout the CY.

The strengths, opportunities for improvement, and recommendations are described below.

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

- Thirteen of the 15 CMS performance measures averaged 90 percent or greater compliance.
- Seven of the 15 CMS performance measures achieved a statistically significant increase in performance when compared to CY 2023.
- All five waivers averaged greater than 90 percent compliance; three achieved a statistically significant increase in overall performance when compared to CY 2023.
- All five health plans averaged greater than 90 percent compliance and achieved a statistically significant increase in performance in at least one performance measure.
- Four of the five health plans achieved a statistically significant increase in overall performance when compared to CY 2023.

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

- Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*, averaged 82 percent compliance. To impact performance on Measure D6, HSAG recommended the following efforts:
  - Conduct root cause analysis to determine opportunities to effect change.
  - Conduct staff training to ensure understanding of contact requirements for all waiver types. Training should include expectations for completion of face-to-face and telephone contacts.
  - Conduct root cause analysis of PD and ELD waiver performance related to contacts, including why valid justification is not documented consistently.
  - Conduct staff training to ensure understanding of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required.
  - Ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.
  - Consider system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.
- Measure G1, *the enrollee is informed how and to whom to report unexplained death, abuse, neglect, or exploitation at the time of assessment/reassessment*, averaged 87 percent compliance. To impact performance on Measure G1, HSAG recommended the following efforts:
  - 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.
  - Evaluate current documentation templates to ensure that all historic versions have been archived and that staff members have access to and are using only the current version of each template.
  - Educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.

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

As part of its continuous effort to evaluate quality improvement activities of the health plans, HFS contracted HSAG to assess each health plan's SFY 2024 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.

HSAG's assessment of annual QA/UR/PR report contract requirements included 24 elements across HealthChoice and MMAI; some elements were applicable to only one contract. For these 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 assessed general requirements, which were prescribed by HFS in its annual outline document provided to the health plans. 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.

Findings: Contract Requirements

Review of the health plans' annual reports identified that all seven health plans achieved a performance score of 100 percent. While there were no findings that required remediation to the annual quality report, HSAG identified the following opportunity for improvement.

- Aetna and BCBSIL have opportunity to ensure future reports include a more robust description and analysis of case management activities conducted for HBIA/HBIS enrollees.

Table 36 summarizes the findings related to contract requirements for all health plans.

Table 36—Summary Scoring for Contract Requirements

Scoring Summary—Contract Elements				
Health Plan	**Number Met**	**Number Not Met**	**Number N/A**	**Performance Score**
Aetna	24	0	0	**100% (24/24)**
BCBSIL	24	0	0	**100% (24/24)**
CountyCare	21	0	3	**100% (21/21)**
Humana	19	0	5	**100% (19/19)**
Meridian	24	0	0	**100% (24/24)**
Molina	24	0	0	**100% (24/24)**
YouthCare	21	0	3	**100% (21/21)**

Findings: General Requirements

Review of the health plans' annual reports identified that all seven health plans demonstrated full compliance with the general requirements.

Findings: Qualitative Assessment

HSAG noted that the health plans' reports demonstrated different maturity and sophistication levels of providing narrative information, drawing conclusions, or assessing data to determine the success of their QA/UR/PR programs. Aetna and Humana received an assessment score of *Effective*; BCBSIL, CountyCare, Meridian, Molina, and YouthCare received a score of *Mature* based on the level of detail and process improvements identified from the prior year.

Recommendations

HSAG did not identify any critical concerns related to the items assessed and had no recommendations.

Mental Health Parity (MHP) Review

Certain mental health and SUD parity provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) apply to the coverage provided to the enrollees of the Medicaid program and CHIP to ensure that financial requirements (such as copays and coinsurance) and treatment limitations (such as visit limits) on mental health and SUD benefits generally are no more restrictive than the requirements and limitations that apply to medical and surgical benefits in these programs. In accordance with the MHPAEA and its implementing regulations (including 42 CFR Parts 438, 440, and 457; and 45 CFR Part 146.136) and Illinois statute 215 ILCS 5/370c.1,[28] HFS and Department of Insurance (DOI) complete oversight activities related to compliance to the State and federal parity laws.

To meet MHP requirements in 42 CFR §438 Subpart K and Illinois statute 215 ILCS 5/370c.1, HFS contracted with HSAG, to conduct a 2023-2024 MHP analysis of all HealthChoice Illinois health plans. The purpose of the review is to provide meaningful information to HFS, DOI, and the health plans regarding the evaluation of each health plan's processes to ensure compliance with MHPAEA requirements.

For each health plan, HSAG made a determination as to whether the health plan demonstrated how it designs and applies nonquantitative treatment limitations (NQTLs), both as written and in operation, for mental, emotional, nervous, or SUD or condition (MH/SUD) benefits as compared to how it designs and applies NQTLs, as written and in operation, for medical and surgical (M/S) benefits.

Methodology

HSAG collaborated with HFS to define the scope of the MHP review to include applicable federal and State regulations and laws and the requirements set forth in the contract, as they relate to the scope of the review. HSAG developed a protocol and tools in alignment with guidance outlined in the toolkit provided by the CMS: *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[29]

The MHP analysis consisted of:

- Review of the health plans' NQTL Submission Form and comparative analyses, which were submitted to HFS and addressed parity reporting for provider reimbursement.
- An Administrative Data Profile review of claims.[30]

[28] Illinois General Assembly. Illinois Compiled Statutes, 215 ILCS 5/370c.1. Available at: https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021500050K370c.1. Accessed on: Feb 4, 2025.

[29] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP are available at https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html. Accessed on: Feb 4, 2025.

[30] Claims data excluded non-emergency medical transportation (NEMT) and pharmacy (Rx) claims.

- An attestation of continued compliance with MHP requirements and documentation of any related policy or procedural changes associated with the designated review period (CY 2023).

Detailed information regarding the methodology is included in the full report.

Findings and Recommendations

Based on the results of the MHP analysis, HSAG offered the following recommendations.

- Although all health plans were found *Compliant* based on comparability and stringency of the information assessed, additional analysis of data would allow for greater examination of the health plans' administration of MH/SUD and M/S benefits to determine whether opportunities for improvement exist.
- HSAG recommended that health plans be required to submit member-level enrollment, demographic, eligibility, and claims data, which would allow for comparison of aggregate data, ensuring that the findings presented in the analysis are both reliable and reflective of actual utilization patterns.
- Future claims reviews, if established, should include longitudinal data to allow for trend analysis and capture changes over time in service usage and access.
- HFS may consider incorporating claims-cost data into annual analyses, allowing for a more thorough measurement of the impact of cost variations in total care. Understanding the cost of care for different service areas and demographic populations would highlight where there may be economic barriers for marginalized populations.

Care Gap Plan Review

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

The HealthChoice health plans and YouthCare are required to have a Care Gap Plan that describes how they will ensure provision of services missed by enrollees. HFS contracted with HSAG to assess each health plan's 2024 Care Gap Plan, as well as each health plan's processes to address provider network gaps.

Methodology

In collaboration with HFS, HSAG developed a methodology for the Care Gap Plan review that included:

- Desk review of documents and information.
- Webinar review with the health plans.
- Completion of an assessment tool, which was based on elements included in the HealthChoice contract, supplemental NCQA standards, and information requested by HFS.

Findings and Recommendations

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

While there were no findings that required revisions to the Care Gap Plan for any health plan, HSAG identified opportunities for improvement for Molina and YouthCare, which are described in Section 4.

1915(b) Waiver Independent Assessments (IAs)

HFS utilized HSAG to complete the access and quality of care IA[31] of Illinois' SNC and MLTSS Waivers.

Objectives

The IA is intended to satisfy the CMS requirement for the regular and periodic independent evaluation of populations enrolled in the SNC and MLTSS Waivers and receiving services through Medicaid managed care.

Methodology

In completing these IAs, HSAG followed the guidelines set forth in the *Independent Assessment Requirement for Section 1915(b) Waiver Programs: Guidance to States*[32], published by the Health Care Financing Administration in December 1998. In addition, HSAG reviewed health plan performance in the domains of access to care, quality of care, and cost-effectiveness, as outlined in the Illinois' SNC and MLTSS Waivers.

Documentation was secured and reviewed by HSAG to determine the extent to which the Waivers were efficient and consistent with the purposes of Title XIX. The program's statewide performance and HFS monitoring efforts were reviewed against 42 CFR §438, SNC and MLTSS Waivers, and HealthChoice

[31] HFS used its actuary to complete the assessment of cost-effectiveness for both waivers.

[32] Centers for Medicare & Medicaid Services. *Independent Assessment Guidelines for Section 1915(b) Waivers*. Available at https://www.hhs.gov/guidance/document/independent-assessment-guidelines-section-1915b-waivers. Accessed on: Feb 4, 2025.

and YouthCare contract requirements associated with access to and quality of care. HSAG also assessed the degree to which HFS has met the assurances provided to CMS in the SNC and MLTSS Waiver proposals. Overall findings relative to statewide program performance are provided for each section as available, and opportunities for improvement are indicated where applicable.

HSAG reviewed multiple information sources to evaluate the accessibility and quality of care for the SNC and MLTSS populations. HSAG also used the results of several EQRO activities related to access to services and quality of care conducted during the review period.

HSAG noted the following limitations for analysis of data:

- HFS and/or the health plans may have had additional SNC and MLTSS monitoring activities or data that were not available for review for the assessments.
- Not all health plan-reported data were validated.
- HSAG was unable to determine if health plan staff categorized data correctly or with common definitions. This was specifically relevant to reports of grievances, appeals, and CIs.
- The COVID-19 pandemic impacted enrollee care during 2021 and 2022. Enrollees may not have chosen or had the ability to access care due to health concerns and factors relating to the pandemic, which may have impacted health plans' performance measure and enrollee experience results.

SNC Conclusions and Recommendations

The IA was conducted from October 2023 through March 2024, assessing data and information from CYs 2021, 2022, and 2023, as available. The final report was delivered to HFS in March 2024 and presented the findings of HSAG's second evaluation of the access to and quality of care of services provided to the SNC Waiver population in regard to the stated goals of Illinois' SNC Waiver.

Overall, HFS met the assurances of the SNC Waiver. HSAG found HFS and its contracted health plans' activities and performance sufficient in providing access to services and quality of care. HFS demonstrated ongoing monitoring processes to assess the access to services and quality of care provided to its SNC Waiver population, including significant program enhancements to address the first evaluation recommendations and ensure monitoring and improvement.

HSAG identified no required areas of correction that would prevent HFS from continuing the current SNC Waiver program.

HSAG identified the following recommendations for SNC Waiver program improvement.

Access to Services

1. Review DCFS and YouthCare customer-facing linked documents on these entities' websites to ensure readability and access to current information.
2. Utilize results of the EQRO's 2024 NAV activity to inform actions to address provider network recommendations.
3. Establish thresholds for health plan performance of self-reported care management data.
4. HFS should continue requiring the health plans to analyze potential key drivers that may contribute to the observed lower performance in the *Childhood Immunization Status—Combination 10* performance measure in a particular age stratification, race/ethnicity stratification, or vaccination and to help determine why their child members are inconsistently receiving immunizations. This analysis should include a drill down to consider whether there are disparities and/or HRSNs within their populations that contribute to lower performance in a particular stratification. Health plans should also consider whether a particular vaccine or vaccines within the vaccine combination were missed more often than others, contributing to lower rates within the measure, and investigate the rationale for the lower rate of the specific vaccine(s) to assist in identifying a plan to increase administration of the vaccine to lead to higher performance.
5. Continue to conduct annual enrollee experience surveys to identify improvements and opportunities for improvement. Health plans should utilize survey results to target enhancements to address low levels of experience.

Quality of Care

1. Health plans could consider analyzing best practices used to ensure follow-up after ED visits for mental illness to determine if processes can be leveraged to impact follow-up after inpatient hospitalizations.

MLTSS Conclusions and Recommendations

The IA was conducted from March 2024 through September 2024, assessing data and information from CYs 2021, 2022, and 2023, as available. The final report was delivered to HFS in October 2024 and presented the findings of HSAG's second evaluation of the access to and quality of care of services provided to the MLTSS Waiver population in regard to the stated goals of Illinois' MLTSS Waiver.

Overall, HFS met the assurances of the MLTSS Waiver. HSAG found HFS and its contracted health plans' activities and performance sufficient in providing access to services and quality of care. HFS demonstrated ongoing monitoring processes to assess the access to services and quality of care provided to its MLTSS Waiver population, including significant program enhancements to address the first evaluation recommendations and ensure monitoring and improvement.

HSAG identified no required areas of correction that would prevent HFS from continuing the current MLTSS Waiver program.

HSAG identified the following recommendations for MLTSS Waiver program improvement.

Access to Services

1. HSAG recommends that, excluding CountyCare, all health plans review their MLTSS member handbooks or MLTSS information to ensure sixth-grade reading levels. Aetna should also review its information to address inconsistent language use.
2. HSAG recommends that HFS use results of the EQRO's 2024 NAV activity to inform actions to address any provider network recommendations.
3. HSAG recommends that HFS collaborate with the health plans to address performance on the LTSS Successful Transition after Long-Term Facility Stay measure.

Quality of Care

1. Continue collaborations with the health plans to inform revisions to reporting instructions for the health plan self-reported assessment measures.
2. After implementation of revised reporting instructions, consider establishing thresholds for health plan self-reported measures that were not previously established.
3. Consider directing a PMV of the health plans' self-reported measures for enrollee contact to ensure accurate data collection and reporting by the health plans.

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

HSAG understood the importance of providing ongoing and specific TA to each health plan, as needed, and provided consultation, expertise, suggestions, and advice to assist with decision making and strategic planning. HSAG worked in partnership and collaboration with HFS and health plans to ensure that it delivered effective technical support that facilitated the delivery of quality health services to Illinois Medicaid members. As requested by HFS, HSAG continued to provide technical guidance to the health plans to enable successful participation in EQR activities. In addition, the following TA activities were conducted in the reporting cycle.

NCQA Accreditation Tracking

The 2010 federal ACA called for the use of accreditation to ensure quality in the managed healthcare sector. The ACA requires that, beginning in 2014, all health plans offered through state insurance exchanges "…must be accredited with respect to local performance on clinical quality measures … by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans…."[33] 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 developed the Illinois Managed Care Program NCQA Medicaid Healthcare Maintenance Organization Accreditation status sheet (status sheet), which succinctly displays each health plan's accreditation status, along with a description of the NCQA accreditation levels. HFS features this status sheet on its website to make the information public. The most recent version can be accessed at: https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/il2025hfsncqaaccreditation.pdf.

Freedom of Information Act (FOIA) Requests

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

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

[33] H.R. 3590—Patient Protection and Affordable Care Act. Available at: https://www.congress.gov/bill/111th-congress/house-bill/3590/text. Accessed on: Feb 4, 2025.

identified all provisions of the final rule and their effective date. HFS may also request HSAG's assistance in providing training for stakeholders on topics relevant to compliance and quality.

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

Report and Data Collection Templates

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

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

Presentations to the Illinois Legislature and HFS Administration

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

HealthChoice Illinois

Aetna

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

Detailed results from the EQR's substantive findings are summarized in Table 37 for each activity. This table highlights the extent to which Aetna furnishes high quality, timely, and appropriate access to healthcare services, and recommendations for how Aetna can best address issues identified for each activity.

Table 37—Aetna Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Aetna achieved a *High Confidence* level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 1 for the *Improving Transportation Services* PIP.	
PMV		
+	**Strength:** Aetna's rates for measures related to diabetes management demonstrated improvement (*Blood Pressure Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Hemoglobin A1c Control for Patients With Diabetes* (one submeasure), and *Statin Therapy for Patients With Diabetes*).	
+	**Strength:** A majority of Aetna members received follow-up after they visited the ED or hospital for mental illness. Three submeasures of *Follow-Up After Emergency Department Visit for Mental Illness* performed at or above the 75th percentile and all submeasures (with comparable rates) of *Follow-Up After Hospitalization for Mental Illness* demonstrated improvement.	
−	**Opportunity for Improvement:** Aetna's rate for the *Adults' Access to Preventive/ Ambulatory Health Services—Total* measure improved compared to last year; however, the rate remained below the 50th percentile. **Recommendations:** HSAG recommends Aetna design and test interventions specific to the 20-39 age group to engage those members in accessing healthcare on a routine basis.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement:** Aetna performed poorly on measures related to women's screenings, below the 25th percentile for *Breast Cancer Screening* and *Cervical Cancer Screening* and below the 50th percentile for *Chlamydia Screening in Women*. **Recommendations:** HSAG recommends Aetna consider whether there are disparities/SDOH factors that contributed to lower access to care. Upon identification of root causes, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. HSAG also recommends Aetna address sexually transmitted infection stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update as well; use multi-modal approaches to contact members to promote women's screenings with incentives to providers to provide screenings, increase access, and outreach eligible members in their panels.	
–	**Opportunity for Improvement:** Aetna was the lowest performing plan for *Child and Adolescent Well-Care Visits*, with a rate below the 50th percentile. **Recommendations:** HSAG recommends Aetna create or reassess PCP outreach policies and automated appointment reminder systems as well as utilize personalized outreach for hard-to-reach patients; encourage providers to partner with teenagers and use teen appropriate language; and increase the availability of telehealth options and focus personalized outreach about telehealth to 18–21 year olds.	
–	**Opportunity for Improvement:** For the *Childhood Immunization Status* measure, Aetna's rate was below the 50th percentile for the *Combination 3* submeasure and below the 25th percentile for the *Combination 10* submeasure. **Recommendations:** HSAG recommends Aetna focus on parent education and clinic practice transformation. If Aetna already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Aetna should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for Improvement:** Aetna struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for all three submeasures in *Pharmacotherapy for OUD* and performed below the 50th percentile. All six submeasures in *Initiation and Engagement of SUD Treatment* declined and five submeasures performed below the 50th percentile. **Recommendations:** To improve treatment of OUD and SUD, HSAG recommends Aetna: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation to determine what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility. • Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment. • Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	
–	**Opportunity for Improvement:** Aetna's child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure continuing to perform below the 50th percentile. **Recommendations:** Aetna should conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	

Strength/ Opportunity for Improvement	Description	Domain(s)
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for Improvement:** Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. **Recommendations:** Continue oversight and monitoring procedures as well as reporting for the CBH Services requirements. Consider increasing the number of internal audits to ensure compliance with contractual requirements.	
−	**Opportunity for Improvement:** Results of the CBH post-implementation review identified that the health plan had an opportunity for improvement related to Family Leadership Council participation. **Recommendations:** The health plan must develop more robust strategies to engage their Family Leadership Council.	
−	**Opportunity for Improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	
NAV		
+	**Strength:** Aetna demonstrated a strong process for maintaining provider information through its annual directory validation process.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** Aetna had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has high confidence in Aetna's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** Aetna met the State's time and distance standards across all public health regions for 17 of 20 provider categories.	
−	**Opportunity for Improvement:** Aetna did not meet the 90 percent time and distance standards in all counties for two provider categories: oral surgeons, adult; and oral surgeons, pediatric. Aetna did not meet the 100 percent time and distance standard in all counties for pharmacists. **Recommendations:** HSAG recommends that Aetna maintain current levels of access to care and continue to address network gaps for the following provider categories: oral surgeons, adult and pediatric, and pharmacies.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Aetna was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that Aetna was compliant with all training requirements for its internal case management staff members.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	

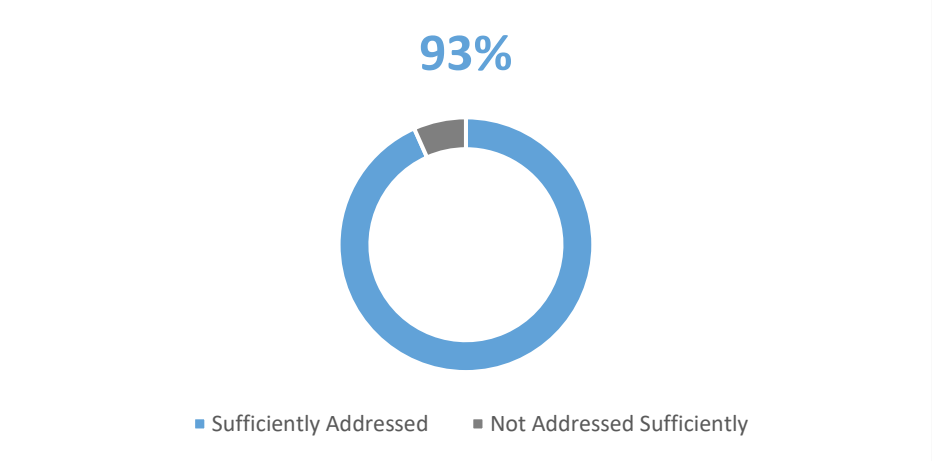
Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for Improvement:** Aetna's experience survey results were below the 50th percentiles for all adult measures and for seven of eight child measures. **Recommendations:** HSAG recommends that Aetna evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. Aetna should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Aetna could consider conducting root cause analyses or focus studies to further explore members' perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.	
−	**Opportunity for Improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	
−	**Opportunity for Improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
−	**Opportunity for Improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for Improvement:** Results of the staffing and training review identified that the health plan had an opportunity for improvement related to ensuring qualification and education requirements were met for its SNC case managers. **Recommendations:** The health plan should review the qualification/education requirements for the SNC members to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.	
−	**Opportunity for Improvement:** Results of the staffing and training review identified that the health plan had an opportunity to ensure its delegate completes annual training requirements. **Recommendations:** The health plan should ensure that all case managers receive required trainings by the end of CY 2024.	
−	**Opportunity for Improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	
−	**Opportunity for Improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

Aetna submitted responses to all prior EQR recommendations and HSAG reviewed Aetna's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 5 illustrates the degree to which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 5—Percentage of Prior EQR Recommendations Addressed by Aetna



Aetna-specific prior recommendations and follow-up assessments are summarized in Table 38.

Table 38—Assessment of Aetna's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
PMV	
Consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommended increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.	**Aetna sufficiently addressed the recommendation.** Aetna noted improvement, conducted population and health equity analytics, and created a bi-monthly workgroup to review performance and implement interventions.
Consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to	**Aetna sufficiently addressed the recommendation.** Aetna noted improvement, conducted key driver analysis, and created a bi-monthly workgroup to review performance and implement interventions.

Prior Recommendation	CY 2024 Assessment
help determine why child and adolescent members are inconsistently receiving well care visits.	
Consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.	**Aetna sufficiently addressed the recommendation.** Aetna noted improvement, described leveraging incentive and outreach programs, and implemented a new initiative to increase patient literacy.
Consider further analysis of potential key drivers that may contribute to the observed low performance for the *Cervical Cancer Screening* measure.	**Aetna sufficiently addressed the recommendation.** Aetna conducted analysis and implemented an outreach and service program through MinuteClinics, providing statewide access to alternative care settings. MinuteClinic teams are outreaching members to complete screenings.
Consider further analysis of potential key drivers that includes a drill down to consider if there are disparities and/or social determinants within its African American population that contribute to lower performance in a particular age stratification for the *Blood Pressure Control for Patients and Diabetes* and *Eye Exam for Patients with Diabetes* measures.	**Aetna sufficiently addressed the recommendation.** Aetna identified data gaps, provider practice patterns, and documentation as key factors. Aetna established a workgroup, deployed provider and member interventions, and noted improvement.
Consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification for the *Follow-Up After Hospitalization for Mental Illness* measure.	**Aetna sufficiently addressed the recommendation.** Aetna expanded Onsite Discharge Planning program and expanded telehealth partnerships, and noted progress in closing the DIA ZIP Code gap.
Review and document the process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation to improve rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure. HSAG also recommended that Aetna review claims data extracts provided to its measure calculation vendor to ensure that all claims for long-term intuitional stays were provided in the extracts, including those with Illinois-specific billing codes as outlined in the MY 2022 P4R Reporting Guidance document.	**Aetna sufficiently addressed the recommendations.** Aetna analyzed and updated membership and claims logic to improve population capture and increased leadership and oversight.

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
To improve UM documentation and processing of denials, Aetna should: • Reeducate of all staff managing authorization requests and/or member transitions of care. • Increase supervision and visibility of corrections to better track and report the healthy dialogue. • Continue to evaluate UM and CM staffing needs to ensure compliance with contractual requirements. • Ensure oversight and monitoring of denials processing to ensure timeliness.	**Aetna did not sufficiently address the recommendation.** Aetna described ongoing outreach efforts to educate providers, indicated it offers peer-to-peer opportunities per contract requirements, and noted that the health plan monitors denial rates and reports to the state. However, the health plan did not implement any initiatives in response to the EQRO's recommendations.
NAV	
Since the health plan supplied HSAG with the provider data used for the access and availability survey, HFS should supply the health plan with the case-level survey data files and a defined timeline by which the health plan will address provider data deficiencies identified during the survey calls.	**Aetna sufficiently addressed the recommendations.** Aetna's Provider Experience Team incorporated Access and Availability Standards into Provider Educational Summits held in 2024. Aetna noted its willingness to review case-level survey data if made available.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.	**Aetna sufficiently addressed the recommendations.** Aetna recently partnered with Quest Analytics/Better Doctor to assist with ensuring the accuracy of Aetna's Medicaid provider data within the health plan directory and systems. Aetna described several interventions that are planned for the upcoming year to train, monitor, and collect information from providers to identify root causes.
Collaborate with HFS to contract with additional oral surgeons, if available, and continue to review oral surgery access standards with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	**Aetna sufficiently addressed the recommendations.** Aetna has contracted with all available oral surgeons in all low-access counties; however oral surgeon deserts exist in gap counties. Aetna will recruit general dentists in low-access areas that offer oral surgery services and offer single-case agreements to out-of-network providers to ensure members receive care.

Prior Recommendation	CY 2024 Assessment
Additional EQR Activities	
Consider including information about the ratings from the CAHPS survey in provider communications during the year and obtaining feedback from patients on their recent office visit.	**Aetna sufficiently addressed the recommendations.** Aetna expanded HEDIS outreach vendors to connect members to care, implemented off-cycle surveys, expanded member listening channels, and conducted staff training. Aetna developed a MY 2024 CAHPS improvement workplan.
Prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. The health plan should continue promoting the results of its member experiences with its contracted providers and staff members.	**Aetna sufficiently addressed the recommendations.** Aetna expanded HEDIS outreach vendors to connect members to care, implemented off-cycle surveys, expanded member listening channels, and conducted staff training. Aetna developed a MY 2024 CAHPS improvement workplan.
In the HCBS waiver measures review, Aetna performed at a statistically significantly lower rate than all other health plans. HSAG recommended that Aetna should consider reviewing its oversight processes to identify improvements to impact performance.	**Aetna sufficiently addressed the recommendations.** Aetna implemented several strategic process improvements and reporting tools to enhance the effectiveness of its case management operations, hired two new supervisors, expanded sign-on bonus and competitive hiring packages, and increased frequency of target refresher trainings.
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**Aetna sufficiently addressed the recommendations.** Aetna's LTSS team implemented a series of operational dashboard tools to proactively plan and maintain compliance.

BCBSIL

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

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

Table 39—BCBSIL's Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** BCBSIL achieved a *High Confidence* level for adhering to acceptable methodology for all PIPs. BCBSIL also demonstrated statistically significant improvement for Remeasurement 1 for the *Improving Transportation Services* PIP and for Remeasurement 2 for the *Timeliness of Prenatal Care* PIP.	
PMV		
+	**Strength:** BCBSIL's rates for measures related to diabetes management demonstrated improvement (*Blood Pressure Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Hemoglobin A1c Control for Patients With Diabetes*, and *Statin Therapy for Patients With Diabetes*).	
+	**Strength:** BCBSIL was the highest performing plan for *Child and Adolescent Well-Care Visits*, with a rate at or above the 75th percentile.	
+	**Strength:** A majority of BCBSIL members received follow-up after they visited the ED for mental illness. Four submeasures of *Follow-Up After Emergency Department Visit for Mental Illness* performed at or above the 50th percentile.	
+	**Strength:** BCBSIL exceeded the 50th percentile for all three of the Women's Health measures.	
+	**Strength:** A majority of BCBSIL's pregnant members received recommended prenatal and postpartum care as demonstrated by performance on the *PPC* measure. The rate for the *Timeliness of Prenatal Care* submeasure exceeded the 75th percentile and the 90th percentile for the *Postpartum Care* submeasure.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** More of BCBSIL's child and adolescent members received well-child visits this year as evidenced by improvement of the *Well-Child Visits in the First 30 Months of Life* measure and performance at or above the 50th percentile.	
−	**Opportunity for improvement:** BCBSIL's child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure continuing to perform below the 50th percentile. **Recommendations:** BCBSIL should conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	
−	**Opportunity for improvement:** BCBSIL struggled to engage members with OUD in appropriate treatment. Although some improvements were made, rates for all three submeasures in *Pharmacotherapy for OUD* performed below the 50th percentile. **Recommendations:** To improve treatment of OUD, HSAG recommends BCBSIL: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation to determine what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility. • Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD treatment.	

Strength/ Opportunity for Improvement	Description	Domain(s)
	• Create and expand partnerships with OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	
NAV		
+	**Strength:** BCBSIL had established, robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** BCBSIL had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in BCBSIL's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** BCBSIL met the State's time and distance standards across all public health regions for 17 of 20 provider categories.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** BCBSIL did not meet the 90 percent time and distance standards in all counties for two provider categories: oral surgeons, adult; and oral surgeons, pediatric. BCBSIL did not meet the 100 percent time and distance standard in all counties for pharmacists. **Recommendations:** HSAG recommends that BCBSIL maintain current levels of access to care and continue to address network gaps for the following provider categories: oral surgeons, adult and pediatric, and pharmacies.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that BCBSIL was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that BCBSIL was compliant with all requirements for waiver case managers.	
+	**Strength:** The staffing and training review identified that BCBSIL was compliant with all training requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	
−	**Opportunity for improvement:** BCBSIL's experience survey results were below the 50th percentiles for seven of eight child measures. **Recommendations:** HSAG recommends that BCBSIL evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. BCBSIL should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. BCBSIL could consider conducting root cause analyses or focus studies to further explore members' perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.	

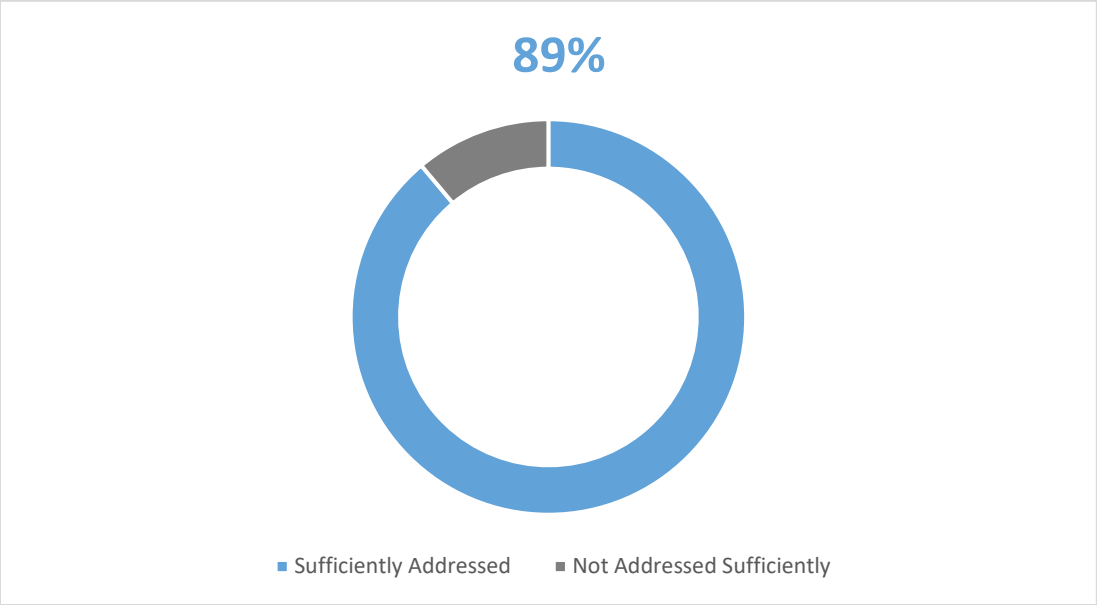
Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	
−	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	
−	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record.* **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and	

Strength/ Opportunity for Improvement	Description	Domain(s)
	ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

BCBSIL submitted responses to all prior EQR recommendations and HSAG reviewed BCBSIL's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 6 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 6—Percentage of Prior EQR Recommendations Addressed by BCBSIL



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

Table 40—Assessment of BCBSIL's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
PMV	
Consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommended increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL conducted a drill-down analysis and implemented collaboration with Medimore Unity Point to serve DIA and rural communities to promote preventive care visits and Howard Brown to outreach LGBTQIA+ members. Launched HealConnect text campaign targeting members in DIA ZIP Codes with access care gaps and partnered with Healthmine for monthly outreach to male members 35 and older. The health plan noted performance improvement.
Determine the cause of the material bias in the Ambulatory Care measure.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL determined the cause and addressed the issue. BCBSIL reported that with this correction the results for the AMB measure for the outpatient visits were in correct alignment and comparable to prior year results.
Consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why child and adolescent members are inconsistently receiving well care visits.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL conducted a drill-down analysis, continued some collaborations with community organizations to serve DIA and rural areas, launched "back to school" text campaign to child/adolescent members, and noted performance improvement.
Consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL conducted a drill-down analysis, collaborated with targeted provider groups in DIA ZIP Codes to identify and outreach members with care gaps, and sponsored a webinar series for providers about vaccine confidence. The health plan also described a text campaign, incentive program, and several ongoing interventions.
Consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification for the *Follow-Up After Hospitalization for Mental Illness* measure.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL continued some prior interventions and launched three initiatives: staff began outreaching members, an FUH text campaign to discharged members, a targeted text campaign to black males in Chicago with

Prior Recommendation	CY 2024 Assessment
	invitation to join men's therapy group. The health plan noted modest performance improvement.
Review and document their process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation to improve rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL made report logic updates and implemented a monthly workgroup to review data and outcome drivers and create and implement outreach strategies. The health plan noted that report accuracy has improved.
NAV	
Since the health plan supplied HSAG with the provider data used for the access and availability survey, HFS should supply the health plan with the case-level survey data files and a defined timeline by which the health plan will address provider data deficiencies identified during the survey calls.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL conducted an analysis and contracted with a third-party vendor to audit provider directory information. The health plan works with third-party vendors to conduct secret shopper surveys, provider directory audits, and follows up with providers. The health plan noted that appointment availability and demographic data has improved.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.	**BCBSIL did not sufficiently address the recommendation.** BCBSIL described its ongoing efforts to improve compliance; however, the health plan did not implement any new initiatives to address recommendations or describe effective interventions to overcome stated barriers.
Collaborate with HFS to contract with additional oral surgeons, if available, and continue to review oral surgery access standards with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL initiated a "plan of action" to address network adequacy issues of oral surgeons. This included recruitment, single-case agreements, monthly monitoring of IMPACT credentialing with DentaQuest, targeted outreach, and other efforts. The health plan noted significant improvement.
BCBSIL failed to meet the time/distance standard for audiology standard for adult and pediatric in one county and therefore should continue to review provider categories (with HFS) for which the access standards were not met, with the goal of determining whether these failures are due to a	**BCBSIL sufficiently addressed the recommendation.** BCBSIL reported it successfully contracted with audiologists in the noncompliant county and now meets access standards.

Prior Recommendation	CY 2024 Assessment
lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	
Additional EQR Activities	
Consider including information about the ratings from the CAHPS survey in provider communications during the year and obtaining feedback from patients on their recent office visits.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL conducted an analysis and identified top complaints. The health plan implemented a CAHPS workgroup that meets at least annually, a CAHPS collaboration team to discuss initiatives, a process change to insource call center quality reviews, and added questions to the quarterly member satisfaction survey. Improvement results were mixed.
Prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. The health plan should continue promoting the results of its member experience with its contracted providers and staff members.	**BCBSIL did not sufficiently address the recommendation.** BCBSIL conducted an analysis and identified top complaints. The health plan implemented a CAHPS workgroup that meets quarterly, a CAHPS collaboration team to discuss initiatives, and described several other ongoing interventions. However, BCBSIL did not appear to implement new, innovative interventions that would indicate that the health plan "prioritized" improvement for the child CAHPS survey as the interventions described were the same as for the adult population. Improvement results were mixed.
Continue ongoing oversight and monitoring of timely internal reporting and continued re-education when identified delay in reporting by CI team.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL retrained all care coordination staff in June 2024. The health plan described a monitoring process that identifies when staff fail to follow the process and provides individual coaching and re-training. The health plan implemented a new initiative to provide "CI office hours" and continued to provide weekly CI tips to staff based on gaps or opportunities identified. The health plan also developed a more focused audit process.
Continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL retrained all care coordination staff in June 2024. The health plan described a monitoring process that identifies when staff fail to follow the process and provides

Prior Recommendation	CY 2024 Assessment
	individual coaching and re-training. The health plan described a revised case manager reminder process that is monitored by managers to ensure compliance.
Reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**BCBSIL sufficiently addressed the recommendation.** BCBSIL reeducated care coordination staff, implemented a new initiative to target seven SLPs with high census and low signature compliance, and implemented a member voice signature within its CM platform. The health plan reported improved performance.
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL developed a unit manager oversight process to conduct in-depth reviews of care coordination reports. Unit managers perform live audits and peer-to-peer discussions about findings. The health plan reported improved performance.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL revised the member checklist to include unexplained death and conducted continued education to ensure care coordination staff was aware of the updated checklist and how to discuss with members. The health plan reported improved performance.
Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL reeducated care coordination staff on a quarterly basis on the use of valid justification along with the use of activity code setting with reminders when member visits are coming due. The health plan also implemented a new report to aid identification and improvement. The health plan reported improved performance.

CountyCare

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

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

Table 41—CountyCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** CountyCare achieved a *High Confidence* level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement for Remeasurement 1 for the *Improving Transportation Services* PIP for the HealthChoice and MLTSS populations.	
−	**Opportunity for improvement:** CountyCare continued to show declines in performance compared to the baseline for the *Timeliness of Prenatal Care* PIP. **Recommendations:** CountyCare should revisit its casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
PMV		
+	**Strength:** CountyCare's rates for measures related to diabetes management demonstrated improvement (*Blood Pressure Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Hemoglobin A1c Control for Patients With Diabetes*, and *Statin Therapy for Patients With Diabetes*).	
+	**Strength:** CountyCare was the highest performing health plan on measures related to women's screenings, at or above the 75th percentile for *Cervical Cancer Screening* and *Chlamydia Screening in Women* and between the 25th and 49th percentile for *Breast Cancer Screening*.	
+	**Strength:** CountyCare's child members were assessed for BMI or counseled about nutrition and physical activity as recommended. CountyCare was the highest performing plan for the *Weight Assessment and Counseling for Nutrition and Physical Activity*	

Strength/ Opportunity for Improvement	Description	Domain(s)
	measure with all three submeasures performing at or above the 75th percentile.	
+	**Strength:** More of CountyCare's child and adolescent members received well-child visits this year as evidenced by improvement of the *Well-Child Visits in the First 30 Months of Life* measure and performance at or above the 50th percentile for both submeasures.	
+	**Strength:** More of CountyCare's adolescent members received immunizations as evidenced by improvement of the *Immunizations for Adolescents* measure and performance at or above the 75th percentile for both submeasures.	
−	**Opportunity for improvement:** CountyCare's rate for the *Adults' Access to Preventive/ Ambulatory Health Services—Total* measure improved compared to last year; however, the rate remained below the 50th percentile. **Recommendations:** HSAG recommends CountyCare design and test interventions specific to the 20-39 age group to engage these members in accessing healthcare on a routine basis.	
−	**Opportunity for improvement:** CountyCare struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for all three submeasures in *Pharmacotherapy for OUD* and performed below the 25th percentile. Rates for two of six submeasures in *Initiation and Engagement of SUD Treatment* declined and five performed below the 50th percentile. Three of four submeasures for *Follow-Up After Emergency Department Visit for Substance Use* performed below the 50th percentile. **Recommendations:** To improve treatment of OUD and SUD, HSAG recommends CountyCare: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility.	

Strength/ Opportunity for Improvement	Description	Domain(s)
	• Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment. • Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	
−	**Opportunity for improvement:** CountyCare's rates for the *Controlling High Blood Pressure* measure continued to perform below the 25th percentile. **Recommendations:** HSAG recommends CountyCare educate and consider incentive plans for providers on appropriate submission of Current Procedural Terminology (CPT) II codes for improving administrative capture of blood pressure control results.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. **Recommendations:** Continue oversight and monitoring procedures as well as reporting for the CBH Services requirements. Consider increasing the number of internal audits to ensure compliance with contractual requirements.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	
NAV		
+	**Strength:** CountyCare demonstrated strong processes for maintaining accurate provider information through quarterly validation of the provider directory.	
+	**Strength:** CountyCare had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in CountyCare's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** CountyCare met the State's time and distance standards across all public health regions for all applicable 20 provider categories.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that CountyCare was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that CountyCare was compliant with all requirements for waiver case managers.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	

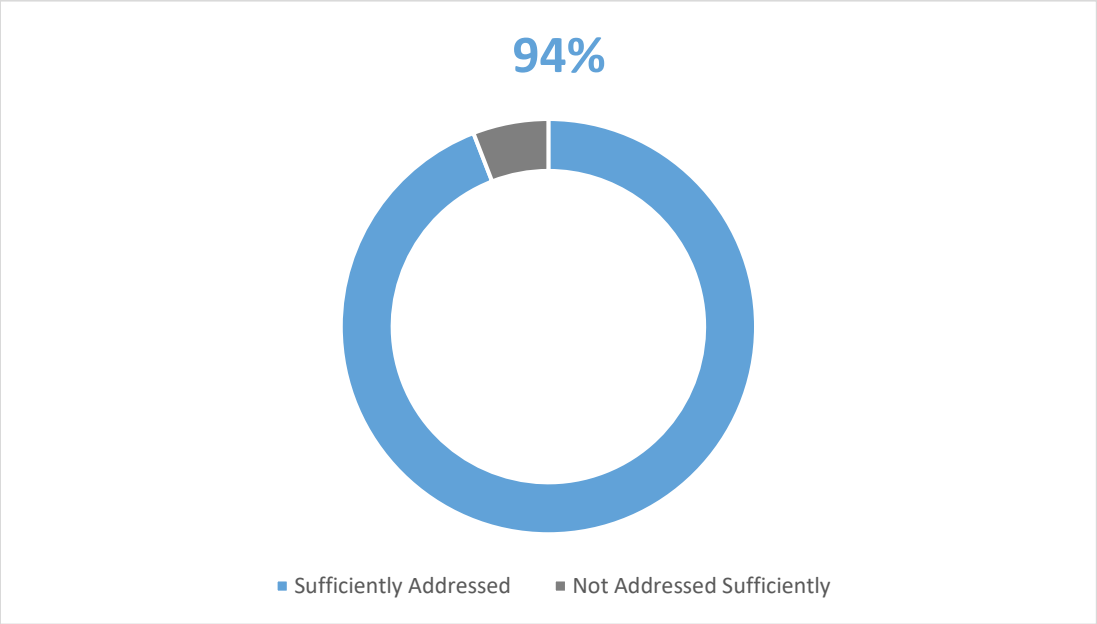
Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	
−	**Opportunity for improvement:** Results of the staffing and training review identified that the health plan had an opportunity to ensure its internal and delegated case managers complete annual training requirements. **Recommendations:** The health plan should ensure that all case managers receive required trainings by the end of CY 2024.	
−	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	

Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

CountyCare submitted responses to all prior EQR recommendations and HSAG reviewed CountyCare's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 7 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 7—Percentage of Prior EQR Recommendations Addressed by CountyCare



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

Table 42—Assessment of CountyCare's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
PMV	
Consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommended increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.	**CountyCare did not sufficiently address the recommendation.** CountyCare described ongoing interventions but did not indicate new initiatives were implemented to drive improvement. In addition, CountyCare identified the barriers of member understanding and correct contact information, but did not implement interventions to address those barriers. The health plan reported improvement in CAHPS measures, but only noted modest improvement for one of the HEDIS measures associated with this recommendation.
Consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why child and adolescent members are inconsistently receiving well care visits.	**CountyCare sufficiently addressed the recommendation.** CountyCare described segmentation analysis used to work with provider groups to outreach members with care gaps and its ongoing Brighter Beginnings program. Although the health plan did not appear to implement new initiatives, it did report significant improvement.
Consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.	**CountyCare sufficiently addressed the recommendation.** CountyCare conducted a root cause analysis, conducted targeted outreach with provider groups, increased member reward for second dose of flu vaccine (to address a key driver), and planned a multi-modal educational campaign to dispel flu vaccine myths. The health plan also reported participation in a vaccine workgroup to improve data capture.
Consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification for the *Follow-Up After Hospitalization for Mental Illness* measure.	**CountyCare sufficiently addressed the recommendation.** CountyCare began a formal partnership with Illinois Health Practice Alliance with the goal of increasing timely and consistent engagement in behavioral health services. The health plan also identified that the ADT feed was incomplete and therefore developed a workflow that uses ADT alerts to outreach recently discharged members. CountyCare also continued its behavioral health workgroups and expanded prior interventions.

Prior Recommendation	CY 2024 Assessment
Review and document the process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation to improve rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure.	**CountyCare sufficiently addressed the recommendation.** CountyCare/Evolent completed a review and documented the process for identifying the eligible population according to the specs from the State, including the data sources for institutional facility claims, and shared results with the EQRO in a recent audit. The health plan is supporting member transitions with its community transitions initiative.
Since the health plan supplied HSAG with the provider data used for the access and availability survey, HFS should supply the health plan with the case-level survey data files and a defined timeline by which the health plan will address provider data deficiencies identified during the survey calls.	**CountyCare sufficiently addressed the recommendation.** CountyCare initiated a request for proposal for a vendor with the ability to access supplemental data to identify opportunities to enhance and correct provider data. CountyCare also began quarterly reviews with larger provider groups that manage 80 percent of members.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.	**CountyCare sufficiently addressed the recommendation.** CountyCare identified key drivers, requested corrective action plans from providers who failed to meet standards, resurveyed providers after correction action implementation, published appointment wait times in the member handbook and newsletter, and expanded provider network. The health plan reported improvement.
Compliance with Standards	
Continue to evaluate care coordination staffing needs to ensure compliance with contractual requirements. Continue to evaluate opportunities for compliance to HFS' readability protocol.	**CountyCare sufficiently addressed the recommendation.** CountyCare conducted several iterations of audits and reported that vendors have significantly improved 6th-grade readability compliance. The health plan also described several additional interventions and reported high degrees of compliance for various types of denial and appeal letters.
Additional EQR Activities	
Consider including information about the ratings from the CAHPS survey in provider communications during the year and obtaining feedback from patients on their recent office visit.	**CountyCare sufficiently addressed the recommendation.** CountyCare described member experience workgroups that implemented new initiatives such as social media campaigns and promoting telehealth and urgent care options. Although only slight improvement was reported,

Prior Recommendation	CY 2024 Assessment
	the health plan indicated it will continue to conduct post-call surveys to assess member satisfaction and audit a selection of member services calls to coach staff.
Prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. The health plan should continue promoting the results of its member experiences with its contracted providers and staff members.	**CountyCare sufficiently addressed the recommendation.** CountyCare described member experience workgroups that analyze CAHPS results and develop targeted interventions. The health plan outreached child members with acute behavioral health episodes to offer care coordination and obtained member feedback through stakeholder groups and councils. The health plan reported improvement.
Continue ongoing oversight and monitoring of timely enrollee follow up after CI identification and provide education to those staff members who are identified as having delayed outreach to enrollee.	**CountyCare sufficiently addressed the recommendation.** CountyCare identified a substantial increase in volume of CIs. The health plan built a monthly CI report into the workflow for each care management entity and held biweekly CI meetings with care coordinators and managers. The health plan also investigated alternative notification systems and reported incremental improvements.
Continue ongoing oversight and monitoring of timely internal CI reporting from date of CI identification and provide education to staff members who are identified with delay in CI reporting.	**CountyCare sufficiently addressed the recommendation.** CountyCare described using daily log which tracks each case as it is received by the health plan which provides immediate feedback. The log includes a column to validate reporting to investigating authority and response. The health plan reported improved alignment.
Reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**CountyCare sufficiently addressed the recommendation.** CountyCare conducted training to implement full return to in-person visits required by HFS effective in July 2023. The health plan reported improvement.
Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required. The health plan should ensure internal audit processes focus on review of this measure, with immediate feedback and discussion with care managers/care	**CountyCare sufficiently addressed the recommendation.** CountyCare conducted training in preparation for unwinding of the PHE and return to face-to-face visits. The health plan retrained staff on use of dashboard to identify due members and track completion. The health plan reported improvement.

Prior Recommendation	CY 2024 Assessment
coordinators to identify opportunities for improvement.	
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**CountyCare sufficiently addressed the recommendation.** CountyCare enhanced its dashboard to include days since previous reassessment, including the service plan, and retrained staff on use of the dashboard. The health plan reported improvement.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured and educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**CountyCare sufficiently addressed the recommendation.** CountyCare added "unexplained death" to the documentation template and trained staff on new template and requirements for member education. The health plan reported improvement.
For the QA/UR/PR review, CountyCare had a finding that would be resolved in future reports by inclusion of MPR statistic reports for all applicable areas. CountyCare should consider incorporating MPR measure performance into future reports.	**CountyCare sufficiently addressed the recommendation.** CountyCare included the utilization of MPR reporting data in the instructions to report drafters and ensured that reports generated by CountyCare's data analytics team were in accordance with HFS MPR methodology, when applicable.

Meridian

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Meridian achieved a *High Confidence* level for adhering to acceptable methodology for all PIPs and demonstrated statistically significant improvement over the baseline in Remeasurement 2 for the *Timeliness of Prenatal Care* PIP.	
−	**Opportunity for improvement:** Meridian demonstrated statistically significant decline in Remeasurement 1 for the *Improving Transportation Services* PIP for all three lines of business (HealthChoice, MLTSS, and SNC). **Recommendations:** Meridian should revisit its casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
PMV		
+	**Strength:** Meridian's rates for measures related to diabetes management demonstrated improvement (*Blood Pressure Control for Patients With Diabetes*, *Eye Exam for Patients With Diabetes*, *Hemoglobin A1c Control for Patients With Diabetes* (one submeasure), and *Statin Therapy for Patients With Diabetes*).	
+	**Strength:** A majority of Meridian members received follow-up after they visited the ED for mental illness. Four submeasures of *Follow-Up After Emergency Department Visit for Mental Illness* performed at or above the 75th percentile.	
+	**Strength:** More of Meridians' child and adolescent members received well-child visits this year as evidenced by improvement of the *Well-Child Visits in the First 30 Months of Life* measure and performance at or above the 50th percentile for both submeasures.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** For the *Childhood Immunization Status* measure, Meridian's rate was below the 25th percentile for both submeasures. **Recommendations:** HSAG recommends Meridian focus on parent education and clinic practice transformation. If Meridian already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Meridian should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules.	
−	**Opportunity for improvement:** Meridian performed poorly on measures related to women's screenings, below the 50th percentile for *Breast Cancer Screening* and *Cervical Cancer Screening* and below the 25th percentile for *Chlamydia Screening in Women*. **Recommendations:** HSAG recommends Meridian consider whether there are disparities/SDOH factors that contributed to lower access to care. Upon identification of root causes, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. HSAG also recommends Meridian address sexually transmitted infection stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update; use multi-modal approaches to contact members to promote women's screenings, and incentives to providers to provide screenings, increase access, and outreach eligible members in their panels.	
−	**Opportunity for improvement:** Meridian's reported rate for the *Timeliness of Prenatal Care* submeasure decreased by nearly six percentage points and fell below the 50th percentile. **Recommendations:** HSAG recommends Meridian analyze further what were the drivers of the significant decrease in the timeliness of prenatal care submeasure. In addition to any member related findings, Meridian should analyze its provider network further to see whether any changes occurred in its provider network that impacted timely identification of newly pregnant members and access to timely prenatal care appointments. Meridian should analyze whether	

Strength/ Opportunity for Improvement	Description	Domain(s)
	any particular provider group disproportionately decreased in its performance of the Timeliness of Prenatal Care submeasure and perform a deeper dive with the provider group to understand any changes in access to care or staffing. Meridian should create an action plan based on its findings to address barriers to timely appointments including targeted outreach to specific populations to assist with appointment scheduling, and working with identified providers that are experiencing access and staffing issues.	
	**Opportunity for improvement:** Meridian's child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure continuing to perform below the 50th percentile. **Recommendations:** Meridian should conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	
	**Opportunity for improvement:** Meridian struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for two of three submeasures in *Pharmacotherapy for OUD* and performed below the 50th percentile. Rates for five of six submeasures in *Initiation and Engagement of SUD Treatment* declined and three submeasures performed below the 50th percentile. **Recommendations:** To improve treatment of OUD and SUD, HSAG recommends Meridian: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the	

Strength/ Opportunity for Improvement	Description	Domain(s)
	providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility. • Evaluate current care coordination between EDs, inpatient facilities and outpatient providers with a focus to increase initiation of OUD/SUD treatment. • Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. **Recommendations:** Continue oversight and monitoring procedures as well as reporting for the CBH Services requirements. Consider increasing the number of internal audits to ensure compliance with contractual requirements.	
−	**Opportunity for improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	

Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength:** Meridian had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** Meridian had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in Meridian's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** Meridian met the State's time and distance standards across all public health regions for 17 of 20 provider categories.	
−	**Opportunity for improvement:** Meridian did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. **Recommendations:** HSAG recommends that Meridian maintain the current level of access to care and continue to address network gaps for pharmacies and oral surgeons.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Meridian was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that Meridian was compliant with all requirements for waiver case managers.	
+	**Strength:** The staffing and training review identified that Meridian was compliant with all training requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	

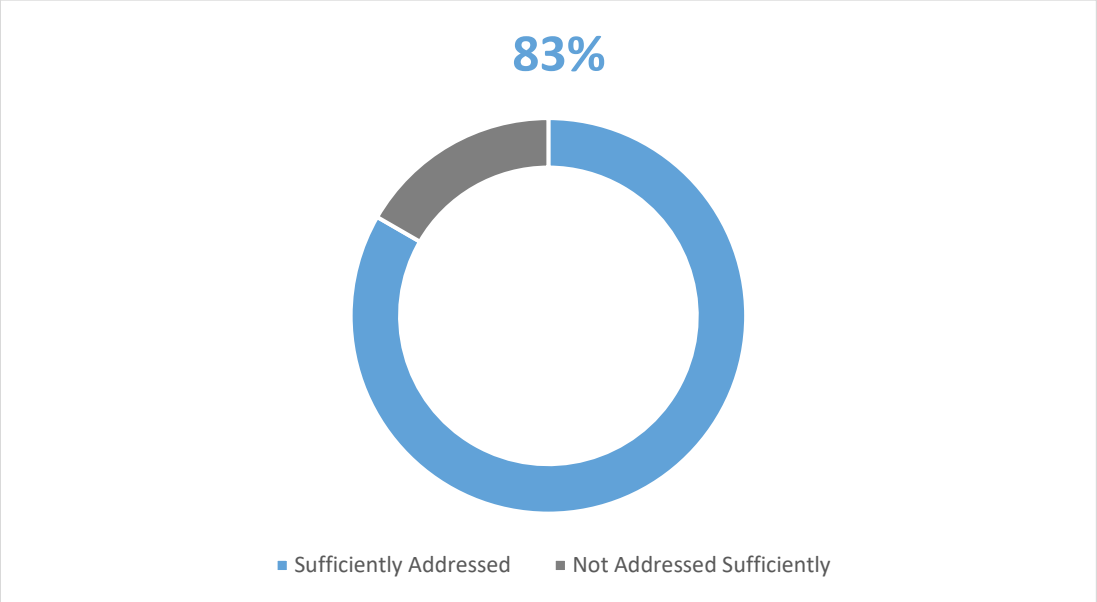
Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	
−	**Opportunity for improvement:** Meridian's experience survey results were below the 50th percentiles for five of eight child measures. **Recommendations:** HSAG recommends that Meridian evaluate the process of care delivery and identify whether there are any operational issues contributing to access to care barriers for members. Meridian should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Meridian could consider conducting root cause analyses or focus studies to further explore members' perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate	

Strength/ Opportunity for Improvement	Description	Domain(s)
	providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	
–	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	
–	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

Meridian submitted responses to all prior EQR recommendations and HSAG reviewed Meridian's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 8 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 8—Percentage of Prior EQR Recommendations Addressed by Meridian



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

Table 44—Assessment of Meridian's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
PMV	
Consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommended increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.	**Meridian sufficiently addressed the recommendation.** Meridian implemented several initiatives, including the creation of an Empowerment Performance Circle group focused on preventive services. The health plan deployed a text campaign and engaged community health workers who performed outreach to Black men in DIA ZIP Codes. The health plan also alerted provider groups of DIA disparities. The health plan reported improvement.
Consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why child and adolescent members are inconsistently receiving well care visits.	**Meridian sufficiently addressed the recommendation.** Meridian implemented several targeted initiatives, including a text and mail campaign, conducting a barrier survey, developing a quick reference guide for providers, and offering educational webinars for providers. The health plan also leveraged social media,

Prior Recommendation	CY 2024 Assessment
	community events, and deployed a transportation survey. The health plan reported improvement.
Consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.	**Meridian sufficiently addressed the recommendation.** Meridian deployed a targeted text and mail campaign, conducted a barrier survey, developed a quick reference guide for providers, and offered educational webinars for providers. The health plan utilized a vendor to provide mail and telephonic outreach to all members due for children's vaccines. The health plan also leveraged social media and community events. The health plan reported improvement.
Consider further analysis of potential key drivers that may contribute to the observed low performance for the *Cervical Cancer Screening* measure.	**Meridian sufficiently addressed the recommendation.** Meridian deployed a text message campaign that linked members to a provider search tool and offered increased member incentives. The health plan also leveraged social media and partnered with clinics to host community events and offer incentives. Although the health plan did not report improvement, it developed strategies for overcoming barriers.
Consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification for the *Follow-Up After Hospitalization for Mental Illness* measure.	**Meridian sufficiently addressed the recommendation.** Meridian reviewed its engagement plan and deployed a weekly text message to noncompliant members, created a member-facing infographic, and developed a behavioral health toolkit for providers. The health plan reported significant improvement.
Review and document the process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation to improve rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure.	**Meridian sufficiently addressed the recommendation.** Meridian created an internal workgroup with leaders from long-term care and transition teams. The workgroup conducts quarterly reviews to validate and monitor rates. To provide additional training, the health plan also updated job aids and included referrals to centers for independent living for all transitions. The health plan reported increased oversight and accuracy of validation.

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
Continue recruitment efforts to fill open care coordination positions and continue to evaluate ongoing care coordination staffing needs to ensure compliance with contractual requirements.	**Meridian did not sufficiently address the recommendation.** The health plan provided information regarding its processes to ensure staffing qualifications and caseload requirements are met; however, it did not describe its successes or barriers to filling vacant positions or its processes or efforts to evaluate its staffing model (i.e., volume of staff) to ensure that case management contract requirements such as timely enrollee assessments, care plans, and contact, are met.
Continue to evaluate UM processes for areas of improvement to ensure compliance with coverage and authorization of service requirements.	**Meridian did not sufficiently address the recommendation.** Meridian identified the opportunity for improvement exists because staff are required to work weekends and holidays but did not describe any initiatives to address the deficiency. The health plan discussed "continual collaboration between all moving parts" but did not indicate whether a process is now in place to ensure compliance or improvements have been realized.
NAV	
Since the health plans supplied HSAG with the provider data used for the access and availability survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls.	**Meridian sufficiently addressed the recommendation.** Meridian made an enterprise-wide decision to default to office phone numbers, and no longer display or house practitioner phone numbers, which greatly decreased phone errors. The health plan also began using a roster analysis tool to ensure updates are made as received from providers. In addition, the health plan enhanced its partnership with a directory accuracy provider. The health plan reported improvement.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, conduct a root cause analysis to identify factors	**Meridian sufficiently addressed the recommendation.** Meridian conducted provider education on standards via provider newsletter, provider meetings, and orientation. The health plan also educated providers on telehealth coverage. The health plan reported improvement.

Prior Recommendation	CY 2024 Assessment
affecting compliance with appointment availability standards.	
Collaborate with HFS to contract with additional oral surgeons, if available, and continue to review oral surgery access standards with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	**Meridian sufficiently addressed the recommendation.** Although there are limited approved providers accepting Medicaid members in 12 counties, Meridian's network team conducted monthly monitoring to identify new providers, contracted with general dentists to perform services, and secured single-case agreements as needed. The health plan reported that all members needing oral surgery services received care.
Additional EQR Activities	
Consider including information about the ratings from the CAHPS survey in provider communications during the year and obtaining feedback from patients on their recent office visit.	**Meridian sufficiently addressed the recommendation.** Meridian hired seven new staff to create a patient care advocate team to provide quality information to targeted providers. The health plan also enhanced member outreach. The health plan reported increased engagement of providers.
Prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. The health plan should continue promoting the results of its member experiences with its contracted providers and staff members.	**Meridian did not sufficiently address the recommendation.** Meridian provided a response that duplicated its efforts to inform providers of CAHPS ratings, but did not indicate any initiatives designed to prioritize improvement for the child survey.
Continue ongoing reeducation to staff members on the expectations for timely internal reporting of CIs from the date of CI identification.	**Meridian sufficiently addressed the recommendation.** Meridian retrained staff on timely reporting of CIs and created an internal process to regularly share audit findings with care management leadership. The health plan expects improvement from the newly implemented initiatives.
Continue ongoing reeducation to staff members on the expectations for timely external reporting of CIs from the date of CI identification.	**Meridian sufficiently addressed the recommendation.** Meridian retrained staff on timely reporting of CIs and created an internal process to regularly share audit findings with care management leadership. The health plan expects improvement from the newly implemented initiatives.
Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE,	**Meridian sufficiently addressed the recommendation.** Meridian described continued initiatives and reported improvement, including

Prior Recommendation	CY 2024 Assessment
including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.	conducting quarterly trainings with LTSS staff and utilizing a daily dashboard to track completion and conduct monitoring and oversight. The health plan also provided staff with a date calculator to correctly compute the number of days between contacts.
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**Meridian sufficiently addressed the recommendation.** Meridian described continued initiatives and reported improvement including quarterly trainings with LTSS staff and utilizing a daily dashboard to track completion and conduct monitoring and oversight. Meridian reported scores above 90 percent for Q1 and Q2.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**Meridian sufficiently addressed the recommendation.** Meridian conducted staff training and updated its annual forms. The updated process is included in quarterly training and is reviewed during internal audits. The health plan reported notable improvement.

Molina

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Molina achieved a *High Confidence* level for adhering to acceptable methodology for the *Improving Timeliness of Prenatal Care* PIP.	
−	**Opportunity for improvement:** Molina, continued to show declines in performance compared to the baseline for the *Timeliness of Prenatal Care* PIP. **Recommendations:** Molina should revisit its casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
−	**Opportunity for improvement:** Molina was assigned a *Low Confidence* level for adhering to acceptable methodology for the *Improving Transportation Services* PIP. **Recommendations:** Molina should develop a process or plan to evaluate the effectiveness of each individual intervention listed in the barriers/interventions table in the PIP Submission Form. The overall indicator for the PIP should not be used to determine effectiveness for the interventions. Intervention data are specific to the intervention and typically collected over short time periods as part of plan-do-study-act cycles or based on the type of data and frequency of availability.	
PMV		
+	**Strength:** A majority of Molina members received follow-up after they visited the ED or hospital for mental illness. All six submeasures of *Follow-Up After Emergency Department Visit for Mental Illness* performed at or above the 50th percentile (with some age groups performing at or above the 90th percentile) and five of	

Strength/ Opportunity for Improvement	Description	Domain(s)
	six submeasures of *Follow-Up After Hospitalization for Mental Illness* demonstrated improvement.	
+	**Strength:** A majority of Molina's pregnant members received recommended prenatal and postpartum care as demonstrated by performance on the *PPC* measure. Both submeasures exceeded the 75th percentile.	
+	**Strength:** More of Molina's child and adolescent members received well-child visits this year as evidenced by improvement of the *Well-Child Visits in the First 30 Months of Life* measure and performance at or above the 50th percentile for both submeasures.	
−	**Opportunity for improvement:** Molina's rate for the *Adults' Access to Preventive/ Ambulatory Health Services—Total* measure improved compared to last year; however, the rate remained below the 50th percentile. **Recommendations:** HSAG recommends Molina design and test interventions specific to the 20-39 age group to engage these members in accessing healthcare on a routine basis.	
−	**Opportunity for improvement:** Molina's rates were below the 50th percentile for *Breast Cancer Screening* and *Cervical Cancer Screening*. **Recommendations:** HSAG recommends Molina consider whether there are disparities/SDOH factors that contributed to lower access to care. Upon identification of root causes, HSAG recommends that the plans implement appropriate interventions to reduce barriers to care. HSAG also recommends Molina address sexually transmitted infection stigma among physicians and patients; clarify payment codes for chlamydia screenings if they are grouped with other screenings and ensure providers are aware of this update; use multi-modal approaches to contact members to promote women's screenings, along with incentives to providers to provide screenings, increase access, and outreach eligible members in their panels.	
−	**Opportunity for improvement:** Molina continues to significantly underperform in the *Eye Exam for Patients with Diabetes* submeasure with results below the 25th percentile and a 5 percent decrease in the rate from MY 2022 to MY 2023. **Recommendations:** HSAG recommends Molina complete further analysis to determine the root cause of the decrease. Molina should determine whether any changes occurred in the provider network that impacted timely access to care and identify any other potential key drivers including whether there are disparities and/or SDOH barriers contributing to lower performance. Molina should engage	

Strength/ Opportunity for Improvement	Description	Domain(s)
	with providers with access issues, expanding available providers, and offering incentives to providers to expand access. Member outreach and engagement activities should be started early in the CY and the impact of performance monitored to continue, pivot, or enhance the approach by mid-Q3.	
–	**Opportunity for improvement:** For the *Childhood Immunization Status* measure, Molina's rate was below the 50th percentile for the *Combination 3* submeasure and below the 25th percentile for the *Combination 10* submeasure. **Recommendations:** HSAG recommends Molina focus on parent education and clinic practice transformation. If Molina already has a program for new parents, the plan should reorganize and/or increase incentives and rewards for families as well as review and improve educational materials to address fears, misinformation, and the reason for multiple doses (better chance of full immunity). To promote influenza vaccination in communities affected by health disparities, it is important to include community members in the development of culturally relevant materials and strategies. Molina should identify specific providers that perform below the 50th percentile and/or who have a large member panel to initiate new processes in the clinic such as automatic four-week scheduling for next vaccine appointment and catch-up vaccination visit slots to fast track infants who are behind on their vaccination schedules.	
–	**Opportunity for improvement:** Molina's child members were not assessed for BMI or counseled about nutrition and physical activity as recommended, as demonstrated by all three submeasures in the *Weight Assessment and Counseling for Nutrition and Physical Activity* measure continuing to perform below the 50th percentile. **Recommendations:** Molina should conduct further analysis to consider whether certain provider groups performed lower on completing weight assessment and nutrition counseling compared to the average rates and top performers. Provider education materials and reminders of acceptable progress notes should be shared with providers with specific attention to the low-performing provider groups. Periodic audits of medical records of specific lower performing providers can monitor improvement or continued missed opportunities. Health plans should implement appropriate interventions based on their findings to improve the performance of the measure.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** Molina struggled to engage members with OUD and SUD in appropriate treatment. Rates decreased for two of three submeasures in *Pharmacotherapy for OUD* and all submeasures performed below the 25th percentile. Rates for two of six submeasures in *Initiation and Engagement of SUD Treatment* performed below the 50th percentile. **Recommendations:** To improve treatment of OUD and SUD, HSAG recommends Molina: • Evaluate current care coordination efforts and ensure patients and providers are aware of treatment options. • Assess demographic variation what obstacles may be present to inform solutions. • Consider creating a multidisciplinary workgroup to understand the eligible members' barriers and create a workplan for education materials, outreach, and training opportunities to the providers to educate and encourage appropriate treatment, including pharmacotherapy for OUD. • Expand treatment options with focus on convenience and accessibility. • Evaluate current care coordination between EDs, inpatient facilities. and outpatient providers with a focus to increase initiation of OUD/SUD treatment. • Create and expand partnerships with SUD/OUD treatment providers to connect with health plan case management, ensure availability of timely appointments, receipt of referrals, and expand telehealth options.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** HSAG identified that the health plan had an opportunity for improvement related to standardized language in its policies and procedures. **Recommendations:** The health plan must implement oversight and monitoring procedures to ensure accurate identification of State and federal requirements within its policies and procedures.	
−	**Opportunity for improvement:** Results of CBH file reviews demonstrated an opportunity for improvement related to oversight of care management activities. **Recommendations:** Continue oversight and monitoring procedures as well as reporting for the CBH Services requirements.	
−	**Opportunity for improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	
NAV		
+	**Strength:** Molina had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** Molina had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in Molina's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** Molina met the State's time and distance standards across all public health regions for 17 of 20 provider categories.	
−	**Opportunity for improvement:** Molina did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. **Recommendations:** HSAG recommends that Molina maintain the current level of access to care and continue to address network gaps for pharmacies and for oral surgery specialists adult and pediatric.	

Strength/ Opportunity for Improvement	Description	Domain(s)
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Molina was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that Molina was compliant with all requirements for waiver case managers.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	
−	**Opportunity for improvement:** Molina's experience survey results were below the 50th percentiles for six of eight child measures. **Recommendations:** HSAG recommends that Meridian evaluate the process of care delivery and identify whether there are any operational issues contributing to access-to-care barriers for members. Aetna should also review member-to-provider ratios within access requirements to determine whether there are enough in-network providers available to allow for timely appointment scheduling. Meridian could consider conducting root cause analyses or focus studies to further explore members' perceptions regarding the access to care and services and obtain feedback from patients on their recent office visit.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	

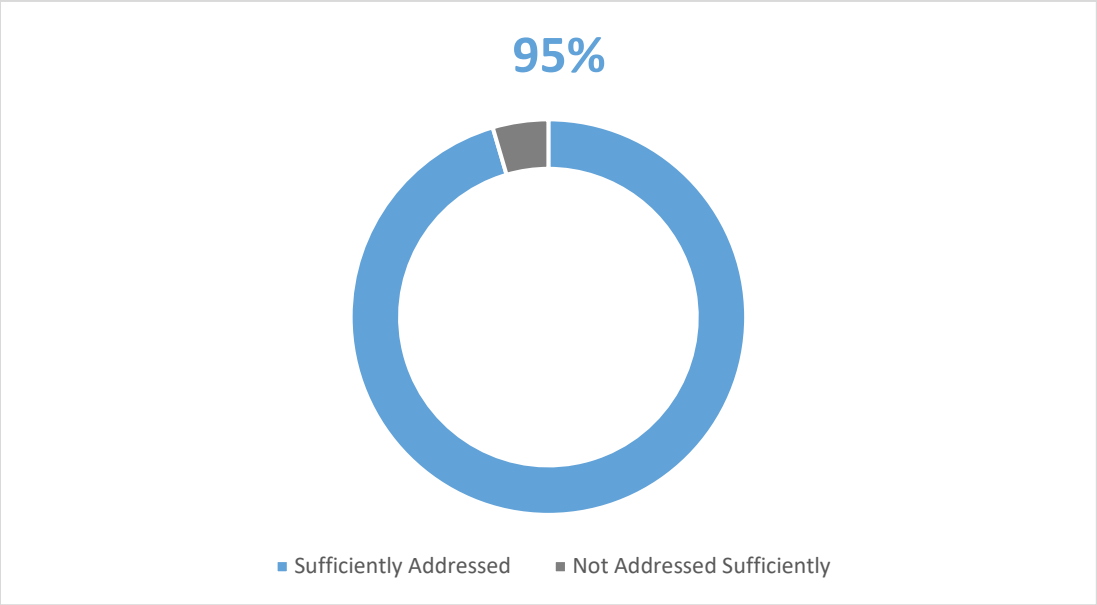
Strength/ Opportunity for Improvement	Description	Domain(s)
–	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
–	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	
–	**Opportunity for improvement:** Results of the staffing and training review identified that the health plan had an opportunity for improvement related to ensuring qualification and education requirements were met for its SNC case managers. **Recommendations:** The health plan should review the qualification/education requirements for the SNC members to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.	
–	**Opportunity for improvement:** Results of the staffing and training review identified that the health plan had an opportunity to ensure its internal and delegated case managers complete annual training requirements. **Recommendations:** The health plan should ensure that all case managers receive required trainings by the end of CY 2024.	

Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	
−	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	
−	**Opportunity for improvement:** As identified during the Care Gap Plan review, care gaps were visible on the enrollee portal; however, the portal did not include a link to additional information, nor did it provide details to the enrollee about next steps to address the gap. The health plan provided information regarding current system enhancements to address the recommendation; however, an estimated time frame for completion was not reported. **Recommendations:** The health plan should ensure enhancements to the enrollee portal to assist enrollees with understanding of care gaps are completed.	

Follow-Up on Prior Year Recommendations

Molina submitted responses to all prior EQR recommendations and HSAG reviewed Molina's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 9 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 9—Percentage of Prior EQR Recommendations Addressed by Molina



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

Table 46—Assessment of Molina's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
PMV	
Consider further analysis to include a drill down of disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification. Additionally, HSAG recommended increasing the frequency of internal and external facing multidisciplinary work groups designed to solicit best practices from other organizations within and/or outside the state and implement appropriate interventions to increase performance related to Access to Care measures.	**Molina sufficiently addressed the recommendation.** Molina leveraged the mobile health unit and a text messaging campaign. The health plan also included the Access to Care measures in its value-based contracts and P4P program to encourage providers to outreach members and close gaps. The health plan reported modest improvement and described additional plans to address barriers.

Prior Recommendation	CY 2024 Assessment
Consider additional analysis to consider if there are disparities and/or social determinants within the DIA population that contribute to lower performance in a particular age stratification or race/ethnicity stratification for the *Annual Dental Visit* measure.	**Molina sufficiently addressed the recommendation.** Molina changed dental vendors. The new vendor established dental homes so that members will have a regular dental provider. In addition, the health plan partnered with community providers to host dental days in high risk and gaps areas and deployed mobile dental units. The new vendor also provided more participating providers. The health plan described month-over-month improvement and plans to launch dental days in rural areas.
Consider further analysis of potential key drivers that may contribute to the observed lower performance for members in DIA ZIP Codes in a particular age or race/ethnicity stratification and to help determine why child and adolescent members are inconsistently receiving well care visits.	**Molina sufficiently addressed the recommendation.** Molina partnered with community organizations and providers to host back-to-school fairs with mobile health units that complete school and sport physicals. The health plan also hosted events with provider groups to close gaps with attendees. The health plan described ongoing outreach efforts and reported improvement.
Consider further analysis of potential key drivers that may contribute to the observed lower performance in a particular age stratification, race/ethnicity stratification, and vaccination and to help determine why their child members are inconsistently receiving immunizations.	**Molina sufficiently addressed the recommendation.** Molina conducted workgroups with providers and identified barriers, including incomplete documentation in ICARE (for various reasons). Molina outreached new moms to promote well-baby visits and began working with several providers to conduct a thorough analysis of *Childhood Immunization Status—Combination 10* data. The health plan also included this measure in its P4P program and expanded access to EMR systems. Though improvement wasn't realized, the health plan described a change in HEDIS specifications that should improve rates and continued strategies for improvement.
Consider further analysis of potential key drivers that may contribute to the observed low performance for the *Cervical Cancer Screening* measure.	**Molina sufficiently addressed the recommendation.** Molina worked with provider groups to offer a series of community events and clinic days that closed a total of 388 gaps. The health plan included the measure in its P4P program and though no improvement was realized, Molina described expansion of its mobile health units' capabilities to conduct screenings and potentially offering at-home test kits.

Prior Recommendation	CY 2024 Assessment
Consider further analysis to consider if there are disparities and/or social determinants within its population that contribute to lower performance in a particular age or race/ethnicity stratification for the *Follow-Up After Hospitalization for Mental Illness* measure.	**Molina sufficiently addressed the recommendation.** Molina funded a discharge planner grant for a high-volume behavioral health hospital to promote timely follow-up. The health plan also increased telehealth services and noted improvement in rates.
Review and document the process for identifying the eligible population and their data sources for institutional facility claims in addition to thorough oversight and validation to improve rates for the *LTSS Successful Transition After Long-Term Institutional Stay* measure.	**Molina sufficiently addressed the recommendation.** Molina completed an analysis and adjusted its reporting logic and data sources to align with the EQRO's expanded guidelines. The health plan reported improvement.
Compliance with Standards	
Continue case management system upgrades to ensure visible initial risk stratification.	**Molina sufficiently addressed the recommendation.** Molina identified a modification to its care management software to add a risk stratification level that allows staff to view the risk level of each member. The health plan anticipates improvement will be verified in subsequent file review.
Distribute and conduct training on the HFS Readability Protocol for all staff members responsible for developing and auditing Illinois-specific enrollee written materials to ensure compliance with a sixth-grade reading level.	**Molina sufficiently addressed the recommendation.** Molina trained all medical directors and distributed the protocol. The health plan also audited a sample of cases for each medical director on a monthly basis to evaluate compliance. The health plan reported improvement.
NAV	
Since the health plans supplied HSAG with the provider data used for the access and availability survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls.	**Molina sufficiently addressed the recommendation.** Molina sent monthly memos to providers to reinforce timely updates and began returning roster submissions with inconsistencies and errors back to the provider for correction.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or	**Molina sufficiently addressed the recommendation.** Molina worked with provider offices to utilize mobile van services to complete appointments in the community and identify providers that can offer telehealth services. The health plan also updated its provider directory to

Prior Recommendation	CY 2024 Assessment
associated with the specialty category. Then, conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.	indicate whether telehealth services are offered by a provider.
Collaborate with HFS to contract with additional oral surgeons, if available, and continue to review oral surgery access standards with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	**Molina sufficiently addressed the recommendation.** Molina continued to recruit oral surgeons and deploy single-case agreements as needed. The health plan analyzed reasons providers are not willing to join its network and developed a future strategy to recruit in contiguous states.
Additional EQR Activities	
Consider including information about the ratings from the CAHPS survey in provider communications during the year and obtaining feedback from patients on their recent office visit.	**Molina sufficiently addressed the recommendation.** Molina included CAHPS information in its provider newsletter and described ongoing efforts to monitor survey results and consult advisory and stakeholder groups. The health plan updated its member handbook and member portal, revamped its welcome kit, and restructured its welcome call to better engage with members and address needs. Molina's member services developed CAHPS talking points for staff and the health plan plans to add CAHPS information to its quarterly provider QI webinar. The health plan reported improvement in some CAHPS measures.
Prioritize improving parents'/caretakers' overall experiences with their child's personal doctor and determine a root cause for the lower performance. The health plan should continue promoting the results of its member experiences with its contracted providers and staff members.	**Molina did not sufficiently address the recommendation.** Molina provided a response that duplicated its efforts to inform providers of CAHPS ratings, but did not indicate any initiatives designed to prioritize improvement for the child survey.
Reeducate staff members on ensuring that the CI reporting form includes who identified the CI event, who reported the CI event, when the CI was identified, where the CI occurred, a thorough narrative of the CI event, and specific information on reporting to the investigating authority.	**Molina sufficiently addressed the recommendation.** Molina identified it was not previously requiring a summary statement and needed a process to ensure the CI form included all required information. Molina trained staff members on new requirement to include summary narrative and proper form completion and began a weekly auditing process.

Prior Recommendation	CY 2024 Assessment
Reeducate staff members on accurate data transfer from the CI reporting form to its Compliance HIPAA Management Program (CHAMPS) which tracks CI reporting.	**Molina sufficiently addressed the recommendation.** Molina identified errors in manually transferring data and evaluated data discrepancies in its CI file layout tool. The health plan initiated monthly pulls of CI reporting data to review and update the data universe prior to submission. The health plan expects improved accuracy of its quarterly data universe.
Continue ongoing oversight and monitoring of the application internal UTR process prior to closure of the CI event.	**Molina sufficiently addressed the recommendation.** Molina retrained staff in following the unable to reach (UTR) process prior to the closure of the CI event and provided supervisor-specific training. The health plan implemented oversight through its CHAMPS system, utilizing a report that is generated and reviewed weekly by supervisor. The health plan reported improvement.
To improve CI reporting, continue ongoing oversight and monitoring of the application of the policy requirements for the adult protective services (APS) report of substantiation (ROS).	**Molina sufficiently addressed the recommendation.** Molina updated its CI process. APS ROS members who do not agree to APS services and are UTR remain open for 90 days so that the UTR process is completed each month. The health plan expects to realize improvement from this newly implemented process change.
Ensure internal audit processes focus on review of Measure D6 (*the case manager made timely contact with the enrollee or there is valid justification in the record*), with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**Molina sufficiently addressed the recommendation.** Molina implemented several data capture improvements for key case management team reports and implemented process improvement plans with enhanced performance monitoring requirements for staff members in all key measure areas. The health plan also conducted a retraining of contract requirements for face-to-face visits with all field case management staff. The health plan reported improvement and identified an additional barrier which has now been resolved.
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**Molina sufficiently addressed the recommendation.** Molina implemented several data capture improvements for key case management team reports and implemented process improvement plans with enhanced performance monitoring requirements for staff members in all key measure areas. The health plan reported improvement.

Prior Recommendation	CY 2024 Assessment
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**Molina sufficiently addressed the recommendation.** Molina identified its prior misunderstanding of HFS guidance and updated its annual rights and responsibilities education process to align with requirements. The health plan also updated its abuse, neglect, exploitation education language, conducted internal monitoring, and reported improvement.
Reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**Molina sufficiently addressed the recommendation.** Molina updated its process and retrained staff on signature expectations. The health plan created a process to send providers an additional request for signature. The health plan reported improvement.

YouthCare

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
−	**Opportunity for improvement:** Meridian/YouthCare demonstrated statistically significant decline in Remeasurement 1 for the *Improving Transportation Services* PIP for the YouthCare line of business. **Recommendations:** Meridian/YouthCare should revisit its casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement	
PMV		
+	**Strength:** The health plan demonstrated its knowledge of the systems, processes, and measure reporting through the PMV audit process, as evidenced by submission of auditor-approved Interactive Data Submission System© (IDSS) performance measures data.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** Results of CBH file reviews demonstrated an opportunity for improvement related to timely post-discharge care management activities. **Recommendations:** The health plan should consider process improvements to ensure compliance with contacting the member or a family member within 48 hours of discharge.	
−	**Opportunity for improvement:** Results of the CBH file reviews demonstrated an opportunity for improvement related to timely follow-up appointments. **Recommendations:** The health plan must develop strategies to improve timely access to outpatient mental health appointments for members seeking treatment after a mental health crisis.	
NAV		
+	**Strength:** YouthCare had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** YouthCare had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in YouthCare's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
+	**Strength:** YouthCare met the State's time and distance standards across all public health regions for 17 of 20 provider categories.	
−	**Opportunity for improvement:** YouthCare did not meet the HCI time and distance standards in all counties for pharmacies or oral surgeons serving adult and pediatric populations. This was also identified during the Care Gap Plan review. **Recommendations:** HSAG recommends that YouthCare maintain the current level of access to care and continue to address network gaps for pharmacies, and oral surgery specialists adult and pediatric. The health plan should ensure that it has specific examples of regional barriers/challenges and recruitment strategies to address network gaps for pharmacy and oral surgery providers.	

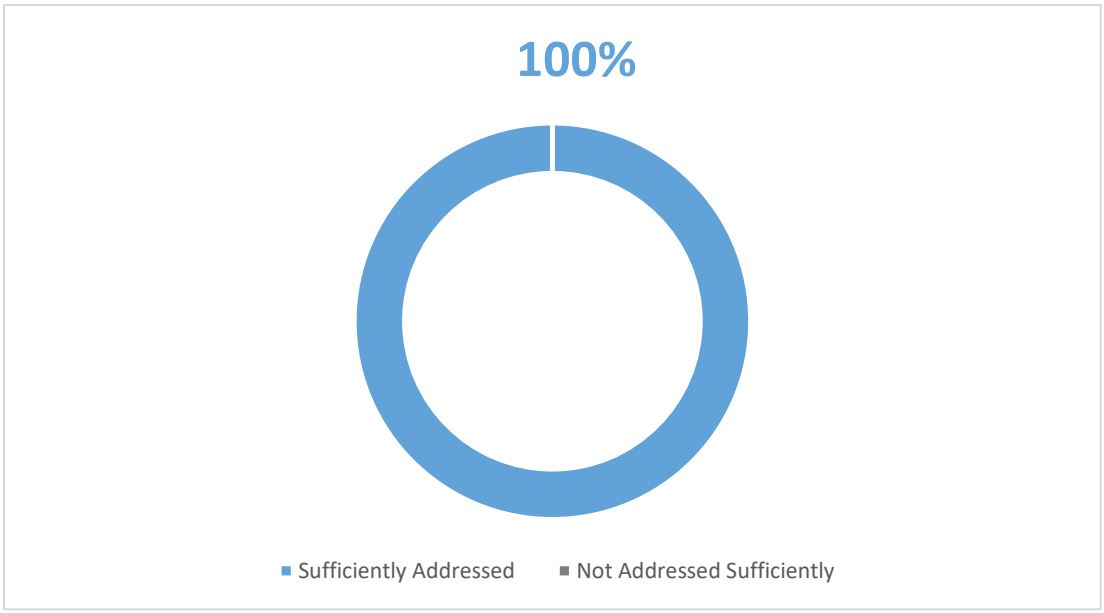
Strength/ Opportunity for Improvement	Description	Domain(s)
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that YouthCare achieved 100 percent compliance for case management supervisor and case manager qualifications and credentials.	
+	**Strength:** Results of the staffing and training review demonstrated that YouthCare was compliant with caseload requirements.	
+	**Strength:** Results of the staffing and training review demonstrated that YouthCare was compliant with all annual training requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
+	**Strength:** In the mental health parity review, the health plan was found *Compliant* based on comparability and stringency.	
+	**Strength:** The health plan achieved 100 percent compliance in the Care Gap Plan review.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the accuracy of behavioral health and prenatal provider data. **Recommendations:** The health plan must address provider data deficiencies identified during the survey calls.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to the availability of appointments for new and existing patients. **Recommendations:** The health plan should conduct a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment and provide insurance acceptance education to provider office staff members.	
−	**Opportunity for improvement:** The access and availability survey results demonstrated that the health plan had an opportunity for improvement related to compliance with appointment availability timeliness standards. **Recommendations:** The health plan should conduct a root cause analysis to identify factors affecting compliance with appointment	

Strength/ Opportunity for Improvement	Description	Domain(s)
	availability standards. Additionally, in coordination with ongoing outreach and network management activities, the health plan should review provider office procedures for ensuring appointment availability standards are being met, address questions or reeducate providers and office staff on HFS standards, and incorporate appointment availability standards into educational materials.	

Follow-Up on Prior Year Recommendations

YouthCare submitted responses to all prior EQR recommendations and HSAG reviewed YouthCare's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities. Figure 10 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 10—Percentage of Prior EQR Recommendations Addressed by YouthCare



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

Table 48—Assessment of YouthCare's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
Work with DCFS and providers on challenges during transitions of care with the providers completing DCFS prior authorization paperwork for prescription drugs.	**YouthCare sufficiently addressed the recommendation.** YouthCare reviewed current procedures, retrained a transition specialist, and assigned care management staff to discuss consent paperwork and status with DCFS and provider before transition. The health plan described that although YouthCare does not complete this task, its transition specialist will begin conducting inquiry with YouthCare pharmacy to verify receipt of consent.
Continue to evaluate care coordination staffing needs to ensure compliance with contractual requirements and continue recruitment efforts to fill the two vacant DCFS liaison positions.	**YouthCare sufficiently addressed the recommendation.** YouthCare launched enhanced recruitment and retention initiatives, hired new care coordinators, and enhanced workflows to address caseload size. The health plan reported all care coordinators are now below caseload threshold.
NAV	
Since the health plans supplied HSAG with the provider data used for the access and availability survey, HFS should supply each health plan with the case-level survey data files and a defined timeline by which each health plan will address provider data deficiencies identified during the survey calls.	**YouthCare sufficiently addressed the recommendation.** YouthCare made an enterprise-wide decision to default to office phone number, and no longer display or house practitioner phone number, which greatly decreased phone errors. The health plan also began using a roster analysis tool to ensure updates are made as received from providers. In addition, the health plan enhanced its partnership with a directory accuracy provider. The health plan reported improvement.
HFS and the health plan should consider conducting a review of the provider offices' requirements to ensure the barriers are not unduly burdening the enrollee's ability to schedule an appointment. The health plan should also investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, conduct a root cause analysis to identify factors affecting compliance with appointment availability standards.	**YouthCare sufficiently addressed the recommendation.** YouthCare conducted provider education on standards via a provider newsletter, provider meetings, and orientation. The health plan also educated providers on telehealth coverage. The health plan reported improvement.

Prior Recommendation	CY 2024 Assessment
Collaborate with HFS to contract with additional oral surgeons, if available, and continue to review oral surgery access standards with the goal of determining whether these failures are due to a lack of providers or due to other reasons such as exclusive contracts, provider unwillingness to contract due to reimbursement rates, or unwillingness to treat Medicaid beneficiaries.	**YouthCare sufficiently addressed the recommendation.** Although there are not available, Medicaid-approved providers accepting YouthCare members in 12 counties, YouthCare's network team conducted monthly monitoring to identify new providers, contracted with general dentists to perform services, and secured single-case agreements as needed. The health plan reported that all members needing oral surgery services received care.
Additional EQR Activities	
Develop a plan to reassign caseloads to those case managers not meeting low risk caseload limits.	**YouthCare sufficiently addressed the recommendation.** YouthCare hired new care coordinators and enhanced workflows to address caseload size. The health plan reported all caseloads were below thresholds.
Review the qualification/education requirements to ensure that only staff members with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to caseload assignment. Staff members without the appropriate qualifications should have those cases reassigned to qualified staff members. The health plan may consider submitting exemption requests to HFS for consideration.	**YouthCare sufficiently addressed the recommendation.** YouthCare reported that findings related to this recommendation were inaccurate and that it ensures staff have adequate qualifications via review of resumes and licensures.
Review its oversight processes to ensure that it is tracking all required trainings and has a process to address outstanding trainings to be completed prior to the end of each CY.	**YouthCare sufficiently addressed the recommendation.** YouthCare launched an improved schedule and cadence of all annual required trainings that enables efficient oversight and launched virtual learning webinars for six of nine required trainings so they can be completed by staff at any time. The health plan reported expected compliance of 100 percent.

MMAI

Aetna

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Aetna achieved a *High Confidence* level for adhering to acceptable methodology for both validation ratings for the *Improving Transportation Services* QIP and demonstrated statistically significant improvement for Remeasurement 1.	
PMV		
+	**Strength:** PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of *Reportable* with high confidence.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	

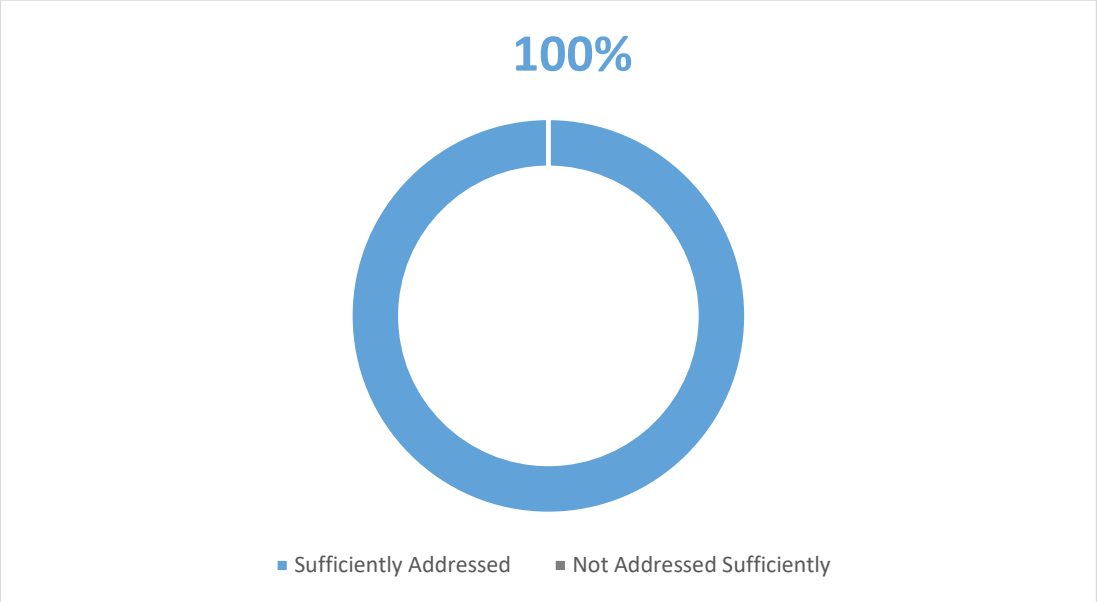
Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength:** Aetna demonstrated a strong process for maintaining provider information through its annual directory validation process.	
+	**Strength:** Aetna had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has high confidence in Aetna's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
−	**Opportunity for improvement:** Aetna did not meet the 100 percent time and distance standard in all counties for nursing facilities. **Recommendations:** HSAG recommends that Aetna maintain current levels of access to care and continue to address network gaps for nursing facilities.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Aetna was compliant with all staffing requirements.	
+	**Strength:** The staffing and training review identified that Aetna was compliant with all training requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
−	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	

Follow-Up on Prior Year Recommendations

Aetna submitted responses to all prior EQR recommendations and HSAG reviewed Aetna's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

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

Figure 11—Percentage of Prior EQR Recommendations Addressed by Aetna



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

Table 50—Assessment of Aetna's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
Aetna's results of the MMAI appeals and grievances file reviews demonstrated opportunities for improvement related to timeliness of decisions and adherence to the HFS Readability Protocol. HSAG recommended that Aetna develop the necessary policies and procedures and operationalized most of the required elements of the MMAI contract.	**Aetna sufficiently addressed the recommendations.** Aetna reported that noncompliance was due to increased case volumes and staff not following protocols. Aetna added new staff, trained all staff on the HFS Readability Protocol, and updated all policies and procedures.

Prior Recommendation	CY 2024 Assessment
Additional EQR Activities	
Review the qualification/education requirements for the BI, ELD, and/or PD waivers to ensure that only staff with those qualifications are assigned waiver caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment.	**Aetna sufficiently addressed the recommendations.** Aetna is now in compliance and reviews all caseload assignments weekly.
Evaluate enrollee contact processes to ensure inclusion of attempts to contact enrollees, or authorized representative, who reside in SLP or LTC facility to ensure mitigation of identified risks prior to closure of the CI. The health plan should evaluate oversight processes to ensure timely completion of enrollee contact following identification of a CI and utilization of the UTR process prior to closure of the CI.	**Aetna sufficiently addressed the recommendations.** Aetna updated its MMAI workflow to include requirements, conducted comprehensive trainings, updated and redistributed job aids, and introduced an embedded form within its EMR system to streamline CI documentation and tracking. Aetna scored 100 percent on the most recent HSAG CI quarterly audit.
Evaluate current CI reporting process and procedures to determine potential improvement in CI reporting template. The health plan should routinely provide training to staff on documentation requirements.	**Aetna sufficiently addressed the recommendations.** Aetna conducted department-wide retraining, one-on-one coaching, and introduced an embedded form within its EMR system to streamline CI documentation and tracking. Aetna scored 100 percent on the most recent HSAG CI quarterly audit.
Reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**Aetna sufficiently addressed the recommendations.** Aetna conducted department-wide retraining, updated documentation templates, and implemented a series of operational dashboard tools to support proactive management and improve oversight.
Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.	**Aetna sufficiently addressed the recommendations.** Aetna conducted exit interviews, reviewed new hire training, created a CM SharePoint to offer clear workflows, conducted department-wide retraining, and implemented a series of operational dashboard tools to support proactive management and improve oversight.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**Aetna sufficiently addressed the recommendations.** Aetna updated forms/tools and rolled them out in Q4 2022, conducted retraining, and added language to the consent form used during interval visits which is now audited monthly.

BCBSIL

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** BCBSIL achieved a *High Confidence* level for adhering to acceptable methodology for both validation ratings for the *Improving Transportation Services* QIP and demonstrated statistically significant improvement for Remeasurement 1.	
PMV		
+	**Strength:** PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of *Reportable* with high confidence.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	

Strength/ Opportunity for Improvement	Description	Domain(s)
NAV		
+	**Strength:** BCBSIL had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** BCBSIL had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks. HSAG has high confidence in BCBSIL's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
−	**Opportunity for improvement:** BCBSIL did not meet the 100 percent time and distance standard in all counties for nursing facilities. **Recommendations:** HSAG recommends that BCBSIL maintain current levels of access to care and continue to address network gaps for nursing facilities.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that BCBSIL was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that BCBSIL was compliant with all requirements for waiver case managers.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
−	**Opportunity for improvement:** Results of the staffing and training review identified that the health plan had an opportunity to ensure its case managers complete annual training requirements. **Recommendations:** The health plan should ensure that all case managers receive required trainings by the end of CY 2024.	
−	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting.	

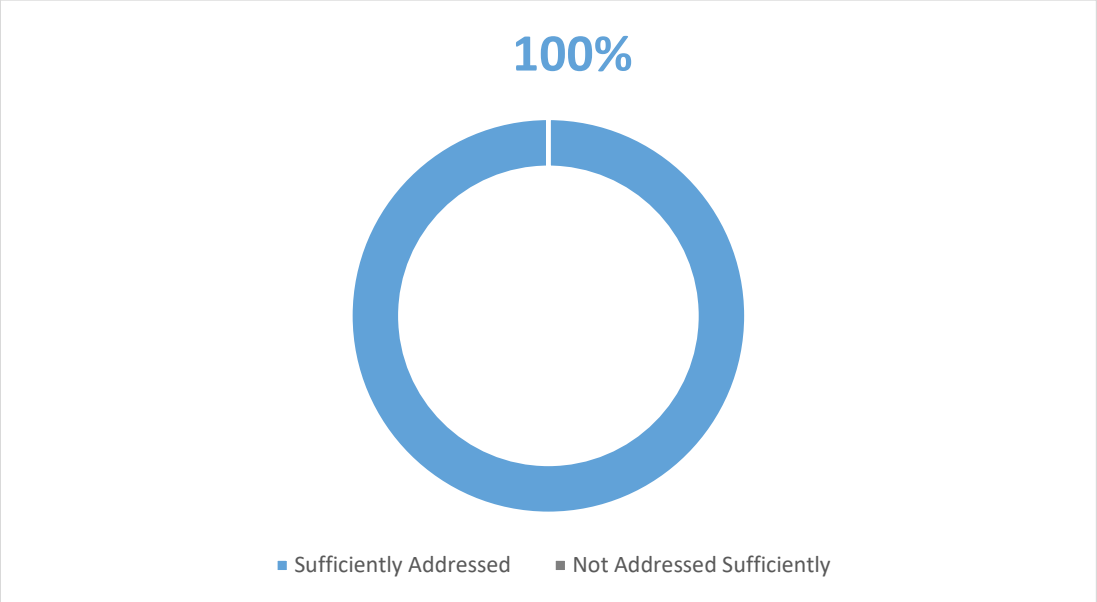
Strength/ Opportunity for Improvement	Description	Domain(s)
	Recommendations: The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	
–	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure, and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

BCBSIL submitted responses to all prior EQR recommendations and HSAG reviewed BCBSIL's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

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

Figure 12—Percentage of Prior EQR Recommendations Addressed by BCBSIL



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

Table 52—Assessment of BCBSIL's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
Continue to evaluate opportunities for compliance to HFS' readability protocol.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL's compliance team provided the grievance and appeals team with a process and procedures to meet protocol for the readability audit. The health plan noted modest performance improvement.
Additional EQR Activities	
Review the qualification/education requirements for the MMAI waiver staff and develop a plan to ensure that only staff meeting requirements are assigned waiver caseloads.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL described a revised process for documenting education requirements, monthly caseload review, and staff training. The health plan reported improvement as it received no findings in the most recent staffing review.
Continue ongoing oversight and monitoring of timely internal reporting and continued re-education when identified delay in reporting by CI team.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL retrained all care coordination staff in June 2024. The health plan described a monitoring process that identifies when staff fail to follow the process and provides individual coaching and re-training. The health

Prior Recommendation	CY 2024 Assessment
	plan implemented a new initiative to provide "CI office hours" and continued to provide weekly CI tips to staff based on gaps or opportunities identified. The health plan also developed a more focused audit process.
Continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL retrained all care coordination staff in June 2024. The health plan described a monitoring process that identifies when staff fail to follow the process and provides individual coaching and re-training. The health plan described a revised case manager reminder process that is monitored by managers to ensure compliance.
Reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**BCBSIL sufficiently addressed the recommendation.** BCBSIL reeducated care coordination staff, implemented a new initiative to target seven SLPs with high census and low signature compliance, and implemented a member voice signature within the CM platform. The health plan reported improved performance.
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL developed a unit manager oversight process to conduct in-depth review of care coordination reports. Unit managers perform live audits and peer-to-peer discussions about findings. The health plan reported improved performance.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL revised the member checklist to include unexplained death and conducted continued education to ensure care coordination staff were aware of the updated checklist and how to discuss with members. The health plan reported improved performance.
Conduct staff training to ensure understanding of HFS' guidance specific to management of enrollees during the unwinding of the PHE, including timelines for resuming face-to-face enrollee contacts and valid justification when contact is not completed as required.	**BCBSIL sufficiently addressed the recommendation.** BCBSIL reeducated care coordination staff on a quarterly basis on the use of valid justification along with the use of activity code setting with reminders when member visits are coming due. The health plan also implemented a new report to aid identification and improvement. The health plan reported improved performance.

Humana

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Humana achieved a *High Confidence* level for adhering to acceptable methodology for both validation ratings for the *Improving Transportation Services* QIP and demonstrated statistically significant improvement for Remeasurement 1.	
PMV		
+	**Strength:** Humana demonstrated its knowledge of the systems, processes, and measure reporting through the PMV audit process.	
+	**Strength:** PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of *Reportable* with high confidence.	
−	**Opportunity for improvement:** During the virtual review, HSAG was unable to confirm numerator compliance for case #3 for the *Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment* sub-rate and requested a root cause analysis of the issue. For this case, Humana indicated that both an administrative claim and supplemental claim were submitted to Humana for the same encounter with two differing provider numbers (individual NPI number on the supplemental claim and facility/center provider number on the administrative claim). Cotiviti's certified logic looked for several criteria to determine the same visit with a different provider, including provider number. An additional 14 cases were identified by Humana as being impacted by the same issue. Due to the differing provider numbers, some cases were erroneously counted toward numerator compliance. **Recommendations:** Even though Humana identified a manual process to correct the issue for MY 2023, HSAG recommends	

Strength/ Opportunity for Improvement	Description	Domain(s)
	further analysis to identify a permanent solution that does not involve a manual fix during future MYs.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 97 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** The compliance review identified that the MMP had an opportunity for improvement related to enrollee engagement in review of enrollee materials. **Recommendations:** The MMP should consider using its Consumer Advisory Committee or Community Stakeholder Committee meetings to solicit feedback from stakeholders about enrollee materials.	
−	**Opportunity for improvement:** The compliance review identified an opportunity for effective oversight and monitoring to ensure accurate identification of State and federal requirements within its policies and procedures. **Recommendations:** The MMP must establish procedures for monitoring appointment availability requirements. The procedures must cover all contractually required appointment standards.	
NAV		
+	**Strength:** Humana demonstrated a strong process for maintaining updated and complete provider data through its monthly validation activities.	
+	**Strength:** Humana demonstrated strong methodologies for monitoring network adequacy in accordance with State standards.	

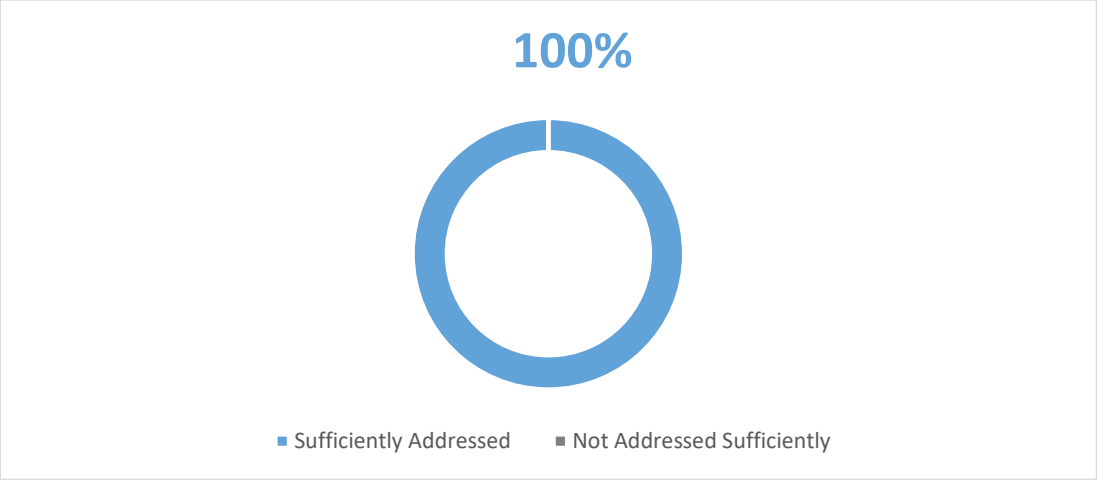
Strength/ Opportunity for Improvement	Description	Domain(s)
−	**Opportunity for improvement:** Humana did not meet the MMAI standard for nursing facilities in all counties. **Recommendations:** HSAG recommends that Humana maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Humana was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that Humana was compliant with all requirements for waiver case managers.	
+	**Strength:** The staffing and training review identified that Humana was compliant with all requirements for annual training of case managers.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	

Follow-Up on Prior Year Recommendations

Humana submitted responses to all prior EQR recommendations and HSAG reviewed Humana's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

Figure 13 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 13—Percentage of Prior EQR Recommendations Addressed by Humana



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

Table 54—Assessment of Humana's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Additional EQR Activities	
Continue ongoing oversight and monitoring of timely internal CI reporting from date of CI identification. Humana should provide education to staff members who are identified with delay in CI reporting.	**Humana sufficiently addressed the recommendation.** Humana implemented a monthly turnaround time report and conducted full care team CI refresher training sessions every six months. Humana noted a reduction in missed reporting requirements.
Continue ongoing oversight and monitoring of the application of the APS ROS process policy and ongoing education.	**Humana sufficiently addressed the recommendation.** Humana conducted full care team CI refresher training sessions every six months that emphasized APS outreach.
Continue ongoing oversight and monitoring of the application internal UTR process prior to closure of the CI event.	**Humana sufficiently addressed the recommendation.** Humana conducted full care team CI refresher training sessions every six months and conducted oversight and monitoring of staff UTR timeliness and process standards.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. Humana should educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**Humana sufficiently addressed the recommendation.** Humana added unexplained death to the attestation section of the plan of care and noted improvement.

Prior Recommendation	CY 2024 Assessment
Ensure that documentation of service plan renewals for those enrollees without face-to-face in-home visits includes required documentation of witnessed verbal consent. Humana should reeducate care managers on HFS' expectations to ensure signatures, and dates of signatures, are documented on the service plan for the enrollee (or representative) and SLP provider (if applicable).	**Humana sufficiently addressed the recommendation.** Humana provided additional education to care coordinators on the signature requirements and added a designated signature line to the SLP service plan.

Meridian

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

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

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

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
+	**Strength:** Meridian achieved a *High Confidence* level for adhering to acceptable methodology for both validation ratings for the *Improving Transportation Services* QIP.	
−	**Opportunity for improvement:** Meridian demonstrated statistically significant decline for Remeasurement 1 for the *Improving Transportation Services* QIP. **Recommendations:** Meridian should revisit their casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
PMV		
+	**Strength:** PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of *Reportable* with high confidence.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
NAV		
+	**Strength:** Meridian had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** Meridian had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in Meridian's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
−	**Opportunity for improvement:** Meridian did not meet the MMAI standard for nursing facilities in all counties. **Recommendations:** HSAG recommends that Meridian maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Meridian was compliant with all caseload requirements.	
+	**Strength:** The staffing and training review identified that Meridian was compliant with all requirements for waiver case managers.	
+	**Strength:** The staffing and training review identified that Meridian was compliant with all training requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
−	**Opportunity for improvement:** Although the CI reviews identified that the health plan demonstrated effective reporting to the	

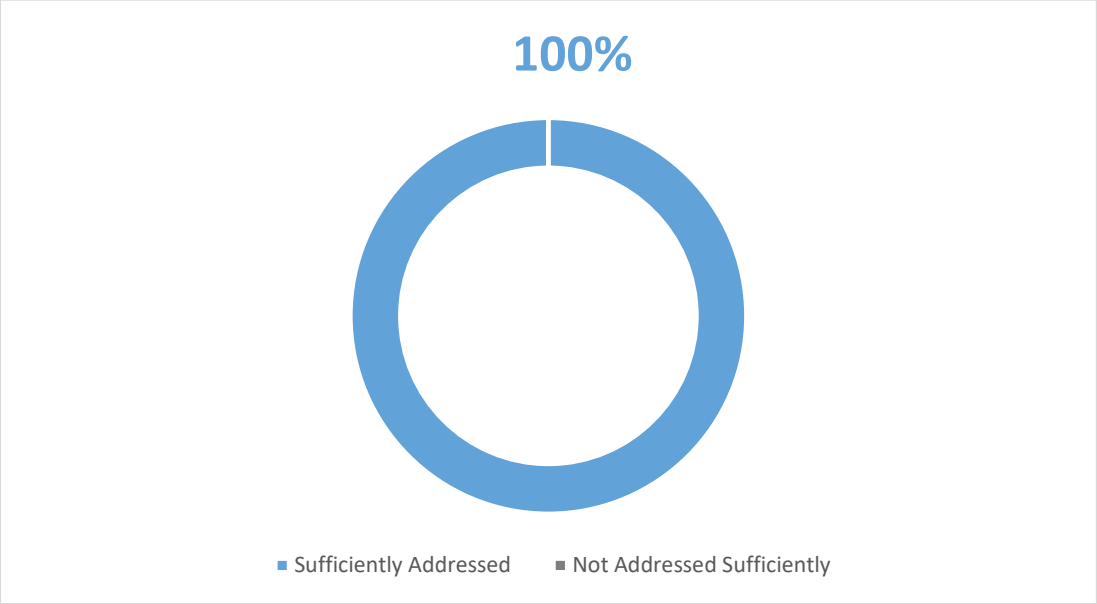
Strength/ Opportunity for Improvement	Description	Domain(s)
	appropriate investigating authority, file reviews identified an opportunity for improvement related to the timeliness of reporting. **Recommendations:** The health plan should ensure that staff members are educated on timely reporting and that oversight procedures examine compliance to timeliness of reporting.	
−	**Opportunity for improvement:** Results of the HCBS waiver reviews identified an opportunity for improvement related to Measure D6, *the case manager made timely contact with the enrollee or there is valid justification in the record*. **Recommendations:** The health plan should consider the EQRO's recommendations, including conducting root cause analysis to determine opportunities to effect change, especially for the PD and ELD waiver members; conducting staff training to ensure understanding of contact requirements for all waiver types and of HFS guidance for valid enrollee contact and valid justification when contact is not completed as required; ensuring internal audit processes focus on review of this measure; and considering system enhancements to alert care managers/care coordinators of time frames to contact beneficiaries.	

Follow-Up on Prior Year Recommendations

Meridian submitted responses to all prior EQR recommendations and HSAG reviewed Meridian's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

Figure 14 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG during the in the prior technical report.

Figure 14—Percentage of Prior EQR Recommendations Addressed by Meridian



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

Table 56—Assessment of Meridian's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Additional EQR Activities	
Ensure internal audit processes focus on review of Measure D7, *the most recent service plan is in the record and completed in a timely manner*, with immediate feedback and discussion with care managers/care coordinators to identify opportunities for improvement.	**Meridian sufficiently addressed the recommendation.** Meridian described continued initiatives and reported improvement including quarterly trainings with LTSS staff and utilizing a daily dashboard to track completion and conduct monitoring and oversight. Meridian reported scores above 90 percent for Q1 and Q2.
Revise enrollee education attestation forms/tools to ensure that documentation of education on how to report unexplained death is captured. The health plan should also educate care managers on expectations for enrollee/authorized representative education of reporting an unexplained death.	**Meridian sufficiently addressed the recommendation.** Meridian conducted staff training and updated its annual forms. The updated process is included in quarterly training and is reviewed during internal audits. The health plan reported notable improvement.

Molina

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

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

Table 57—Molina's Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Opportunity for Improvement	Description	Domain(s)
PIPs		
−	**Opportunity for improvement:** Molina was assigned a *Low Confidence* level for adhering to acceptable QIP methodology for *the Improving Transportation Services* QIP and failed to achieve statistically significant improvement for Remeasurement 1. **Recommendations:** Molina should revisit their casual barrier analysis to determine why improvement was not achieved and develop new, active interventions to target the lack of significant improvement.	
PMV		
+	**Strength:** PMV of the state-specific IL 3.6 measure revealed no concerns related to assignment of members to the correct reporting elements and resulted in a rating of *Reportable* with high confidence.	
Compliance with Standards		
+	**Strength:** The health plan's policies and procedures were generally compliant with contract requirements, and interviews demonstrated that health plan staff were generally knowledgeable about the requirements, policies, and procedures.	
+	**Strength:** The health plan demonstrated compliance with access requirements as evidenced by a final overall domain score of 100 percent.	
+	**Strength:** The health plan demonstrated compliance with structure and operations requirements as evidenced by a final overall domain score of 100 percent.	

Strength/ Opportunity for Improvement	Description	Domain(s)
+	**Strength:** The health plan demonstrated compliance with measurement and improvement requirements as evidenced by a final overall domain score of 100 percent.	
−	**Opportunity for improvement:** HSAG identified that the health plan had an opportunity for improvement related to standardized language in its policies and procedures. **Recommendations:** The health plan must implement oversight and monitoring procedures to ensure accurate identification of State and federal requirements within its policies and procedures.	
NAV		
+	**Strength:** Molina had established and robust processes in place for maintaining enrollee and provider information by conducting routine internal auditing activities to ensure the accuracy and completeness of enrollee and provider records.	
+	**Strength:** Molina had sufficient policies and procedures in place to ensure that it used sound methods to assess the adequacy of its managed care networks as required by the State. HSAG has high confidence in Molina's ability to produce accurate results to support its own and the State's network adequacy monitoring efforts.	
−	**Opportunity for improvement:** Molina did not meet the MMAI standard for nursing facilities in all counties. **Recommendations:** HSAG recommends that Molina maintain the current level of access to care and continue to address network gaps for nursing facilities for MMAI enrollees.	
Additional EQR Activities		
+	**Strength:** The staffing and training review identified that Molina was compliant with all caseload requirements.	
+	**Strength:** The CI monitoring review identified that the health plan had an effective system to identify, report, and manage CI events.	
+	**Strength:** For the HCBS waiver reviews, the health plan performed at over 90 percent compliance overall and achieved a statistically significant increase in overall performance when compared to CY 2023.	
+	**Strength:** Results of the QA/UR/PR review showed that the health plan achieved a performance score of 100 percent and demonstrated full compliance with general requirements.	
−	**Opportunity for improvement:** Results of the staffing and training review identified that the health plan had an opportunity for	

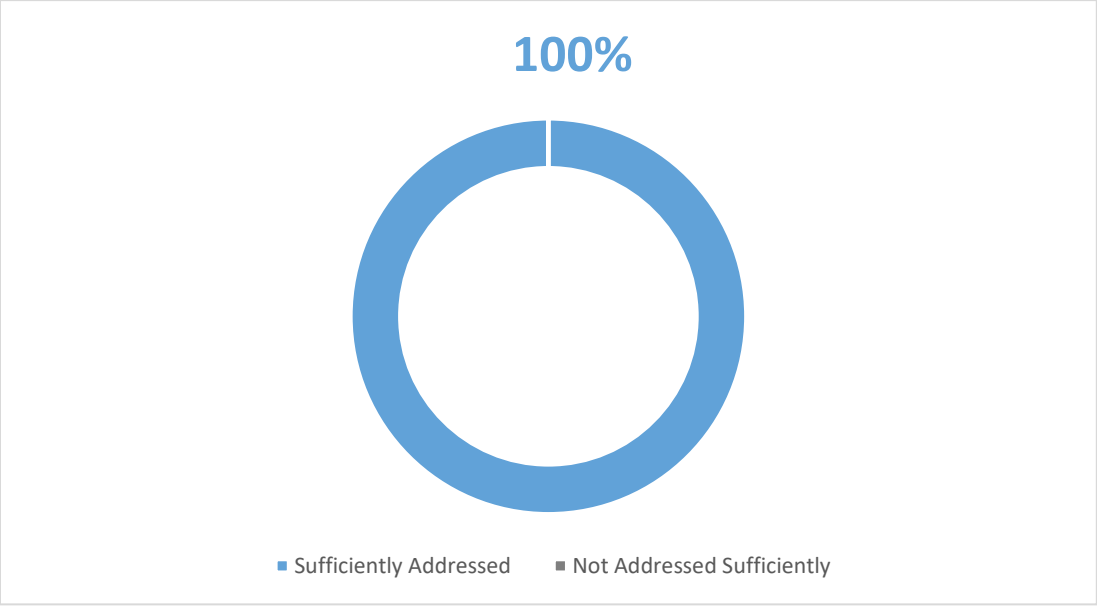
Strength/ Opportunity for Improvement	Description	Domain(s)
	improvement related to ensuring qualification and education requirements were met for its HCBS waiver case managers. **Recommendations:** The health plan should review the qualification/education requirements for the HCBS waivers to ensure that only staff with those qualifications are assigned caseloads and develop a plan to ensure that qualifications are reviewed prior to waiver caseload assignment. Staff without the appropriate qualifications should have those cases reassigned to qualified staff. The health plan may consider submitting exemption requests to HFS for consideration.	

Follow-Up on Prior Year Recommendations

Molina submitted responses to all prior EQR recommendations and HSAG reviewed Molina's approach to addressing the recommendations and/or findings issued in the prior technical report while conducting the CY 2024 EQR activities.

Figure 15 illustrates the degree in which the health plan sufficiently addressed the recommendations for QI made by HSAG in the prior technical report.

Figure 15—Percentage of Prior EQR Recommendations Addressed by Molina



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

Table 58—Assessment of Molina's Approach to Addressing Previous Annual Recommendations

Prior Recommendation	CY 2024 Assessment
Compliance with Standards	
Continue case management system upgrades to ensure visible initial risk stratification.	**Molina sufficiently addressed the recommendation.** Molina identified a modification to its care management software to add a risk stratification level that allows staff to view the risk level of each member. The health plan anticipates improvement will be verified in subsequent file review.
Distribute and conduct training on the HFS Readability Protocol for all staff members responsible for developing and auditing Illinois-specific enrollee written materials to ensure compliance with a sixth-grade reading level.	**Molina sufficiently addressed the recommendation.** Molina trained all medical directors and distributed the protocol. The health plan also audited a sample of cases for each medical director on a monthly basis to evaluate compliance. The health plan reported improvement.
Additional EQR Activities	
Molina performed at a statistically significantly lower rate than all other health plans in the HCBS waiver measures. The health plan should consider reviewing its oversight processes to identify improvements to impact performance.	**Molina sufficiently addressed the recommendation.** Molina identified staffing constraints and leadership changes that attributed to the opportunity for improvement and implemented oversight, monitoring metrics, and monthly chart audits; hired additional staff; and reorganized leadership. The health plan reported improved compliance and completion rates.

PIP/QIP

Objective

As part of the State's Quality Strategy, each health plan is required to conduct PIPs/QIPs in accordance with 42 CFR §438.330(b)(1) and §438.330(d)(2)(i–iv). As one of the mandatory EQR activities required under the BBA, HSAG, as the State's EQRO, validated the PIPs/QIPs through an independent review process. To ensure methodological soundness while meeting all State and federal requirements, HSAG used CMS' publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity* (CMS Protocol 1), February 2023.[34]

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

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

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

Approach to PIP/QIP Validation

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

Table 59—CMS EQR Protocol 1 Steps

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

[34] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 4, 2025.

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

Validation Scoring

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

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

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

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

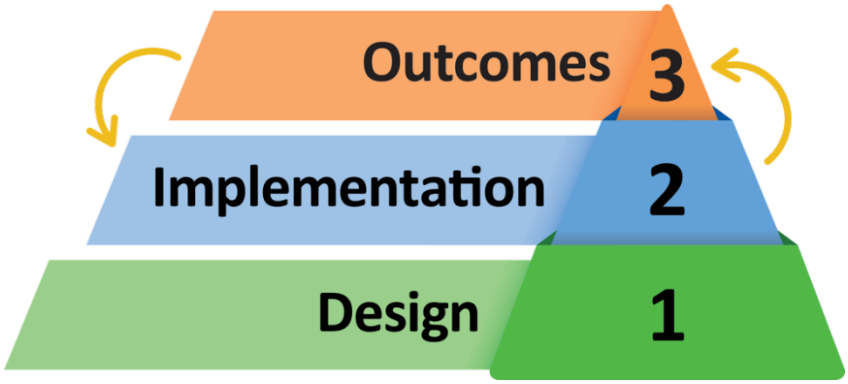
- *No Confidence*: No confidence in reported PIP/QIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

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

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

Figure 16 illustrates the three stages of the PIP/QIP process—i.e., Design, Implementation, and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage (Steps 1–6) establishes the methodological framework for the PIP/QIP. The steps in this section include development of the PIP/QIP topic, Aim statement, population, sampling methods, performance indicators, and data collection. To implement successful improvement strategies, a methodologically sound PIP/QIP design is necessary.

Figure 16—Stages of the PIP Process



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

HEDIS Compliance Audits

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 2023 data. HFS contracted with HSAG to conduct an audit for each HealthChoice Illinois health plan. HSAG adhered to NCQA's *HEDIS Measurement Year 2023, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*, which outlines the accepted approach for auditors to use when conducting an 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 Meetings*, 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 (December 2023 through March 2024)

- Forwarded HEDIS MY 2023 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 which listed outstanding items and areas that required additional clarification.
- 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.

Audit Review Phase (January 2024 Through April 2024)

- 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 2024 Through July 2024)

- 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.
- 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 2023 Audit Means and Percentiles. The report also included requests for clarification on any notable changes in rates, eligible populations, and measures with rates that remained the same from year to year.
- Approved the final rates and assigned a final, audited result to each selected measure.
- Produced and provided final audit reports containing a summary of all audit activities.

Description of Data Obtained

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

- HEDIS Roadmap.
- Supporting documentation such as file layouts, system flow diagrams, system log files, and policies and procedures.

- Re-abstraction 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 as well as through 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. For measures that had administrative (admin) and hybrid specifications, HFS allowed the health plans to choose the data collection methodology (i.e., admin or hybrid) that worked best for its health plan.

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 2023 Roadmap, published by NCQA as Appendix 2 to NCQA's *HEDIS Measurement Year 2023, 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, computer database and file structure review, and discussion and feedback sessions.
- 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 2023 (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 60.

Table 60—Performance Measure Audit Results and Definitions

Rate/Result	Definition
R	*Reportable.* A reportable rate was submitted for the measure.
NR	*Not Reported*. The health plan chose not to report the measure.
*NA**	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (e.g., < 30) to report a valid rate. a. For Effectiveness of Care (EOC) and EOC-like measures, when the denominator is < 30. b. For utilization measures that count member months, when the denominator is < 360 member months. c. For all risk-adjusted utilization measures, when the denominator is < 150. d. For electronic clinical data systems measures, when the denominator is < 30.
*NB***	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.
*NQ****	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The health plan chose to report a measure that is not required to be audited. This result only 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 an error that causes a deviation of more than 5 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 *PPC*). 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, 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.

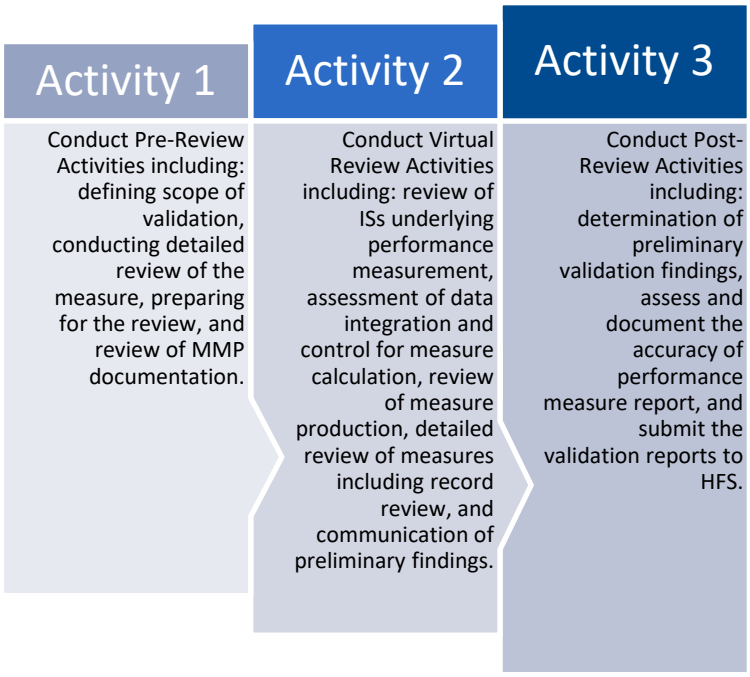
HSAG completed the MRRV component of the audit and provided an assessment of each health plan's medical record abstraction accuracy.

PMV

HSAG validated the data collection and reporting processes the HealthChoice plans and Humana used to report the performance measure data for MY 2023 (January 1, 2023, through December 31, 2023) in accordance with CMS' Protocol 2 cited earlier in this report[35]. Figure 17 presents the protocol activities conducted.

[35] YouthCare PMV was conducted by its independent LO.

Figure 17—Protocol 2 Activities



NCQA,[36] CMS, and HFS provided the specifications and supplemental guidance that the HealthChoice plans and Humana were required to use for reporting the performance measures, and which HSAG utilized to define the scope of the validation.

The following list describes the types of documentation and data collected and how HSAG conducted analysis of data:

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

[36] National Committee for Quality Assurance. HEDIS Measures and Technical Resources. Available at: https://www.ncqa.org/hedis/measures/ Accessed on: Feb 4, 2025.

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

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

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

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

Network Adequacy Validation

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Virtual Review Validation Activities

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

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

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

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

Network Adequacy Indicator Validation Rating Determinations

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

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the health plan used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table 61.

Table 61—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. The overall validation rating refers to HSAG's overall confidence that the health plan used acceptable methodology for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, as shown in Table 62. HSAG assigns a rating once it has calculated the validation score for each indicator.

Table 62—Indicator-Level Validation Rating Categories

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

Table 63 and Table 64 present example validation rating determinations. Table 63 presents an example of a validation rating determination based solely on the validation score, as there were no *Not Met* elements that were determined to have significant bias on the results, whereas Table 64 presents an example of a validation rating determination that includes a *Not Met* element that had significant bias on the results.

Table 63—Example Validation Rating Determination—No Significant Bias

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

Table 64—Example Validation Rating Determination—Includes Significant Bias

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

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

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

Network Monitoring

Access and Availability Survey

Eligible Population

The eligible population included behavioral health and prenatal care locations in a DIA ZIP Code that were actively enrolled in the Illinois Medicaid program as of February 23, 2024, when the provider network files were submitted.

Data Collection

HSAG received provider data files from the health plans on approximately February 23, 2024. Health plan data included the following minimum data elements for each provider's location: demographic information (e.g., provider name, address, phone number, Medicaid ID), provider type (e.g., behavioral health, prenatal care), county location, contract status, appropriate provider directory inclusion, and panel information (i.e., open or closed). Upon receipt of the data, HSAG reviewed the address and telephone number information to assess potential duplication and completeness of key data fields.

To minimize duplicated provider records between the health plans, HSAG standardized the providers' address data to align with the United States Postal Service (USPS) Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population.

Case Identification Approach

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

addresses within a health plan, HSAG randomly assigned the number to a single plan and standardized address, prioritizing assignment to the least-represented plans. HSAG selected a statistically valid number of provider locations based on a 95 percent confidence interval and ±5 percent margin of error. A 25 percent oversample was included to increase the probability of capturing appointment availability information from a statistically valid number of service locations.

Telephone Survey Process

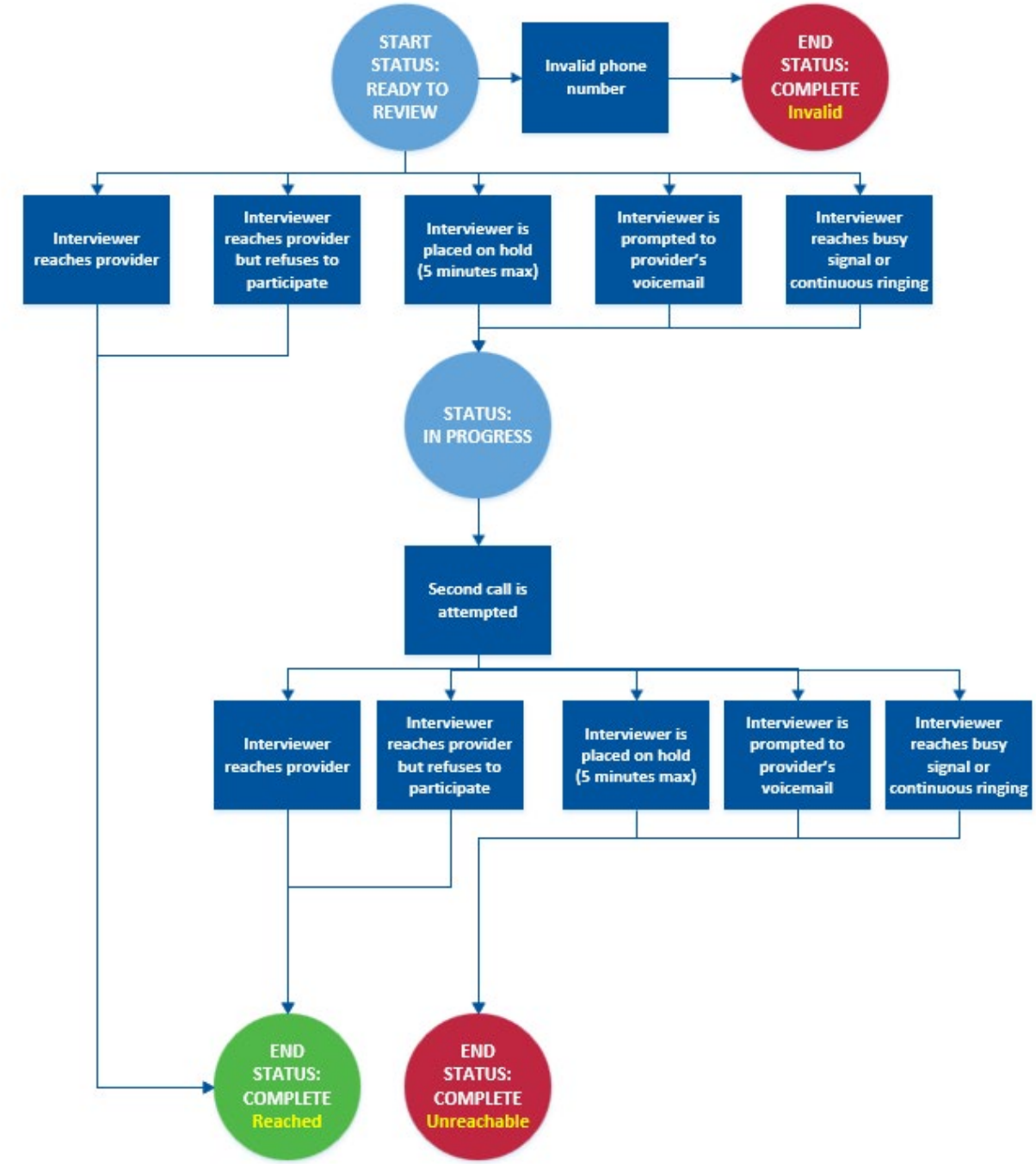
HSAG conducted the survey during March and April 2024. Survey calls requested appointment availability with the sampled health plans for the sampled location. Since HSAG revealed the interviewer's identity to the provider's office, interviewers used the same HFS-approved script for all survey calls.

During the survey, interviewers attempted up to two calls to each sampled case during standard operating hours (i.e., 9:00 a.m.–5:00 p.m. Central Time).[37] Interviewers who were put on hold at any point during the call waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the interviewer made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

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

[37] HSAG does not consider a call attempted when the interviewer reaches an office outside of the office's usual business hours. For example, if the interviewer reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. Interviewers attempted to contact the office up to two times outside of the known lunch hour.

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



Survey Indicators

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

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's identification as offering services for the designated provider specialty category
- Accuracy of accepting Medicaid
- Affiliation with the requested health plan

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

- Information concerning whether the provider location is accepting new patients
- Next available behavioral health or prenatal care appointment date with any practitioner at the sampled location for a new and existing patient
- Any limitations to accepting new patients or scheduling an appointment. Limitations include, but are not limited to, the following:
  - Location requires a review of the member's medical records prior to offering an appointment
  - Location requires registration with the practice prior to offering an appointment
  - Location requires verification of the member's Medicaid eligibility prior to offering an appointment

Study Limitations

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

- Survey calls were conducted at least four weeks following HSAG's receipt of each health plan's provider data, resulting in the possibility that provider locations updated their contact information with the health plan prior to HSAG's survey calls.
- Time to the first available appointment is based on appointments requested with the sampled provider location. Cases were counted as being unable to offer an appointment if the case offered an appointment at a different location. As such, survey results may underrepresent timely appointments for situations in which Medicaid enrollees are willing to travel to an alternate location.

- Survey findings were compiled from self-reported responses supplied to HSAG's interviewers by provider office personnel. As such, survey responses may vary from information obtained at other times or using other methods of communication. The survey script did not address specific clinical conditions that may have resulted in more timely appointments or greater availability of services (e.g., a patient with a time-sensitive health condition or a referral from another provider).
- Health plans are responsible for ensuring that enrollees have access to a provider within the contract standards, rather than requiring that each individual provider offer appointments within the defined time frames. As such, a lack of compliance with appointment availability standards by individual provider locations should be considered in the context of the health plans' processes for aiding enrollees who require timely appointments.
- Since this survey required interviewers to indicate that they were conducting a survey on behalf of HFS, responses may not accurately reflect an enrollee's experience when seeking an appointment. Of note, 1.4 percent of the sampled locations declined to participate in the survey (i.e., considered a refusal), an outcome that may differ for prospective patients.

Time and Distance Study

Study Population

The study population for the time and distance study consisted of all HealthChoice Illinois Medicaid Managed Care Program providers contracted and loaded in the health plan database submitted by the health plans. One time and distance standard applicable to the MMAI plans was also included, as indicated in Table 65. The provider data included all providers active as of the second quarter of 2024. Provider categories for inclusion in the report have been chosen in collaboration with HFS based on available HealthChoice Illinois Managed Care program contract standards and are guided by definitions contained in the Provider Network Data Submission Instruction Manual.[38] Provider categories are shown in Table 65, as are the enrollee populations for the analyses.

Table 65—Provider Categories

Provider Type	Enrollee Population
PCPs*	Adult and Pediatric
Behavioral Health Service Providers**	Adult and Pediatric
OB/GYN Providers	Adult
Dental Providers	Pediatric
Specialty Providers	
Allergy and Immunology	Adult and Pediatric
Endocrinology	Adult and Pediatric
Neurosurgery	Adult and Pediatric

[38] HFS Provider Network Data Submission Instruction Manual, April 2022, Version 3.0.

Provider Type	Enrollee Population
Oral Surgery	Adult and Pediatric
Pulmonology	Adult and Pediatric
Audiology	Adult and Pediatric
Facilities	
Hospitals	All
Pharmacies	All
Skilled Nursing Facilities	MMAI population (Dual Eligibles)

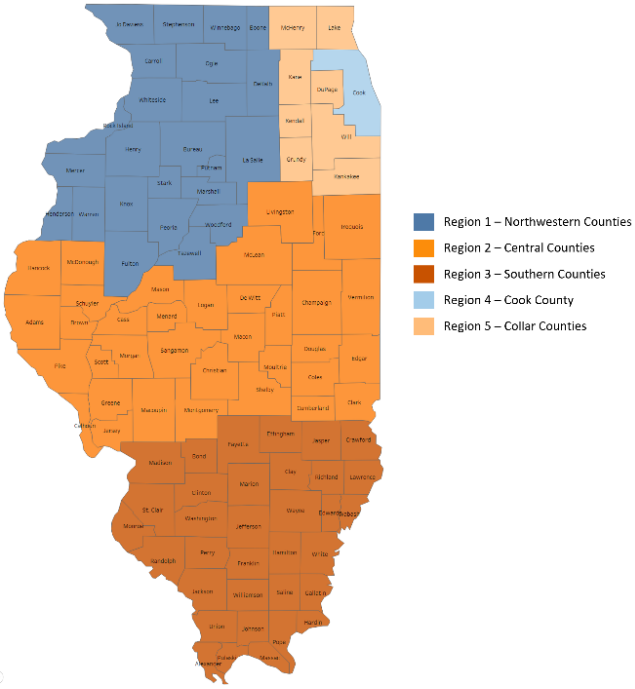
* PCPs: Adult PCPs include Family Practice, General Practice, Internal Medicine, Nurse Practitioners, Physician Assistants. Pediatric PCPs include Pediatric Medicine, Pediatric Nurse Practitioners, Pediatric Physician Assistants.

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

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

Figure D-18 illustrates Illinois' healthcare regions. Each health plan's results are stratified by region in the main body of the report.

Figure D-18—Illinois Healthcare Regions



Study Indicators

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

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

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

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

Stratification and Targeting of Results

As in the time and distance analyses performed for HFS in previous years, for 2024, HSAG stratified these analyses by race, ethnicity, age, and sex, and highlighted results for ZIP Codes that qualify as DIAs as identified by the Illinois Department of Commerce & Economic Opportunity (DCEO).[39]

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

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

For DIAs, the following targeted analyses were performed:

- The percentage of enrollees living in DIA ZIP Codes with network access as defined by the time and distance standards by region.

[39] Illinois Department of Commerce & Economic Opportunity. *Zip Codes that Qualify as Disproportionately Impacted Areas for the Illinois Back to Business (B2B) Grant Program*. Available at: https://dceo.illinois.gov/content/dam/soi/en/web/dceo/smallbizassistance/documents/diazipcodelist.pdf. Accessed on: Feb 4, 2025.

Interactive Dashboards

The data sources and indicators listed above were incorporated into the Tableau dashboards. HSAG refreshed the interactive dashboards created in previous years to facilitate data exploration using Tableau software. The dashboards include:

- Interactive color-coded maps showing the results of the time and distance analysis for a specified plan, region, urbanicity, and provider type by county.
- Interactive tables with detailed information on health plan network performance relative to time and distance standards at the county level for a specified plan, county, urbanicity, and provider type.
- Health equity dashboards displaying comparable information stratified by race, ethnicity, age, and sex at the county level and DIA status at the ZIP Code level.
- Interactive tables with average time (in minutes) and distance (in miles) to the three nearest providers for a specified plan, county, and provider type.
- The capacity to download results of the time and distance and health equity analyses in Microsoft Excel files.

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.[40] Results for all five health plans were provided to HSAG for analysis. For the statewide Illinois Medicaid (i.e., children covered under Title XIX) and All Kids (i.e., children covered under Title XXI/CHIP) programs and the SNC populations, 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. Under the Statewide Survey, a statewide sample of child members enrolled in the All Kids and

[40] In 2022, 2023, and 2024, the Center for the Study of Services (CSS) administered the CAHPS surveys on behalf of Aetna. In 2022 and 2023, SPH Analytics administered the CAHPS surveys on behalf of BCBSIL, CountyCare, Meridian, and Molina. In 2024, Press Ganey administered the CAHPS surveys on behalf of BCBSIL, CountyCare, Meridian, and Molina.

Illinois Medicaid programs were surveyed.[41] Under the SNC Survey, children served by a HealthChoice Illinois health plan in the SNC population and FYiC were surveyed.

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

Overview

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

Technical Methods of Data Collection and Analysis

HealthChoice Health Plans

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

All Kids and Illinois Medicaid Statewide and SNC Surveys

The technical method of data collection was through the administration of the CAHPS 5.1 Child Medicaid Survey with the CCC measurement set to a statewide sample of the child population enrolled in each program/SNC plan. 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/SNC plan. A standard mixed-mode methodology for data collection was used, which included mail, web, and telephone surveys for data collection, with the option to complete the survey in English and Spanish.

Survey Measures for CAHPS

The survey questions were categorized into measures of experience. The global ratings reflected members' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite measures were derived from sets of questions to address different aspects of care (e.g., getting needed care

[41] The Illinois statewide program aggregate results presented in this report represent the results of the All Kids and Illinois Medicaid programs combined.

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

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

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

For each of the CCC composites and items for the CCC population, the percentage of respondents who chose a positive response was calculated. CAHPS CCC composite measure/item question response choices fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always" or (2) "No" and "Yes." For three of the CCC composite measures/items (*Access to Specialized Services*, *Access to Prescription Medicines*, and *Family-Centered Care* (*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 2024 top-box scores were compared to their corresponding 2023 scores to determine whether there were statistically significant differences. Statistically significant differences between the 2024 top-box scores and the 2023 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2024 than 2023 are noted with black upward triangles (▲). Scores that were statistically significantly lower in 2024 than 2023 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 2024 top-box scores were compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data and the resulting 2023 top-box scores were compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data.[42,43] 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 66.

Table 66—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

[42] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA. September 2024.

[43] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA. September 2023.

Appendix B. PIP Aim Statements and Interventions

Aim Statements

Table 67—PIP Aim Statements

Health Plan	Aim Statement
***Improving Timeliness of Prenatal Care* PIP**	
Aetna	Do targeted interventions increase the percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date, or within 42 days of enrollment into the health plan?
BCBSIL	Does performing targeted outreach to pregnant women within the first trimester or within 42 days of enrollment with BCBSIL increase the HEDIS *Timeliness of Prenatal Care* annual results?
CountyCare	Improved care coordination processes, increased outreach earlier in pregnancy by care management staff, and improved linkage to prenatal provider groups will result in improved linkage to timely prenatal care in the first trimester among pregnant members.
Meridian	By 12/31/2023, Meridian aims to increase the percentage of prenatal care visits among women in their first trimester of pregnancy (within 280–176 days of delivery or estimated date of delivery), from 80.08% to 82.08% in CY 2022 and to 84.08% in CY 2023 (2.00 percentage point increase each year) through targeted interventions including, but not limited to, member and provider engagement and community partnerships to support the needs of this population.
Molina	Do targeted interventions increase HEDIS *PPC* prenatal rates for Molina Medicaid members who deliver a live birth during the measurement year?
***Improving Transportation Services* PIP**	
Aetna	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
BCBSIL	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
CountyCare	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Meridian	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?
Molina	Do targeted interventions increase the percentage of scheduled Leg A trip requests wherein the member was delivered before or on time for a scheduled appointment?

Table 68—QIP Aim Statements

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

Interventions

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

Improving Timeliness of Prenatal Care PIP

Table 69 through Table 73 illustrate the progression of interventions for the *Improving Timeliness of Prenatal Care* PIP.

Table 69—Intervention Status for Aetna Better Health

Intervention	Identified Disparities	Status
Engagement Hub: Outreach to engage members in care management.	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*
Educational member outreach via telephone and mail.	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*

Intervention	Identified Disparities	Status
Maternity Matters: Prenatal case management program.	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*
Member incentive program for timely notification of pregnancy (NOP).	*None specified*	*Revised*
Improved NOP form for providers to notify health plan of member's pregnancy.	*None specified*	*Completed*
Provider incentive program for timely NOP.	*None specified*	*Continued*
Transportation voucher and mileage reimbursement program for members to attend prenatal care appointments.	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*
Provider outreach and training to improve accurate coding and billing for prenatal care services.	*None specified*	*Continued*
Onsite Baby Showers	*None specified*	*New*
Community Health Workers Program	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
Mae Program: Community based Doula program.	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
Quality Provider Liaison Strategy	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
Advocate Health and ACHN partnership	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*

Table 70—Intervention Status for Blue Cross Blue Shield of Illinois

Intervention	Identified Disparities	Status
Active recruitment of new staff to support the Special Beginnings program outreach efforts.	*African American members residing in Cook County*	*Continued*
To accurately identify pregnant members, the Pharmacy Fill file was replaced by 834 File in August 2022. 843 File was replaced by IL Pregnant High-Risk File in November 2022.	*African American members residing in Cook County*	*Revised*

Intervention	Identified Disparities	Status
To accurately identify member pregnancy status, the Special Beginnings team conducts a manual verification of the Illinois High Risk Pregnant file utilizing the Guiding Care platform.	*African American members residing in Cook County*	*Continued*
Special Beginnings team collaborates with Provider Network to obtain updated provider contacts and provider in-network status verification.	*African American members residing in Cook County*	*New*
HealConnect text messages sent to eligible members to connect members to Special Beginnings and inform of incentives when a member receives prenatal care.	*African American members residing in Cook County*	*Revised*
Unable to Reach (UTR) members are sent letters regarding attempted outreach, and Special Beginnings team conduct database research to update member's contact information.	*African American members residing in Cook County*	*Continued*
Special Beginnings initiated the telephone outreach to all eligible members as an added layer of outreach and ensure that members are educated on the importance of prenatal care.	*African American members residing in Cook County*	*New*
In order to accurately identify prenatal visit compliance of the outreach target members, compliance verification utilizing HEDIS PPC CPT, and Healthcare Common Procedure Coding System codes related to prenatal care visits was added to the HEDIS claims verification.	*African American members residing in Cook County*	*Revised*

Table 71—Intervention Status for County Care Health Plan

Intervention	Identified Disparities	Status
Prenatal care member outreach with members residing in disproportionately impacted geographic areas prioritized for outreach efforts.	*Residence: Disproportionately impacted geographic areas*	*Completed*
Recruitment and hiring of additional community health workers and care management staff to support member outreach efforts and carry out workflows.	*None specified*	*Continued*

Intervention	Identified Disparities	Status
Pregnant members under 19 years old are routed to care management regardless of screened risk level.	*Members under 19 years of age*	*Completed*

Table 72—Intervention Status for Meridian Health

Intervention	Identified Disparities	Status
Healthy Rewards member incentive program for completion of prenatal care services and mail, email, phone, and text outreach to members eligible for the incentive program.	*Race: Non-Hispanic Black*	*Revised*
Start Smart for Baby (SSFB) program that facilitates early identification of members who are pregnant and engagement of those members in prenatal care management.	*Race: Non-Hispanic Black*	*Continued*
Obstetrics (OB) Desert Strategy Workgroup: Investment in community-based approaches to maternity care, such as certified practicing midwives offering holistic and culturally appropriate care.	*Race: Non-Hispanic Black*	*Revised*

Table 73—Intervention Status for Molina Healthcare of Illinois

Intervention	Identified Disparities	Status
Bump Boxes program: Distribute maternal comfort items (socks, tea, nausea band, and blanket), educational materials, and information on gift card incentives for completing prenatal and postpartum care visits to members identified as being pregnant.	*Residence: Disproportionately impacted geographic areas* *Race: Non-White*	*Continued*
Direct outreach by Molina to members identified as pregnant and have not completed an initial prenatal visit to assist scheduling member into an appointment. Outreach attempts to member were increased from three to four.	*Residence: Disproportionately impacted geographic areas* *Race: Non-White*	*New*

Improving Timeliness of Transportation Services PIP

Table 74 through Table 78 illustrate the interventions for the *Improving Transportation Services* PIP by Lines of Business.

Table 74—Intervention Status for Aetna Better Health

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

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

Intervention	Identified Disparities	Status
Mass Transit	*None specified*	*New*
Market Place	*None specified*	*New*
Performance Improvement Plans for Transportation Providers	*None specified*	*New*
Digitized and Increased use of incentive process	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
SNC*		
Real-time, GPS-enabled Mobile App	*None specified*	*Continued*
VIP Programs	*None specified*	*Continued*
Fleet expansion efforts	*None specified*	*Continued*
Data-driven enhancements	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*
Know Your Ride: Member outreach	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*Continued*
Champion Provider Program	*None specified*	*Continued*
Mass Transit	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
Market Place	*None specified*	*New*
Performance Improvement Plans for Transportation Providers	*Race: Non-Hispanic Black* *Residence: Disproportionately impacted geographic areas*	*New*
Digitized and increased use of incentive process	*None specified*	*New*

Table 75—Intervention Status for Blue Cross Blue Shield of Illinois

Intervention	Identified Disparities	Status
HealthChoice, MLTSS, SNC		
Training to educate ModivCare drivers on the BCBSIL population that they service. The training gives basic details about different medical conditions and the vital role that transportation plays in service delivery and members' health. **Revised in 2023**: Comprehensive training now included for all new hires (drivers).	*Not Applicable: The health plan indicated that the PIP would focus on all members as there were no trends noted across race and ethnicity as well as at the individual ZIP Code level. This was observed across all three lines of business.*	*Revised*
Training to address and educate ModivCare drivers on BCBSIL expectations when interacting with BCBSIL members. Training included modules on professional boundaries, trauma-informed care, emotional intelligence, and mini medical training. **Revised in 2023**: Annual re-education sessions conducted for providers.	*Not Applicable*	*Revised*
Assisted members with requesting services, selecting preferred providers, and arranging transportation for upcoming scheduled appointments.	*Not Applicable*	*Continued*
Integrated education opportunities into the telephonic engagement. Members were educated on their rights as BCBSIL members, the process they should follow if they feel unsafe, preferred provider selection, ride share opportunities, care coordination services, and grievance procedures for ModivCare and BCSBIL	*Not Applicable*	*Continued*
Members were educated about transportation benefits through a social media campaign.	*Not Applicable*	*New*
ModivCare started utilizing Lyft as a credentialed Provider to help with network adequacy needs	*Not Applicable*	*New*
BCBSIL conducted member surveys (post ride completion) to gage the member's satisfaction with provider/driver interaction	*Not Applicable*	*New*
Performed telephonic outreach to transportation providers who received grievances and conducted training session to low-performing providers.	*Not Applicable*	*New*

Table 76—Intervention Status for County Care Health Plan

Intervention	Identified Disparities	Status
HealthChoice, MLTSS, SNC		
Addition of at least 30 vehicles to Fleet Operations to service all ZIP Codes for HealthChoice, MLTSS, and SNC populations, with an emphasis on adding more vehicles in DIAs and the West Side of Chicago.	*DIA ZIP Codes Across All Lines of Business*	*Continued*
Continued use of timeliness scorecards for all providers servicing HealthChoice, MLTSS, and SNC populations.	*None Specified*	*Continued*
Post verification call process with all members to review their experience.	*None Specified*	*Continued*
Re-education and enforcement of having field supervisors monitor transportation providers in the field to evaluate timeliness and ensure safety.	*None Specified*	*Continued*
Release of a Non-Emergency Medical Transportation (NEMT) Vendor request for proposal (RFP) to evaluate the current NEMT market.	*None Specified*	*Continued*
Evaluation of COVID-19 single rides to determine if benefit is still needed in 2024.	*None Specified*	*New*
Partnering with new transportation broker, ModivCare to improve transportation services.	*None Specified*	*New*
Partnering with previous transportation broker, Transdev, to add Lyft to network.	*None Specified*	*New*
Enforcement of monetary fines for underperformance for both Transdev and ModivCare.	*None Specified*	*New*

Table 77—Intervention Status for Meridian Health

Intervention	Identified Disparities	Status
HealthChoice, MLTSS, SNC		
The Meridian team collaborating with Network Contracting and Adequacy teams to increase the number of specialty providers, especially in rural areas.	*DIA ZIP Codes Across All Lines of Business*	*Continued*

Intervention	Identified Disparities	Status
Meridian's transportation vendor, medical transportation management (MTM,) continues to recruit transportation providers, with a focus on specific counties/areas with higher numbers of late trips as identified in the monthly trip reports.	*DIA ZIP Codes Across All Lines of Business*	*Continued*
MTM is collaborating with existing transportation providers to expand service in targeted areas identified in the monthly reports.	*DIA ZIP Codes Across All Lines of Business*	*Continued*
MTM identified and continues to partner with counties with a public transit solution/paratransit service to provide transportation to specific members in need.	*DIA ZIP Codes Across All Lines of Business*	*Continued*
MTM Link feature prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not serve a particular geographic area.	*None Specified*	*Continued*
MTM uses an online dispatching tool called MTM Marketplace, which allows transportation providers to log in and quickly find available trips in their area. This tool facilitates the placement of unassigned or reassigned trips in a timely manner and allows for increased automation and reduction in late trips.	*None Specified*	*Continued*
If a trip is going to be delayed, the MTM Link feature generates a notification so MTM or the transportation provider can reassign trips to an alternate driver or provider in the area if necessary.	*None Specified*	*Continued*
MTM Community Outreach Team scheduled interactive training for six long term care consultant (LTCC) facilities in October 2023. Topics for this training included: MTM contact information i.e., reservation phone number, fax number and email contact, online reservations within the MTM Link, trip notice requirements, resources related to filing a complaint, trip.	*Targeting lower performing facilities*	*New*
MTM monitors on time performance (OTP) monthly and providers who continuously do not meet the requirements for the OTP metrics are placed on PIPs.	*None Specified*	*New*

Table 78—Intervention Status for Molina Healthcare of Illinois

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

Intervention	Identified Disparities	Status
MTM monitoring on-time performance for providers monthly. Providers not meeting requirements are placed on a Performance Improvement Plan.	*None Specified*	*New*
SNC		
Molina health educators directly schedule members into appointments to address gaps in care and schedule the members' transportation, allowing the health educators to address issues as they arise.	*Not Applicable: Disparity was not identified based on baseline data analysis*	*Continued*
Recruit new transportation providers to network.	*None Specified*	*New*
Collaborating with existing providers to expand service in target areas	*None Specified*	*New*
MTM Link feature to prevent assignment of trips to providers that have exceeded capacity	*None Specified*	*New*
MTM dispatch tool, MTM Marketplace, allows providers to find available trips in their areas	*None Specified*	*New*
Upgrade of MTM Link feature generates a notification that allows MTM to reassign trips if the provider is going to be late	*None Specified*	*New*
MTM monitoring on-time performance for providers monthly. Providers not meeting requirements are placed on a Performance Improvement Plan.	*None Specified*	*New*

Improving Timeliness of Transportation Services QIP

Table 79 through Table 83 illustrate the progression of interventions for the *Improving Transportation Services* QIP.

Table 79—Intervention Status for Aetna Better Health

Intervention	Identified Disparities	Status
Implementation of Medical Transportation Management (MTM) Link (MTM's transportation tool), which allows for real-time, drag-and-drop alterations to providers' schedules, as needed.	*None Specified*	*Continued*

Intervention	Identified Disparities	Status
MTM identified provider network adequacy concerns in existing and expansion regions. MTM identified providers that were adversely influencing overall member on-time arrival and used a performance improvement plan (QIP) to hold vendors accountable.	*None Specified*	*Continued*
MTM incorporated an online dispatching tool called MTM Marketplace. This tool allows providers to log in and find available trips in their area. The tool facilitates unassigned or reassigned trips in a timely manner allowing for increased automation and potentially a reduction in late arrivals.	*None Specified*	*Continued*
MTM implemented a campaign to actively recruit new vendors into its existing provider network to increase provider availability.	*None Specified*	*Continued*
Targeted on-site visits to provide a one-page educational document to nursing homes that have the highest volume of impacted membership.	*Nursing Homes, Large Metro Areas, and Metro Areas*	*Continued*

Table 80—Intervention Status for Blue Cross Blue Shield of Illinois

Intervention	Identified Disparities	Status
Training to educate ModivCare drivers on the BCBSIL population that they service. The training gives basic details about different medical conditions and the vital role that transportation plays in service delivery and members' health.	*Not Applicable: The MMAI plan indicated that the QIP would focus on all members as there were no trends noted across race and ethnicity as well as at the individual ZIP Code level.*	*Revised*
Training to address and educate ModivCare drivers on BCBSIL expectations when interacting with BCBSIL members. Training included modules on professional boundaries, trauma-informed care, emotional intelligence, and mini medical training.	*Not Applicable*	*Revised*
Assisted members with requesting services, selecting preferred providers, and arranging transportation for upcoming scheduled appointments.	*Not Applicable*	*Continued*

Intervention	Identified Disparities	Status
Integrated education opportunities into the telephonic engagement. Members were educated on their rights as BCBSIL members, and the process they should follow if they feel unsafe.	*Not Applicable*	*Continued*
Members were also educated in the following areas: preferred provider selection, ride share opportunities, care coordination services, and grievance procedures for ModivCare and BCSBIL.	*Not Applicable*	*Continued*
ModivCare performed outreach to transportation providers receiving member complaints to get their input on service gaps and barriers to delivering services.	*Not Applicable*	*New*
ModivCare started utilizing Lyft as a credentialed Provider to help with network adequacy needs.	*Not Applicable*	*New*
BCBSIL conducted member surveys (post ride completion) to gage the member's satisfaction with provider/driver interaction.	*Not Applicable*	*New*

Table 81—Intervention Status for Humana Medical Plan, Inc.

Intervention	Identified Disparities	Status
MTM identified transportation providers who were adversely influencing overall member on-time arrival and used a QIP to hold identified providers accountable.	*None Specified*	*Continued*
MTM identified areas requiring additional transportation providers and began a campaign to actively recruit new providers.	*None Specified*	*Continued*
Implementation of MTM Link: 1) Prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not service a particular geographic area. 2) Offers a real-time provider view of scheduled trips, allowing for modifications to accommodate specific needs. 3) Provides system notifications for the trip reassignment to an alternate driver or provider if needed.	*None Specified*	*Continued*

Intervention	Identified Disparities	Status
Targeted on-site visits to provide a one-page educational document to long term care (LTC) facilities that have the highest volume of LTC membership. Targeted on-site training offered to provide one pager education to LTCs with high unique member utilizers not residing in high volume facilities.	*Members Residing in LTC Facilities*	*Revised*

Table 82—Intervention Status for Meridian Health

Intervention	Identified Disparities	Status
The Meridian team will coordinate with Network Contracting and Adequacy teams to increase the number of specialty providers, especially in rural areas.	*Disproportionately Impacted Rural Areas*	*Continued*
Meridian's transportation vendor, MTM, continues to recruit transportation providers, with a focus on specific counties/areas with higher numbers of late trips as identified in the monthly trip reports.	*Disproportionately Impacted Rural Areas*	*Continued*
MTM is collaborating with existing transportation providers to expand service in targeted areas identified in the monthly reports.	*Disproportionately Impacted Rural Areas*	*Continued*
MTM has identified and continues to partner with counties with a public transit solution/paratransit service to provide transportation to specific members in need.	*Disproportionately Impacted Rural Areas*	*Continued*
New MTM Link feature prevents the assignment of trips to transportation providers who have exceeded capacity for the day or do not serve a particular geographic area.	*None Specified*	*Continued*
MTM uses an online dispatching tool called MTM Marketplace, which allows transportation providers to log in and quickly find available trips in their area. This tool facilitates the placement of unassigned or reassigned trips in a timely manner and allows for increased automation and reduction in late trips.	*None Specified*	*Continued*

Intervention	Identified Disparities	Status
If a trip is going to be delayed, the MTM Link feature generates a notification so MTM or the transportation provider can reassign trips to an alternate driver or provider in the area if necessary.	*None Specified*	*Continued*
MTM Community Outreach Team scheduled interactive training for six LTCC facilities in October 2023. Topics for these trainings included: MTM contact information i.e., reservation phone number, fax number and email contact, online reservations within the MTM Link, trip notice requirements, resources related to filing a complaint, trip.	*Targeting lower performing facilities*	*New*
MTM monitors on time performance (OTP) monthly and providers who continuously do not meet the requirements for the OTP metrics are placed on PIPs.	*None Specified*	*New*

Table 83—Intervention Status for Molina Healthcare of Illinois

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

Appendix C. Performance Measure Results

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

To evaluate performance levels and to provide an objective, comparative review of Illinois health plans' quality-of-care outcomes and performance measures, HFS required its health plans to report results following NCQA's HEDIS protocols.[44]

In this appendix, Illinois health plans' performance for required HEDIS MY 2023 measures is compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022, when available, which is an indicator of health plan performance on a national level (referred to as "percentiles" throughout this section of the report).[45]

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

Star Ratings

The star ratings in Table 84 represent the following percentile comparisons.

Table 84—Star Ratings

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

HealthChoice Results

Table 85 presents the HEDIS MY 2021 through HEDIS MY 2023 rates for the health plans and the statewide average, which represents the average of all the health plans' performance measure rates

[44] National Committee for Quality Assurance. HEDIS and Performance Measurement. Available at: http://www.ncqa.org/hedis-quality-measurement. Accessed on: Feb 4, 2025.

[45] Benchmarking data (e.g., Quality Compass) are the proprietary intellectual property of NCQA; therefore, this report does not display actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays. Since the HEDIS process is retrospective, HEDIS MY 2022 results are calculated using CY 2022 data and HEDIS MY 2023 results are calculated using CY 2023 data.

weighted by the eligible population. In addition, star ratings are displayed for rates compared to the national Medicaid percentiles, where applicable.

Table 85—HealthChoice Performance Measure Results for HEDIS MY 2021–2023

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Adults' Access to Preventive/Ambulatory Health Services							
Total	MY 2021	★ 69.89%	★★ 75.90%	★ 71.44%	★★ 74.81%	★ 71.06%	★★ 73.27%
	MY 2022	★ 68.12%	★★ 73.48%	★ 69.56%	★★ 73.09%	★ 70.00%	★★ 71.43%
	MY 2023	★★ 69.06%	★★★ 74.65%	★★ 70.76%	★★★ 74.70%	★★ 71.27%	★★ 72.69%
Ambulatory Care (per 1,000 Member Months) [1]							
ED Visits—Total	MY 2021	★ 612.36	★★ 514.80	★ 576.00	★★ 543.60	★ 615.60	★★ 560.88
	MY 2022	★ 631.16	BR	★★ 594.11	★★ 581.05	★ 635.83	★★ 602.74
	MY 2023	★★ 612.44	★★★ 535.76	★★ 580.13	★★ 573.45	★★ 603.38	★★ 574.13
Outpatient Visits—Total	MY 2021	★★ 3,269.28	★★★★ 4,258.68	★★ 3,445.32	★★ 3,463.20	★★ 3,318.60	★★ 3,602.52
	MY 2022	★★ 3,322.84	BR	★★ 3,381.92	★★ 3,655.18	★★ 3,460.29	★★ 3,498.78
	MY 2023	★★ 3,432.89	★★★★ 4,869.17	★★ 3,518.56	★★★ 3,845.31	★★ 3,421.45	★★★ 3,946.46
Annual Dental Visit^							
Annual Dental Visit	MY 2021	★★ 43.31%	★★ 36.46%	★★★ 52.15%	★★★ 49.77%	★★★★ 54.47%	★★★ 46.61%
	MY 2022	★★ 45.10%	★★★ 51.91%	★★★ 55.00%	★★★ 52.00%	★★ 48.70%	★★★ 51.16%
	MY 2023	—	—	—	—	—	—
Blood Pressure Control for Patients With Diabetes							
Blood Pressure Control (<140/90 mm Hg)	MY 2021	★★ 54.74%	★★★ 64.72%	★ 52.07%	★ 46.96%	★★★ 60.34%	★★ 54.73%
	MY 2022	★ 49.88%	★★★ 63.75%	★★ 58.15%	★★★ 61.80%	★★★ 61.56%	★★ 59.79%
	MY 2023	★★ 61.07%	★★★ 66.67%	★★★ 65.45%	★★ 63.75%	★★★ 68.13%	★★★ 64.93%
Breast Cancer Screening							
Breast Cancer Screening	MY 2021	—	—	—	—	—	—
	MY 2022	—	—	—	—	—	—
	MY 2023	★ 45.76%	★★★ 53.90%	★★★ 55.25%	★★ 50.21%	★★ 49.73%	★★ 51.39%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Cervical Cancer Screening							
Cervical Cancer Screening	MY 2021	★ 45.50%	★★ 56.93%	★★★ 60.00%	★ 48.26%	★★ 56.69%	★★ 52.83%
	MY 2022	★ 49.64%	★★★ 59.85%	★★★ 60.51%	★★ 56.45%	★★ 55.72%	★★ 56.83%
	MY 2023	★ 49.88%	★★★ 58.64%	★★★★ 62.28%	★★ 54.60%	★★ 53.77%	★★ 56.14%
Child and Adolescent Well-Care Visits							
Total	MY 2021	★★★ 46.07%	★★★ 52.70%	★★★★ 53.86%	★★★ 52.41%	★★★ 50.18%	★★★ 51.60%
	MY 2022	★★ 43.62%	★★★ 52.32%	★★★ 50.73%	★★★ 51.04%	★★ 47.91%	★★★ 49.99%
	MY 2023	★★ 46.30%	★★★★ 55.10%	★★★ 54.36%	★★★ 54.59%	★★★ 49.96%	★★★ 53.10%
Childhood Immunization Status							
Combination 3	MY 2021	★ 53.77%	★ 60.34%	★ 60.10%	★ 54.74%	★ 58.88%	★ 57.15%
	MY 2022	★★ 58.64%	★★ 60.83%	★★ 60.58%	★★ 60.34%	★★ 58.39%	★★ 60.05%
	MY 2023	★★ 63.02%	★★ 60.16%	★★★ 63.99%	★ 58.64%	★★ 59.37%	★★ 60.57%
Combination 10	MY 2021	★ 22.14%	★ 31.39%	★★ 34.79%	★ 26.03%	★ 26.28%	★ 28.08%
	MY 2022	★ 20.92%	★ 27.74%	★★ 32.36%	★ 24.33%	★ 21.17%	★ 25.63%
	MY 2023	★ 23.84%	★★ 25.69%	★★ 30.41%	★ 24.33%	★ 20.68%	★★ 25.14%
Chlamydia Screening in Women							
Total	MY 2021	★★★ 56.80%	★★★ 55.31%	★★★ 61.37%	★ 43.89%	★★★ 56.38%	★★ 52.87%
	MY 2022	★★★ 55.32%	★★★ 56.01%	★★★★ 65.08%	★★ 46.13%	★★★ 57.21%	★★ 54.23%
	MY 2023	★★ 55.32%	★★★ 56.58%	★★★★ 64.42%	★ 47.03%	★★★ 56.12%	★★ 54.65%
Controlling High Blood Pressure							
Controlling High Blood Pressure	MY 2021	★ 49.88%	★★★ 57.66%	★ 45.50%	★ 43.80%	★★★ 60.10%	★ 50.03%
	MY 2022	★ 53.77%	★★★ 61.56%	★ 53.53%	★★ 58.39%	★★★ 61.31%	★★ 57.96%
	MY 2023	★★ 57.18%	★★★ 63.99%	★ 54.63%	★★★ 62.04%	★★ 59.37%	★★ 60.15%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Diagnosed Mental Health Disorders[1]							
Ages 18–64 Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 28.76%	NC 25.48%	NC 20.74%	NC 28.43%	NC 28.69%	NC 26.56%
	MY 2023	★★★ 30.35%	★★ 26.66%	★ 21.36%	★★ 29.68%	★★ 29.95%	★★ 27.67%
Ages 65+ Years	MY 2021	—	—	—	—	—	—
	MY 2022	NC 31.29%	NC 27.69%	NC 26.87%	NC 28.49%	NC 35.11%	NC 29.12%
	MY 2023	★★★ 31.86%	★★ 27.84%	★★ 26.96%	★★★ 29.87%	★★★★ 40.20%	★★★ 30.19%
Eye Exam for Patients With Diabetes							
Eye Exam (Retinal) Performed	MY 2021	★★★ 51.58%	★★ 48.18%	★★ 50.85%	★ 41.61%	★ 42.82%	★★ 46.43%
	MY 2022	★★ 46.47%	★★ 45.01%	★★★ 52.31%	★★★ 51.09%	★ 44.28%	★★ 48.29%
	MY 2023	★★★ 52.31%	★★★ 56.69%	★★★ 56.45%	★★★ 52.80%	★ 39.28%	★★★ 52.93%
Follow-Up After Emergency Department Visit for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2021	★★★★ 75.23%	★★★★★ 75.85%	★★★★ 66.03%	★★★★★ 77.88%	★★★★★ 76.12%	★★★★★ 75.98%
	MY 2022	★★★★★ 77.45%	★★★★ 71.91%	★★★★ 70.93%	★★★★★ 77.94%	★★★★★ 79.68%	★★★★★ 76.06%
	MY 2023	★★★★★ 74.90%	★★★★ 73.45%	★★★ 62.58%	★★★★★ 76.78%	★★★★★ 77.75%	★★★★★ 74.45%
7-Day Follow-Up—Ages 18–64	MY 2021	★★★★ 46.61%	★★★ 43.01%	★★★ 34.65%	★★★★ 46.26%	★★★★ 49.72%	★★★ 45.10%
	MY 2022	★★★ 45.79%	★★★ 43.72%	★★ 33.18%	★★★★ 47.38%	★★★ 44.71%	★★★ 44.15%
	MY 2023	★★★★ 45.29%	★★★ 45.04%	★★ 31.77%	★★★★ 50.22%	★★★★ 50.12%	★★★★ 45.67%
7-Day Follow-Up—Ages 65+	MY 2021	—	—	—	★★ 31.94%	—	★★ 31.50%
	MY 2022	—	—	—	—	—	★★★ 36.36%
	MY 2023	—	—	—	—	—	★★★ 39.08%
30-Day Follow-Up—Ages 6–17	MY 2021	★★★★ 81.75%	★★★★★ 84.15%	★★★ 71.29%	★★★★ 83.18%	★★★★★ 85.04%	★★★★ 82.58%
	MY 2022	★★★★ 83.33%	★★★★ 80.39%	★★★★ 77.00%	★★★★ 83.56%	★★★★★ 87.90%	★★★★ 82.75%
	MY 2023	★★★★ 81.18%	★★★★ 79.76%	★★★ 72.33%	★★★★ 83.97%	★★★★ 83.80%	★★★★ 81.37%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
30-Day Follow-Up—Ages 18–64	MY 2021	★★★ 56.20%	★★★ 53.98%	★★ 44.14%	★★★ 55.96%	★★★★ 60.54%	★★★ 55.20%
	MY 2022	★★★ 56.12%	★★★ 54.01%	★★ 43.23%	★★★ 56.48%	★★★ 55.62%	★★★ 54.13%
	MY 2023	★★★ 54.71%	★★★ 56.11%	★ 40.30%	★★★★ 59.63%	★★★★ 60.25%	★★★ 55.46%
30-Day Follow-Up—Ages 65+	MY 2021	—	—	—	★★ 45.83%	—	★★ 43.31%
	MY 2022	—	—	—	—	—	★★ 42.42%
	MY 2023	—	—	—	—	—	★★★ 50.57%
Follow-Up After Emergency Department Visit for Substance Use							
7-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 13.68%	NC 17.30%	NC 12.22%	NC 25.56%	NC 22.99%	NC 19.92%
	MY 2023	★★★ 20.30%	★★★ 24.27%	★★★ 19.50%	★★★ 26.01%	★★ 19.13%	★★★ 22.86%
7-Day Follow-Up—Ages 18+	MY 2021	—	—	—	—	—	—
	MY 2022	NC 24.62%	NC 27.72%	NC 19.20%	NC 26.92%	NC 28.64%	NC 25.63%
	MY 2023	★★★ 25.47%	★★★ 27.51%	★★ 24.22%	★★ 23.76%	★★★ 25.96%	★★★ 25.29%
30-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	★ 10.00%
	MY 2022	—	—	—	—	—	★★★ 43.18%
	MY 2023	★★ 25.56%	★★★ 31.55%	★★ 27.67%	★★★ 33.75%	★★★ 34.78%	★★★ 31.20%
30-Day Follow-Up—Ages 18+	MY 2021	—	—	—	—	—	—
	MY 2022	NC 34.83%	NC 38.02%	NC 27.11%	NC 37.31%	NC 41.16%	NC 35.86%
	MY 2023	★★ 35.10%	★★★ 37.27%	★★ 32.76%	★★ 33.67%	★★★ 39.43%	★★ 35.32%
Follow-Up After High Intensity Care for SUD							
7-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	★ 6.67%
	MY 2022	—	—	—	—	—	★★★ 25.00%
	MY 2023	—	—	—	—	—	★★ 20.00%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
30-Day Follow-Up—Ages 13–17	MY 2021	—	—	—	—	—	★ 10.00%
	MY 2022	—	—	—	—	—	★★★ 43.18%
	MY 2023	—	—	—	—	—	★★ 31.43%
7-Day Follow-Up—Ages 18–64	MY 2021	★★★ 38.03%	★★★ 39.49%	★★★ 39.27%	★★★ 39.77%	★★★ 39.75%	★★★ 39.28%
	MY 2022	★★★ 38.44%	★★★ 37.55%	★★★ 38.58%	★★★ 37.74%	★★★★ 40.19%	★★★ 38.28%
	MY 2023	★★★ 36.51%	★★★ 38.05%	★★★ 35.57%	★★★ 36.41%	★★★ 36.93%	★★★ 36.69%
7-Day Follow-Up—Ages 65+	MY 2021	—	—	★★★★ 42.86%	★★★★ 40.63%	—	★★★★ 36.89%
	MY 2022	—	—	★★★ 26.32%	★★★ 22.58%	—	★★★ 28.46%
	MY 2023	—	—	★★★ 30.19%	—	—	★★★ 29.92%
30-Day Follow-Up—Ages 18–64	MY 2021	★★ 53.71%	★★★ 56.31%	★★ 54.37%	★★★ 55.27%	★★★ 55.68%	★★★ 55.04%
	MY 2022	★★★ 55.34%	★★★ 53.68%	★★★ 54.04%	★★★ 55.43%	★★★ 57.54%	★★★ 55.03%
	MY 2023	★★★ 54.03%	★★★ 56.67%	★★★ 54.10%	★★★ 53.93%	★★★ 55.04%	★★★ 54.74%
30-Day Follow-Up—Ages 65+	MY 2021	—	—	★★★★ 52.38%	★★★ 46.88%	—	★★★ 48.36%
	MY 2022	—	—	★★ 38.60%	★★ 38.71%	—	★★★ 39.84%
	MY 2023	—	—	★★★ 50.94%	NA	—	★★ 40.16%
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up—Ages 6–17	MY 2021	★★ 42.34%	★★ 48.92%	★★ 43.49%	★★ 42.05%	★★ 47.23%	★★ 44.46%
	MY 2022	★★ 46.27%	★★★ 48.42%	★ 37.74%	★★ 42.28%	★★ 43.27%	★★ 43.99%
	MY 2023	★★★ 49.21%	★★★ 47.50%	★ 36.81%	★★ 41.47%	★★ 44.09%	★★ 43.85%
7-Day Follow-Up—Ages 18–64	MY 2021	★★ 26.67%	★ 25.69%	★ 18.52%	★ 21.26%	★ 24.26%	★ 23.24%
	MY 2022	★★ 27.69%	★ 23.99%	★ 18.93%	★ 25.50%	★ 24.48%	★ 24.45%
	MY 2023	★★★ 36.51%	★★★ 38.05%	★★★ 35.57%	★★★ 36.41%	★★★ 36.93%	★★★ 36.69%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
7-Day Follow-Up—Ages 65+	MY 2021	—	★★★ 26.47%	★ 15.38%	★ 5.45%	—	★ 16.46%
	MY 2022	—	★★ 19.35%	★★ 19.57%	★ 12.96%	—	★★ 15.85%
	MY 2023	—	NA	★★★ 30.19%	NA	—	★★★ 29.92%
30-Day Follow-Up—Ages 6–17	MY 2021	★★ 69.82%	★★★ 73.32%	★★ 67.71%	★★ 64.84%	★★★ 74.94%	★★ 69.08%
	MY 2022	★★ 70.58%	★★★ 74.46%	★ 62.37%	★★ 68.65%	★★ 69.54%	★★ 69.71%
	MY 2023	★★★★ 78.02%	★★★ 72.19%	★ 61.90%	★★ 67.96%	★★★ 74.19%	★★ 70.54%
30-Day Follow-Up—Ages 18–64	MY 2021	★★ 45.27%	★★ 45.79%	★ 34.72%	★ 37.24%	★★ 45.75%	★ 41.34%
	MY 2022	★★ 46.99%	★ 42.18%	★ 34.17%	★ 44.55%	★★ 46.16%	★ 43.12%
	MY 2023	★★★ 54.03%	★★★ 56.67%	★★★ 54.10%	★★★ 53.93%	★★★ 55.04%	★★★ 54.74%
30-Day Follow-Up—Ages 65+	MY 2021	—	★ 38.24%	★ 28.21%	★ 23.64%	—	★ 32.91%
	MY 2022	—	★ 35.48%	★ 36.96%	★ 37.04%	—	★ 33.54%
	MY 2023	—	—	★★★ 50.94%	—	—	★★ 40.16%
Hemoglobin A1c Control for Patients With Diabetes							
HbA1c Control (<8.0%)	MY 2021	★★ 42.34%	★★★ 47.69%	★★ 40.39%	★ 35.28%	★★ 42.34%	★★ 40.98%
	MY 2022	★★★★ 57.18%	★★★ 51.58%	★★ 48.91%	★★ 49.64%	★★ 44.04%	★★★ 50.55%
	MY 2023	★★★★ 58.15%	★★★★★ 61.07%	★★★★ 58.15%	★★★ 54.99%	★★★ 54.50%	★★★★ 57.61%
HbA1c Poor Control (>9.0%)	MY 2021	★★ 50.61%	★★★ 40.39%	★★ 50.85%	★ 58.64%	★★ 47.45%	★★ 50.47%
	MY 2022	★★★★ 34.31%	★★ 42.09%	★★ 44.77%	★★ 40.88%	★★ 46.47%	★★ 41.51%
	MY 2023	★★★ 33.58%	★★★★ 29.93%	★★★★ 32.36%	★★ 39.17%	★★★ 37.96%	★★★ 34.47%
Immunizations for Adolescents							
Combination 1 (Meningococcal, Tdap)	MY 2021	★★★★★ 89.29%	★★★★★ 90.02%	★★★ 84.67%	★★★★ 88.56%	★★★ 85.69%	★★★★ 88.12%
	MY 2022	★★★ 85.16%	★★★★★ 89.09%	★★★ 83.94%	★★★★★ 90.27%	★★★★ 86.70%	★★★★ 87.94%
	MY 2023	★★★★ 85.76%	★★★★ 88.44%	★★★★ 88.32%	★★★★ 88.81%	★★★★ 86.72%	★★★★ 88.01%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Combination 2 (Meningococcal, Tdap, HPV)	MY 2021	★ 26.03%	★★ 34.79%	★★★ 40.15%	★ 27.98%	★★ 31.43%	★★ 31.50%
	MY 2022	★ 27.25%	★★★ 36.14%	★★★ 38.69%	★ 28.22%	★★ 31.24%	★★ 31.89%
	MY 2023	★ 26.96%	★★★ 35.20%	★★★★ 45.26%	★★ 32.36%	★★ 32.02%	★★ 34.30%
Initiation and Engagement of SUD Treatment							
Initiation of Substance Use Treatment—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 47.81%	NC 50.00%	NC 46.20%	NC 49.22%	NC 49.51%	NC 48.77%
	MY 2023	★★ 38.66%	★★★★ 50.26%	★★ 40.47%	★★★ 46.59%	★★★ 43.55%	★★★ 44.86%
Engagement of Substance Use Treatment—Ages 13–17	MY 2021	—	—	—	—	—	—
	MY 2022	NC 9.63%	NC 13.84%	NC 10.33%	NC 13.06%	NC 6.55%	NC 11.58%
	MY 2023	★ 5.38%	★★★ 15.15%	★ 4.90%	★ 7.61%	★ 7.71%	★★ 8.67%
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose Testing—Total	MY 2021	★★★★ 61.25%	★★★★★ 62.80%	★★★★★ 62.73%	★★★★ 59.90%	★★★★ 56.85%	★★★★ 60.56%
	MY 2022	★★★★ 62.35%	★★★★ 64.90%	★★★ 58.28%	★★★ 59.32%	★★★ 58.15%	★★★★ 60.79%
	MY 2023	★★★★ 61.28%	★★★★ 60.60%	★★★ 59.42%	★★★ 59.88%	★★★ 58.64%	★★★★ 60.04%
Cholesterol Testing—Total	MY 2021	★★ 31.11%	★★★★ 40.69%	★★★ 38.48%	★★★ 33.26%	★★ 28.56%	★★★ 34.32%
	MY 2022	★★ 32.46%	★★★ 39.78%	★★ 34.70%	★★ 32.29%	★★ 31.01%	★★ 34.04%
	MY 2023	★ 29.44%	★★★ 36.58%	★★★ 38.82%	★★ 32.24%	★★ 32.44%	★★ 33.43%
Metabolic Monitoring for Children and Adolescents on Antipsychotics							
Blood Glucose and Cholesterol Testing—Total	MY 2021	★★ 30.54%	★★★★ 39.21%	★★★★ 37.58%	★★★ 32.67%	★★ 28.03%	★★★ 33.52%
	MY 2022	★★ 31.76%	★★★ 38.75%	★★ 33.51%	★★ 31.51%	★★ 30.34%	★★ 33.19%
	MY 2023	★★ 28.72%	★★★ 35.67%	★★★ 37.06%	★★ 31.75%	★★ 31.49%	★★ 32.62%
Oral Evaluation, Dental Services							
Total	MY 2021	—	—	—	—	—	—
	MY 2022	—	—	—	—	—	—
	MY 2023	NC 40.70%	NC 31.52%	NC 53.70%	NC 48.61%	NC 41.33%	NC 43.04%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Pharmacotherapy for OUD							
Ages 16–64	MY 2021	★★ 25.77%	★★ 24.98%	★★ 23.54%	★★ 25.64%	★ 7.91%	★ 21.80%
	MY 2022	★★ 27.26%	★★ 24.92%	★★ 22.11%	★★ 26.07%	★ 7.68%	★★ 21.75%
	MY 2023	★★ 22.75%	★★ 26.74%	★ 18.71%	★★ 21.46%	★ 7.35%	★ 19.11%
Ages 65+	MY 2021	★★ 29.23%	★★ 35.44%	★★ 33.04%	★★ 34.94%	★ 2.86%	★★ 30.50%
	MY 2022	★★★ 35.85%	★ 26.79%	★★★ 36.99%	★ 18.06%	★ 1.82%	★ 27.38%
	MY 2023	★ 25.71%	★★ 31.82%	★ 28.40%	★ 20.93%	★ 2.27%	★ 22.67%
Total (Ages 16+)	MY 2021	★★ 25.86%	★★ 25.31%	★★ 23.92%	★★ 25.85%	★ 7.84%	★ 22.04%
	MY 2022	★★ 27.46%	★★ 24.96%	★★ 22.91%	★★ 25.91%	★ 7.56%	★★ 21.91%
	MY 2023	★★ 22.81%	★★ 26.83%	★ 19.01%	★★ 21.45%	★ 7.27%	★ 19.17%
PPC							
Timeliness of Prenatal Care	MY 2021	★★ 83.70%	★★★ 87.83%	★★ 82.16%	★★★ 85.89%	★★★★ 90.27%	★★★ 86.10%
	MY 2022	★★ 81.51%	★★★★ 89.78%	★★ 84.23%	★★★★ 89.29%	★★★★ 89.78%	★★★ 87.54%
	MY 2023	★★★ 85.64%	★★★★ 89.05%	★★★ 86.89%	★★ 83.21%	★★★★ 89.78%	★★★ 86.51%
Postpartum Care	MY 2021	★★ 72.02%	★★★★ 81.27%	★★★★ 79.82%	★★★★ 79.56%	★★★★ 79.56%	★★★ 78.96%
	MY 2022	★★★ 77.37%	★★★ 79.08%	★★ 76.70%	★★★★ 81.51%	★★★ 77.86%	★★★ 79.09%
	MY 2023	★★★ 81.02%	★★★★★ 85.40%	★★★ 81.64%	★★★★★ 86.37%	★★★★ 82.73%	★★★★ 84.23%
Statin Therapy for Patients With Diabetes							
Received Statin Therapy	MY 2021	★★★ 67.87%	★★★★ 71.74%	★★★★ 71.27%	★★★ 69.26%	★★★ 68.28%	★★★★ 69.95%
	MY 2022	★★★ 66.88%	★★★★ 70.06%	★★★★ 70.34%	★★★ 67.14%	★★★ 66.77%	★★★ 68.42%
	MY 2023	★★★ 66.79%	★★★★ 70.57%	★★★★ 70.04%	★★★ 67.05%	★★★ 66.45%	★★★★ 68.43%
Statin Adherence 80%	MY 2021	★★★ 69.15%	★★ 67.55%	★★★ 73.17%	★★ 67.79%	★★ 65.57%	★★★ 68.84%
	MY 2022	★★★ 70.14%	★★★ 66.77%	★★★ 71.56%	★★★ 67.45%	★★★★★ 87.52%	★★★ 70.38%
	MY 2023	★★★ 71.91%	★★★ 67.56%	★★★★ 72.93%	★★★ 69.65%	★★ 65.95%	★★★ 69.69%

Measure	Year	Aetna	BCBSIL	CountyCare	Meridian	Molina	Statewide Average
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile Documentation—Total	MY 2021	★ 65.94%	★★★ 77.62%	★★★★ 83.17%	★ 60.83%	★★★ 80.54%	★★ 70.85%
	MY 2022	★ 64.72%	★★ 74.21%	★★★★ 85.14%	★ 66.67%	★★ 78.10%	★ 72.16%
	MY 2023	★★ 73.72%	★★ 75.18%	★★★★ 87.85%	★★ 72.02%	★★★ 80.78%	★★ 76.37%
Counseling for Nutrition—Total	MY 2021	★★ 63.75%	★★★ 72.26%	★★★★ 81.52%	★ 53.77%	★★ 68.13%	★★ 64.97%
	MY 2022	★★ 65.21%	★★ 65.45%	★★ 65.45%	★★★★ 83.33%	★★ 67.15%	★★ 65.94%
	MY 2023	★★ 65.45%	★★ 65.45%	★★★★ 83.33%	★★ 67.15%	★★ 65.94%	★★ 68.72%
Counseling for Physical Activity—Total	MY 2021	★★ 62.77%	★★★ 68.13%	★★★★ 77.56%	★ 49.39%	★★★ 68.13%	★★ 61.62%
	MY 2022	★★ 61.07%	★★ 63.50%	★★★★ 78.72%	★ 57.91%	★★ 60.58%	★★ 62.93%
	MY 2023	★★ 63.99%	★★ 63.02%	★★★★★ 82.29%	★★ 65.69%	★★ 64.72%	★★ 67.09%
Well-Child Visits in the First 30 Months of Life							
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	MY 2021	★★ 51.24%	★★ 50.15%	★★ 51.70%	★★ 50.33%	★★★ 58.51%	★★ 51.49%
	MY 2022	★★★ 58.90%	★★★★ 66.22%	★★ 54.96%	★★★ 58.64%	★★★★ 61.64%	★★★ 60.47%
	MY 2023	★★★ 61.59%	★★★★ 64.12%	★★★★ 63.40%	★★★★ 66.60%	★★★★ 63.94%	★★★★ 64.41%
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	MY 2021	★ 57.82%	★ 63.31%	★ 59.49%	★ 60.53%	★ 59.84%	★ 60.48%
	MY 2022	★ 59.59%	★★★ 67.87%	★ 60.38%	★★ 64.07%	★★ 61.37%	★★ 63.59%
	MY 2023	★★ 63.49%	★★★ 69.51%	★★★ 68.11%	★★★ 68.79%	★★ 65.57%	★★★ 67.81%

^ The Annual Dental Visit measure was retired by NCQA in MY 2023.
* Indicates this is a "lower is better" measure.
[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.
NA indicates that the health plan followed the specifications, but the denominator was too small (i.e., <30) to report a valid rate.
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 2023.
BR indicates that the calculated rate was found to be materially biased.
— Indicates that the health plan was not required to report the measure during the MY or that the rate is not appropriate to display due to changes in the technical specifications resulting in a break in trending; therefore, the applicable rate is not displayed.

YouthCare Results

Table 86 presents the HEDIS MY 2023 rates for YouthCare.

Table 86—YouthCare Performance Measure Results for MY 2023

Measure	YouthCare
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	48.88%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	71.47%
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	77.68%
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	87.39%
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	52.25%
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	62.16%
Diagnosed Mental Health Disorders—Total	50.19%
Initiation and Engagement of SUD Treatment—Initiation of SUD Treatment—Total	47.39%
Initiation and Engagement of SUD Treatment—Engagement of SUD Treatment—Total	10.63%
Follow-Up Care for Children Prescribed ADHD Medications—Initiation Phase—Total	56.15%
Follow-Up Care for Children Prescribed ADHD Medications—Continuation and Maintenance Phase—Total	64.52%
Use of First Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	68.69%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total	70.79%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total	51.57%
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	50.94%
Ambulatory Care—ED Visits	46.35%
Child and Adolescent Well-Care Visits—Total	62.26%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentage—Total	33.22%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	23.08%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	22.50%
Childhood Immunization Status—Combination 10	32.83%
Immunizations for Adolescents—Combination 2	39.28%
Annual Dental Visit—Total	59.33%

Measure	YouthCare
Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents—Total	25.77%
Emergency Department Visits that Result in an Inpatient Admissions for Children and Adolescents—Total	17.76%
Inpatient Utilization—Behavioral Health Hospitalization for Children and Adolescents—Inpatient Behavioral Health Utilization—Total	4.38
Inpatient Utilization—Behavioral Health Hospitalization for Children and Adolescents—Average Length of Stay—Total	20.00
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percent of Members with Repeat Behavioral Health Hospitalizations—Total	29.78%
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat Behavioral Health Hospitalizations Per Member—Total	0.49

HealthChoice P4R

Table 87 presents the MY 2023 rates for the health plans for P4R measures.

Table 87—HealthChoice Pay for Reporting Performance Measure Results for MY 2023

Measure	Aetna	BCBSIL	CountyCare	Meridian	Molina
Follow-Up After High-Intensity Care for SUD—7-Day Follow-Up—Total	37.24%	36.99%	40.71%	36.35%	36.64%
Follow-Up After High-Intensity Care for SUD—30-Day Follow-Up—Total	53.76%	55.17%	56.91%	54.15%	54.61%
Pharmacotherapy for OUD	16.48%	26.17%	24.36%	15.08%	7.23%
Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents	35.70%	40.47%	27.36%	25.52%	13.61%
Emergency Department Visits that Result in an Inpatient Admission for Children and Adolescents	27.52%	47.78%	13.06%	25.27%	15.87%
Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Inpatient Behavioral Health Utilization	1.63	0.69	0.56	0.80	0.65
Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents—Average Length of Stay	6.91	8.22	9.39	8.00	9.49

Measure	Aetna	BCBSIL	CountyCare	Meridian	Molina
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Average Number of Repeat Hospitalizations Per Member—Total	0.33	0.36	0.33	0.33	0.36
Repeat Behavioral Health Hospitalizations for Children and Adolescents—Percentage of Repeat Hospitalizations Per Member—Total	17.76%	21.29%	19.65%	17.75%	22.29%
HIV Viral Load Suppression—Percentage of Members with a Viral Load Less Than 200 Copies/mL	8.03%	49.83%	43.57%	38.01%	52.45%
HIV Viral Load Suppression—Percentage of Members with a Valid Lab Result and a Viral Load Less Than 200 Copies/mL	26.29%	87.33%	88.15%	90.94%	95.81%
Gap in HIV Medical Visits—Total	20.33%	24.66%	34.91%	20.51%	12.31%
Prescription of HIV Antiretroviral Therapy—Total	90.33%	94.65%	95.84%	91.96%	93.16%
Annual Dental Visit—Total	41.25%	58.04%	58.82%	54.76%	50.88%
Child and Adolescent Well-Care Visits—Total	37.07%	53.55%	54.36%	54.66%	49.97%
Childhood Immunization Status—Combination 10	19.50%	25.51%	28.53%	21.85%	21.05%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.42%	60.56%	63.40%	66.67%	63.94%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	63.50%	68.01%	68.11%	68.81%	65.57%
Managed Long-Term Services and Supports—Comprehensive Care Plan and Update—Care Plan with Core Elements	83.33%	54.17%	71.88%	76.04%	82.29%
Managed Long-Term Services and Supports—Comprehensive Care Plan and Update—Care Plan with Supplemental Elements	83.33%	54.17%	71.88%	76.04%	82.29%
Managed Long-Term Services and Supports—Successful Transition After Long-Term Institutional Stay—Observed/Expected Ratio	NA	0.14	0.19	0.10	01.0

MMAI

Table 88 presents MY 2023 MMAI rates for Humana.

Table 88—MMAI HEDIS Performance Measure Results for MY 2023

Measure	Humana
Adults' Access to Preventive/Ambulatory Health Services	
20–44 years	82.22%
45–64 years	90.09%
65+ years	90.42%
Total	89.44%
Initiation and Engagement of SUD Treatment	
Initiation of SUD Treatment—18–64 years	53.55%
Initiation of SUD Treatment—65+ years	44.49%
Initiation of SUD Treatment—Total	49.85%
Engagement of SUD Treatment—18–64 years	7.87%
Engagement of SUD Treatment—65+ years	4.78%
Engagement of SUD Treatment—Total	6.61%

Table 89 presents MY 2023 rates for the IL 3.6 measure for each MMP.

Table 89—MMAI IL 3.6 Performance Measure Results for MY 2023

Health Plan	Percentage of members who were classified as being in LTC as of the first day of the reporting period.	Percentage of members who were classified as being in LTC as of the last day of the reporting period.	Percentage of members who were not classified as being in LTC as of the first day of the reporting period.	Percentage of members who were not classified as being in LTC as of the last day of the reporting period.
Aetna	7.00%	7.00%	93.00%	93.00%
BCBSIL	4.40%	4.50%	95.60%	95.50%
Humana	5.40%	3.10%	94.60%	96.90%
Meridian	8.60%	8.00%	91.40%	92.00%
Molina	7.70%	8.30%	92.30%	91.70%

Mandatory Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Validation of PIPS				
Improving Timeliness of Prenatal Care	Annual	CY 2023	Health plan submission of PIP Submission Form: January 2024 Initial validation findings and health plan responses: February 2024	Final validation findings provided to HFS and health plans: March 2024
Improving Transportation Services	Annual	CY 2023	Health plan submission of PIP Submission Form: August 2024 Initial validation findings and health plan responses: September 2024	Final validation findings provided to HFS and health plans: October 2024
PMV				
HEDIS Compliance, PMV	Annual	MY 2023	Audit Validation Phase: December 2023 Audit Review Phase: January 2024 Follow-Up and Reporting Phase: May 2024	Audit Validation Phase: March 2024 Audit Review Phase: April 2024 Follow-Up and Reporting Phase: July 2024
MMAI IL 3.6	Annual	MY 2023	Data receipt: August 2024 Validation phase: September–October 2024	Final report delivered December 2024

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Compliance Monitoring				
Compliance Monitoring Review	Once every three years; conducted over two-year period with the three-year cycle	SFY 2024	Desk review: July-September 2023 File and webinar review: July–November 2023 Reporting and remediation: January–March 2024	Final reports delivered May 2024
Readiness Review	As directed for new programs or populations	CY 2023	Desk review: November 2023 Webinar review: November 2023 Reporting: December 2023	Final reports delivered March 2024
NAV				
NAV	Annual	SFY 2024	ISCA submission by health plans: May–June 2024 Virtual reviews and system demonstrations: July–August 2024 Validation and report development: August–December 2024	Final report delivered December 2024

Optional/Additional Activities

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Optional Activities				
Beneficiary Experience With Care (CAHPS)	Annual	2024 survey	Member letters mailed April 2024 CATI for non-respondents completed June 2024 Data reconciliation, analysis and reporting conducted July–November 2024	Final reports delivered December 2024
Additional Activities				
Quality Rating System	Annual	MY 2023	Data receipt: June 2024 Analysis and report development: June–July 2024	Production of consumer report card: August 2024
Network Adequacy Monitoring	Quarterly	Provider network data submitted by the health plans: February 2024 May 2024 August 2024 November 2024	February 2024 May 2024 August 2024 November 2024	April 2024 July 2024 October 2024 December 2024
Access and Availability Survey	Annual	Provider network data submitted by the health plans on February 23, 2024	Survey: March 2024	Survey: April 2024 Final report delivered: October 2024

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
Time and Distance Study	Annual	Provider network data submitted by the health plans in May 2024 Enrollee data provided by HFS in May 2024	Analysis: August 2024 Validation: September 2024	Final report delivered: December 2024
Evaluation of Quality Strategy	Once every three years per the quality strategy revision cycle	CY 2020, 2021, 2022 (MY 2020, 2021, 2022)	October 2024	April 2024
CM Staffing and Training Reviews	Biannual	CY 2024 First review inclusive of data for staff with hire dates on or before April 1, 2024 Second review inclusive of data for staff with hire dates on or before November 1, 2024	First review Submission of health plan data: April 2024 Analysis: April–May 2024 Second review Submission of health plan data: November 2024 Analysis: November–December 2024	First review report delivery: May 2024 Second review report delivery: January 2025
Critical Incident Monitoring Review	Quarterly	CY 2024 Health plan data submissions occur two months prior to each quarter.	Q1 reviews: January–March 2024 Q2 reviews: May–June 2024 Q3 reviews: August–September 2024 Q4 reviews: November–December 2024	Reports developed and submitted one month post-quarter end

Activity	Activity Cadence	MY/Activity Year/Data Span Included in Report	Activity Commenced	Activity Concluded
CMS HCBS Waiver Performance Measure Record Review	Quarterly	CY 2024 The CY 2024 reviews assessed performance during a lookback period (retrospective review) of case management activities conducted and documented from June 1, 2023, through August 31, 2024.	Q1 reviews: January–March 2024 Q2 reviews: April–June 2024 Q3 reviews: July–September 2024 Q4 reviews: October–December 2024	Reports developed and submitted one month post-quarter end
QA/UR/PR Annual Report Review	Annual	SFY 2024	October 2024	January 2025
Care Gap Plan Review	Annual	SFY 2023	Health plan submissions: May 2024 Review and analysis: June 2024	Report development and submission: August 2024
MHP Review	Annual	CY 2023–CY 2024	October 2024	December 2024
1915b Waiver IA	Per the waiver renewal cycle	CY 2021, 2022, 2023	SNC: October 2023 MLTSS: March 2024	SNC: March 2024 MLTSS: September 2024

Appendix E. EQR Technical Report Requirements

Table 90 lists the required and recommended elements for the EQR technical report, per 42 CFR §438.364 and recent CMS technical report feedback received by states. Table 90 also identifies the page number where the corresponding information that addresses each element is located in the EQR technical report, if applicable. In the table below, NA represents "not applicable" to indicate that this information will be included in subsequent reports and page numbers will be able to be determined.

Table 90—EQR Technical Report Requirements

Item #	Required Elements	Page Number
1.	The state submitted its EQR technical report by April 30th.	NA
2.	Include a clickable or hyperlinked table of contents for easy navigation throughout the report.	i
3.	All eligible Medicaid and CHIP plans are included in the report.	1–2, 6
4.	Describe the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO, PIHP, or PAHP, or PCCM entity.	3, Appendix A
5.	Validation of PIPs: A description of PIP interventions associated with each state-required PIP topic for the current EQR review cycle, and the following for the validation of PIPs: objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	16–24, Appendix A
6.	Validation of performance measures: A description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	24–30, Appendix A
7.	Review for compliance: 42 CFR §438.358(b)(1)(iii) (cross-referenced in CHIP regulations at 42 CFR §457.1250[a]) requires the technical report include information **on a review, conducted within the previous three-year period**, to determine each MCO's, PIHP's, PAHP's or PCCM's compliance with the standards set forth in Subpart D and the QAPI requirements described in 42 CFR §438.330. Additional information that needs to be included for compliance is listed below:	30–35, Appendix A
8.	Network Adequacy Validation: A description of objectives, technical methods of data collection and analysis, description of data obtained, and conclusions drawn from the data.	35–38, Appendix A
9.	Include an assessment of each MCE's strengths and weaknesses for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries. Include recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, or PAHP.	79–158

Item #	Required Elements	Page Number
10.	The technical report must include recommendations for how the state can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality, timeliness, and access to healthcare services furnished to Medicaid or CHIP beneficiaries.	6–15
11.	Ensure methodologically appropriate, comparative information about all *MCE*s, consistent with guidance included in the EQR protocols issued in accordance with § 438.352(e).	Throughout report
12.	Include an assessment of the degree to which each MCE has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.	79–158
13.	Include the names of the MCOs exempt from external quality review by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.	6
14.	EQR technical reports should share the EQRO's timeline for conducting EQR activities.	Appendix D
15.	The information included in the technical report must not disclose the identity or other protected health information of any patient. 42 CFR 438.364(d).	NA