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

Due date	Last edited	Edited by	Status
06/28/2024	06/28/2024	Amy Harris Roberts	Submitted

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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Illinois
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	[redacted]
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	[redacted]
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	[redacted]
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	[redacted]
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/28/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2023
A6	**Program name** Auto-populated from report dashboard.	HealthChoice Illinois (HCI)

Add plans (A.7)

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

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

Add BSS entities (A.8)

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

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

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

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	3,739,978
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	2,799,505

Topic III. Encounter Data Report

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	The Department's Office of the Inspector General (OIG) conducts Program Integrity (PI) activities for Medicaid providers who bill through fee-for-service as well as managed care. These activities include audits, criminal and administrative investigations, and data analytics. The OIG oversees the MCP's special investigative units (SIUs), which perform contractually mandated PI activities for the Medicaid providers in their networks. The OIG operates a MCP fraud reporting portal into which SIUs report all of their activities related to fraud, waste and abuse. The OIG monitors that system to identify opportunities for information sharing, collaboration on investigations and audits, approvals for overpayment recoupments, and tracking of metrics and outcomes. The OIG and SIUs meet monthly to discuss specific allegations of fraud, waste and abuse; fraud trends in the field; and any problems and solutions encountered in complementary work. In 2023, the MCO SIUs worked on 1060 audits and investigations, referred 434 cases to the OIG, and established over $26,696,000 in overpayments.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	Allow plans to retain overpayments
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Sections 5.35.10, 5.35.11 and 5.35.12 of the Contract.
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments,	Section 5.35.11 of the Contract establishes the plans' requirement to report to the state any overpayments to providers and to request approval to recover those overpayments. The plans must process all recoveries and overpayments as a service line level or claim level void to the original encounter data.

	or administers a hybrid system) selected in indicator B.X.2.	
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The Department's OIG monitors the plans' established overpayments and requests for recoveries through its MCO Fraud Reporting Portal. The OIG also collects data on the plans' actual recoveries after they are approved to start collection activities.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Department sends the MCP's a daily HIPAA Compliant 834 file that contains any enrollments and disenrollment's that happened within the State system on that day. This file contains all up-to-date information kept on each customer by the State including status details such as address changes, new phone numbers, date of death information, estimated delivery dates and plan switch information. Monthly, the Department sends the MCPs a reconciliation HIPAA Compliant 834 Audit file that contains every customer that will be enrolled in their plan for the next calendar month. The audit file includes all up-to-date information that has been captured by the Department on the customer, such as contact information, address, case updates, and the capitation payment that the Department is paying the MCP for each customer that month. The audit file ensures any updates that may have been missed through processing the daily 834 files has been provided to the MCPs and is updated in the MCPs system. This process ensures that both systems are in sync on the first day of the following month. MCP's at anytime can contact the Department's eligibility and enrollment team if there are questions and also utilize tools that the Department has made available, such as enrollment error files that are exchanged between the Department and the MCPS to troubleshoot any differences identified between the Department's record and the MCPs record. The Department systematically closes recipients who become ineligible for

		MCO coverage weekly and on the last system day of the month. Results of the disenrollment's are analyzed and reviewed by Department staff for accuracy and ensure any enrollment changes made are in compliance with State Statutes, Contract requirements and Program Policy. In addition, the Department recoups payments from the MCPs based off of an 18 month look back adjustment period.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	Yes
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	No
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to	No

	§455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	The Department conducted an Encounter and Financial Data Audit for the period of 2022 - 2023. The Audit Report was posted in September 2023 at the following link: https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/fy20222023encounterdatavalidationreport.pdf

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	HealthChoice Illinois (HCI)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	01/01/2018
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://hfs.illinois.gov/medicalproviders/cc/managedcarecontracts.html
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Other, specify – 5 Managed Care Organizations (Aetna, Blue Cross, Meridian, Molina and YouthCare) and 1 Managed Care Community Network (CountyCare).
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health Long-term services and supports (LTSS) Dental Transportation
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	In the HCI program, Long-term services and supports (LTSS) is only offered to the individuals enrolled in Long Term Care and the five Home Community Based Service Waiver Programs.
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	2,799,505

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	In CY2023, the Department resumed regular eligibility verifications, also known as renewals or redeterminations, for its Medicaid customers. The Department implemented strategies to help individuals get ready to renew and connect to coverage. These strategies included coordinating with other State Agencies, providers and community-based partners and the MCOs to ensure customers received important information during this unwinding period and informing customers of their Medicaid eligibility redetermination date. Customers that were no longer eligible for Medicaid as a result of the eligibility verification process, were disenrolled from the Managed Care Program/MCO. In addition, effective March 1, 2023, the Department transitioned the Interstate Compact Children into HealthChoice Illinois. These are children that have been DCFS children in another state and have either been adopted or are being fostered and now live in Illinois. No additional major changes in enrollment occurred. Also in CY2023, benefits were expanded to include • Pharmacists – provide HIV services and assessments for birth control • Peer Recovery Support Services • Acupuncture Services • Certified Professional Midwives Services

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Use of correct file formats Overall data accuracy (as determined through data validation) Other, specify – The State applies a Quarterly Encounter Utilization Monitoring (EUM) process to evaluate the MCPs for the completeness of data submissions for Healthchoice Illinois. The State reviews and evaluates the MCPs based data submissions for completeness based on 4 rolling quarters. The MCPs are required to meet minimum 98% of overall completeness and 88% of the category level completeness to avoid monetary sanctions (financial penalties). In addition, other includes: Medical Record Procurement Rate, Second Date of Service Submission Rate, Medical Record Omission Rate, Encounter Data Omission Rate, Diagnosis Code Accuracy, Procedure Code Accuracy, Procedure Coe Modifier Accuracy, and All-Element Accuracy Rate.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Contract Sections 1.1.73 and 5.27.3; and Attachment XI, Attachment XIII, and Attachment XXIII
C1III.4	**Financial penalties contract language**	Contract Section 7.16.6.

	Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	The Department did not experience any barriers to collecting or validating encounter data during the reporting period.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A critical incident is defined in the HCI Contract in Section 1.1.5 as any event that is indicated in Attachment XVII. Contract Section 5.23.2 and Attachment XVII outline specific critical incident definitions.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Timely resolution of appeals is defined in HCI Contract Section 5.30.3.4, and says "If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State agency's hearing office that there is a need for additional information and the delay is in the Enrollee's interest."
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Expedited resolution of appeals is defined in HCI Contract Section 5.30.3.3, and says "If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not discriminate or take punitive action against a Provider who either requests an expedited resolution of Appeal or supports an Enrollee's Appeal pursuant to 42 CFR §438.410(b)."
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution	Timely resolution of grievances is defined in HCI Contract Section 5.30.1.5 and says "Contractor shall attempt to resolve all Grievances as soon as possible but no later than ninety (90) days from receipt of a Grievance. Contractor may inform an Enrollee of the resolution orally or in writing."

	of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	Per the Department's most recent Network Access Verification (NAV) report, completed in June of 2023, and covered data from the plans regarding providers contracted as of February 24, 2023, the biggest challenges identified were: Providing adequate access to pharmacies in urban counties located in the Northwestern, Central, and Collar Counties Public Health Regions. Access to pharmacies is held to a higher standard than other provider categories, requiring that 100 percent of urban enrollees have access within 15 minutes or miles and rural residents have access within 60 minutes or miles from their residence. All statewide health plans met this standard in rural counties, but some health plans did not meet the standard in all urban counties. While there was some variation in findings, no statewide health plan met the time and distance standard for pharmacies in three of 102 Illinois counties. Overall, 99.9% of members statewide had access to pharmacies within the required time and distance standards for urban and rural counties. Access to Oral Surgery specialists for adults and children was also a challenge, with all plans failing to meet standards in the Southern region, and two plans also failing to meet standards in Northwestern and Central regions. Overall, 95.9% of members statewide had access to Oral Surgery providers within the required time and distances standards for urban and rural counties.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The State requires the MCPs to submit written responses and their plan of action to address and close any identified network gaps. If necessary, MCPs are placed on a corrective action plan (CAP) if continued noncompliance occurs with network requirements. The State monitors the MCPs' progress for remediating any identified network gaps by completing a review of responses and any associated data file submissions. All CAPs are approved for closure by the State if MCPs demonstrate compliance with network standards. The State also asked the EQRO to stratify results by age, gender, race, and ethnicity as well as whether enrollees live in disproportionately impacted zip codes to examine whether there are

	disparities in access among groups. In addition, the state continues to explore options to assess enrollee access to providers using revised time and distance standards that reflect the intense urban development in Illinois such as walking or travel by public transportation or other alternatives in addition to drive times.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 28

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 28

C2.V.2 Measure standard

Access to 2 PCPs within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 28

C2.V.2 Measure standard

Access to 1 PCPs within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 28

C2.V.2 Measure standard

Access to 2 behavioral health service providers within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

4 / 28

C2.V.2 Measure standard

Access to 1 behavioral health service provider within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

5 / 28

C2.V.2 Measure standard

Access to 2 OB/GYN providers within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider
OB/GYN

C2.V.5 Region
Urban

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods
Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

6 / 28

C2.V.2 Measure standard
Access to 1 OB/GYN provider within 60 miles or 60 minutes

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
OB/GYN

C2.V.5 Region
Rural

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods
Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

7 / 28

C2.V.2 Measure standard
Access to 1 pediatric dentist within 30 miles or 30 minutes

C2.V.3 Standard type
Maximum time or distance

C2.V.4 Provider
Pediatric Dental

C2.V.5 Region
Urban

C2.V.6 Population
Pediatric

C2.V.7 Monitoring Methods
Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

8 / 28

C2.V.2 Measure standard

Access to 1 pediatric dentist within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pediatric Dental	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

9 / 28

C2.V.2 Measure standard

Access to 1 general or critical access hospital within 30 miles or 30 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

10 / 28

C2.V.2 Measure standard

Access to 1 general or critical access hospital within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

11 / 28

C2.V.2 Measure standard

Access to 1 pharmacy within 15 miles or 15 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

12 / 28

C2.V.2 Measure standard

Access to 1 pharmacy within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

13 / 28

C2.V.2 Measure standard

Access to 1 specialty services provider within 60 miles or 60 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

14 / 28

C2.V.2 Measure standard

Access to 1 specialty services provider within 90 miles or 90 minutes

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 28

C2.V.2 Measure standard

Five weeks for routine, preventive care; Three weeks for problems or complaints that are not deemed serious

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary Care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 28

C2.V.2 Measure standard

Two weeks for an enrollee in her first trimester; One week for an enrollee in her second trimester

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 28

C2.V.2 Measure standard

Percentage of provider availability for specialty providers

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Revealed shopper calls

C2.V.8 Frequency of oversight methods

As needed

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 28

C2.V.2 Measure standard

Percentage of provider availability for specialty providers

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Revealed Shopper Calls

C2.V.8 Frequency of oversight methods

As needed

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

C2.V.2 Measure standard

One or more contracted provider for at least 80% of counties statewide

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS	Statewide	MLTSS

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

C2.V.2 Measure standard

Access to at least two (2) LTSS Providers within a thirty (30)-mile radius of or thirty (30)-minute drive from the Enrollee's residence

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS	Urban	MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

EQRO Compliance Reviews

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

C2.V.2 Measure standard

If an Enrollee lives in a Rural Area, the Enrollee shall have access to at least two (2) LTSS Providers within a sixty (60)-mile radius of or sixty (60)-minute drive from the Enrollee's residence.

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS	Rural	MLTSS

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

EQRO Compliance Reviews

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
OB/GYN	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialist	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Hospital	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 28

C2.V.2 Measure standard

Bi-annual provider network capacity report and gap analysis completed to monitor the MCOs network to ensure that no significant changes occurred.

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Nursing Facilities, Ancillary Providers, Health Clinics	Statewide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider Distribution Analysis

C2.V.8 Frequency of oversight methods

Bi-annually

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://enrollhfs.illinois.gov/
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	The Illinois Client Enrollment Broker (ICEB) provides an interactive website at Enroll HFS and a Call Center that can be reached toll-free phone at 1-877-912-8880 or with a TTY Number: 1-866-565-8576. The Call Center is staffed with both English and Spanish-speaking individuals. When a caller speaks a language other than English or Spanish, the ICEB offers and supplies interpretive services for any language at no charge to the caller. The ICEB in conjunction with the Department and with input from the MCPs develops and maintains educational materials designed to provide Potential Enrollees and Enrollees with clear, concise, and accurate information about the Health Plans. Written materials are available in English and Spanish, and other prevalent languages determined by the Department. In addition, they are available in alternative formats, such as large print, Braille, or audio CDs and in a manner that takes into consideration the special needs of those who, for example, are visually limited, or hearing-impaired. Materials are at or below a sixth-grade level for clarity and for those who have limited reading proficiency. The materials are reviewed by a health literacy group within the ICEB organization to ensure that the materials are easily understood. Key Oral Contacts are in a language the customer understands.
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Review and oversight of the LTSS program data is handled largely by the State Medicaid Agency. The ICEB largely becomes aware of LTSS system issues via customer inquiries. The ICEB maintains a Customer Call center and when the ICEB becomes aware of issue where a seemingly LTSS eligible customer is not able to enroll in an LTSS plan or is enrolled and is not receiving assistance with a specific service. In either instance, the ICEB Customer Service Representative will intake the issue and submit it as an incident through the ICEB Internal

		Enrollment Portal as a task. Urgent requests are given a priority one and are sent to the state within 1 business day of receipt. The state regularly monitors the task queue in the internal portal throughout the day. The issues are then promptly researched and resolved by the state and outreach, if necessary is completed by the ICEB or the appropriate section within the state.
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	The Stare uses variety of methods to evaluate the quality, effectiveness, and efficiency of the ICEB's performance. The ICEB is required to submit the following reports to the State either monthly, quarterly, or annually to demonstrate their quality of their performance. Monthly • Monthly Enrollment Summary Report • IP Address Report • Task Queue Report • Call Center Report • Enrollment Report • Enrollee Complaint and Grievance Report Enrollee Assignment Report • Operator Availability Report • Monthly QA Call Monitoring Report • ICEB Staffing Report Quarterly • Vendor Compliance Matrix • Current Organizational Chart Annually • Annual Financial Statements • Annual Hiring Report The State has also established Call Center Standards that are designed to ensure a high level of customer service and assist in our evaluation of the quality, effectiveness, and efficiency of the performance of the ICEB. The performance standards are listed below and are evaluated monthly via analysis of monthly reports. • Less than three percent (3%) of incoming calls receive a busy signal. • All calls are answered by the automated voice response system within 3 rings. • Average wait time after the initial automated voice pick-up until interaction with Call Center staff • is 3 minutes or less. (Updated 10/1/23 to be 30 seconds or less) • Average abandonment rate is no more than 7 percent. (Updated 10/1/23 to be less than 2.5%) • Average time on hold after initial interaction with Call Center staff is 3 minutes or less. • Sufficient number of qualified staff are available on-site to communicate with callers who speak • English or Spanish. • Interpretive services are available via telephone 100 percent of the time when requested by • callers who speak languages other than English or Spanish. • TDD/TTY capabilities are available 100 percent of the time when requested. The contract with

the ICEB provides for the following Service Level Performance Guarantees. • Pattern of Failure to Provide Services. • Charging Enrollees. • Enrollee Discrimination. • Misrepresentation. • Enrollment Materials. • Outreach Materials. • Education. • Data Systems. • Call Center. • Staffing. • Reporting. • Close Out and Turnover. Service Level Performance Guarantees were updated 10/1/23 with the signing of a new contract. They include the following: • Service availability. • Public facing enrollment website availability. • Call Center vendor enrollment system availability. • Vendor Provided Electronic Data Interface (EDI) Portal • Vendor Call Recording and Archiving System • Average Speed of Answer (ASA) by the Integrated Voice Recognition (IVR) • Average Speed of Answer (ASA) by live Client Service Representatives (CSRs) • First Call Resolution • Open Call (Client Issue) Resolution • Call Back Requests • Telephone Abandonment Rate • Client Service Representative (CSR) Quality Assurance • Transaction Processing – Accuracy • Transaction processing – Timeliness • Client Material Mailings • Returned, non-deliverable initial enrollment packet mailings. • Communication fulfillment – On-line updates to enrollment website/portal • Complaint Escalation to Agency • Management reporting timeliness • Client satisfaction • Root cause analysis of system or processing error State staff member randomly reviews several ICEB calls daily to ensure compliance with Department guidelines. In addition, State staff and ICEB conduct monthly call calibration sessions with the purpose of reviewing the effects of policies, procedures, and scripting to enrich the client experience and ensure that customers are receiving unbiased, accurate education and are treated with dignity and respect. In addition, State and ICEB staff conduct bi-weekly Operations meeting. At these meetings, topics such as Updates, New Projects, Current Projects, In Process Projects, Future Projects and On Hold Items are discussed and reviewed. And the ICEB prepares and presents A Year in Review Power Point presentation which highlights their performance and accomplishments and details completed initiatives.

Topic X: Program Integrity

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

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Aetna Better Health** 401,127 **Blue Cross Community Health Plans** 761,180 **CountyCare Health Plan** 427,086 **Meridian Health** 839,679 **Molina HealthCare** 334,699 **YouthCare** 35,734
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Aetna Better Health** 10.7% **Blue Cross Community Health Plans** 20.4% **CountyCare Health Plan** 11.4% **Meridian Health** 22.5% **Molina HealthCare** 8.9% **YouthCare** 1%

D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Aetna Better Health** 14.3% **Blue Cross Community Health Plans** 27.2% **CountyCare Health Plan** 15.2% **Meridian Health** 30% **Molina HealthCare** 12% **YouthCare** 1.3%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Aetna Better Health** 90% **Blue Cross Community Health Plans** 89% **CountyCare Health Plan** 90% **Meridian Health** 92% **Molina HealthCare** 87% **YouthCare** N/A
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Aetna Better Health** Statewide all programs & populations **Blue Cross Community Health Plans** Statewide all programs & populations **CountyCare Health Plan** Statewide all programs & populations **Meridian Health** Statewide all programs & populations **Molina HealthCare** Statewide all programs & populations **YouthCare**

		Other, specify – Undefined - YouthCare is included in the Meridian HCI 2022 MLR as reported to CMS in December 2023.
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Aetna Better Health** N/A **Blue Cross Community Health Plans** N/A **CountyCare Health Plan** N/A **Meridian Health** N/A **Molina HealthCare** N/A **YouthCare** N/A
D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Aetna Better Health** Yes **Blue Cross Community Health Plans** Yes **CountyCare Health Plan** Yes **Meridian Health** Yes **Molina HealthCare** Yes **YouthCare**

		Yes
N/A	Enter the start date.	**Aetna Better Health** 01/01/2022 **Blue Cross Community Health Plans** 01/01/2022 **CountyCare Health Plan** 01/01/2022 **Meridian Health** 01/01/2022 **Molina HealthCare** 01/01/2022 **YouthCare** 01/01/2022
N/A	Enter the end date.	**Aetna Better Health** 12/31/2022 **Blue Cross Community Health Plans** 12/31/2022 **CountyCare Health Plan** 12/31/2022 **Meridian Health** 12/31/2022 **Molina HealthCare** 12/31/2022 **YouthCare** 12/31/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Aetna Better Health** The State requires the MCPs to submit encounter data no later than 90 days after being paid. **Blue Cross Community Health Plans** The State requires the MCPs to submit encounter data no later than 90 days after being paid. **CountyCare Health Plan** The State requires the MCPs to submit encounter data no later than 90 days after being paid. **Meridian Health** The State requires the MCPs to submit encounter data no later than 90 days after being paid. **Molina HealthCare** The State requires the MCPs to submit encounter data no later than 90 days after being paid. **YouthCare** The State requires the MCPs to submit encounter data no later than 90 days after being paid.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data	**Aetna Better Health** 100% **Blue Cross Community Health Plans** 100% **CountyCare Health Plan** 100% **Meridian Health**

	submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	100% **Molina HealthCare** 100% **YouthCare** 100%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	**Aetna Better Health** 100% **Blue Cross Community Health Plans** 100% **CountyCare Health Plan** 100% **Meridian Health** 100% **Molina HealthCare** 100% **YouthCare** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna Better Health** 2,937 **Blue Cross Community Health Plans** 4,234 **CountyCare Health Plan** 2,982 **Meridian Health** 3,408 **Molina HealthCare** 1,338 **YouthCare** 139
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health** 454 **Blue Cross Community Health Plans** 95 **CountyCare Health Plan** 43 **Meridian Health** 163 **Molina HealthCare** 22 **YouthCare** 5

D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**Aetna Better Health** 34 **Blue Cross Community Health Plans** 326 **CountyCare Health Plan** 4 **Meridian Health** 14 **Molina HealthCare** 71 **YouthCare** 0
D1IV.4	**Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the	**Aetna Better Health** 5 **Blue Cross Community Health Plans** 13 **CountyCare Health Plan** 0 **Meridian Health** 0 **Molina HealthCare** 0 **YouthCare** 0

same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Aetna Better Health** 2,862 **Blue Cross Community Health Plans** 3,758 **CountyCare Health Plan** 1,920 **Meridian Health** 3,289 **Molina HealthCare** 1,291 **YouthCare** 128
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Aetna Better Health** 108 **Blue Cross Community Health Plans** 439 **CountyCare Health Plan** 1,000

Meridian Health

101

Molina HealthCare

41

YouthCare

10

D1IV.6a

Resolved appeals related to denial of authorization or limited authorization of a service

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

Aetna Better Health

2,936

Blue Cross Community Health Plans

3,904

CountyCare Health Plan

460

Meridian Health

3,408

Molina HealthCare

187

YouthCare

119

D1IV.6b

Resolved appeals related to reduction, suspension, or termination of a previously authorized service

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

Aetna Better Health

33

Blue Cross Community Health Plans

4

CountyCare Health Plan

0

Meridian Health

0

Molina HealthCare

1

YouthCare

20

D1IV.6c

Resolved appeals related to payment denial

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

Aetna Better Health

70

Blue Cross Community Health Plans

73

CountyCare Health Plan

0

Meridian Health

2,213

Molina HealthCare

2

YouthCare

102

D1IV.6d

Resolved appeals related to service timeliness

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

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

0

Meridian Health

0

Molina HealthCare

759

YouthCare

0

D1IV.6e

Resolved appeals related to lack of timely plan response to an appeal or grievance

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

Aetna Better Health

0

Blue Cross Community Health Plans

0

CountyCare Health Plan

2

Meridian Health

0

Molina HealthCare

6

YouthCare

0

D1IV.6f

Resolved appeals related to plan denial of an enrollee's right to request out-of-network care

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).

Aetna Better Health

0

Blue Cross Community Health Plans

5

CountyCare Health Plan

6

Meridian Health

0

Molina HealthCare

382

YouthCare

0

D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Aetna Better Health** 1 **Blue Cross Community Health Plans** 0 **CountyCare Health Plan** 0 **Meridian Health** 0 **Molina HealthCare** 1 **YouthCare** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Aetna Better Health** 164 **Blue Cross Community Health Plans** 160 **CountyCare Health Plan** 27 **Meridian Health** 54 **Molina HealthCare** 29 **YouthCare** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Aetna Better Health** 2,782 **Blue Cross Community Health Plans** 275 **CountyCare Health Plan** 339 **Meridian Health** 1,903 **Molina HealthCare** 1 **YouthCare** 16

D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Aetna Better Health** 49 **Blue Cross Community Health Plans** 104 **CountyCare Health Plan** 5 **Meridian Health** 419 **Molina HealthCare** 2 **YouthCare** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Aetna Better Health** 55 **Blue Cross Community Health Plans** 4 **CountyCare Health Plan** 246 **Meridian Health** 3 **Molina HealthCare** 0 **YouthCare** 1
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs**	**Aetna Better Health** 1,760

	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Blue Cross Community Health Plans** 2,813 **CountyCare Health Plan** 845 **Meridian Health** 3,973 **Molina HealthCare** 500 **YouthCare** 49
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Aetna Better Health** 70 **Blue Cross Community Health Plans** 7 **CountyCare Health Plan** 10 **Meridian Health** 13 **Molina HealthCare** 0 **YouthCare** 0
D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that	**Aetna Better Health** 29 **Blue Cross Community Health Plans**

	were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	20 **CountyCare Health Plan** 0 **Meridian Health** 14 **Molina HealthCare** 5 **YouthCare** 0
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Aetna Better Health** 282 **Blue Cross Community Health Plans** 779 **CountyCare Health Plan** 955 **Meridian Health** 1,089 **Molina HealthCare** 313 **YouthCare** 45
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 0 **CountyCare Health Plan**

0

Meridian Health

0

Molina HealthCare

1

YouthCare

0

D1IV.7j

Resolved appeals related to other service types

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

Aetna Better Health

837

Blue Cross Community Health Plans

74

CountyCare Health Plan

47

Meridian Health

166

Molina HealthCare

487

YouthCare

9

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Aetna Better Health** 45 **Blue Cross Community Health Plans** 48 **CountyCare Health Plan** 25 **Meridian Health** 26 **Molina HealthCare** 14 **YouthCare** 3
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Aetna Better Health** 2 **Blue Cross Community Health Plans** 10 **CountyCare Health Plan** 2 **Meridian Health** 0 **Molina HealthCare** 0 **YouthCare** 0

D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Aetna Better Health** 1 **Blue Cross Community Health Plans** 4 **CountyCare Health Plan** 4 **Meridian Health** 14 **Molina HealthCare** 6 **YouthCare** 2
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Aetna Better Health** 36 **Blue Cross Community Health Plans** 27 **CountyCare Health Plan** 13 **Meridian Health** 5 **Molina HealthCare** 8 **YouthCare** 0
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee**	**Aetna Better Health** 27

	If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Blue Cross Community Health Plans** 208 **CountyCare Health Plan** 48 **Meridian Health** 24 **Molina HealthCare** 16 **YouthCare** 0
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Aetna Better Health** 103 **Blue Cross Community Health Plans** 209 **CountyCare Health Plan** 87 **Meridian Health** 36 **Molina HealthCare** 21 **YouthCare** 0

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Aetna Better Health** 1,765 **Blue Cross Community Health Plans** 21,151 **CountyCare Health Plan** 4,042 **Meridian Health** 2,845 **Molina HealthCare** 7,124 **YouthCare** 125
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Aetna Better Health** 275 **Blue Cross Community Health Plans** 3,201 **CountyCare Health Plan** 5 **Meridian Health** 6 **Molina HealthCare** 278 **YouthCare** 20

D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Aetna Better Health** 167 **Blue Cross Community Health Plans** 2,243 **CountyCare Health Plan** 131 **Meridian Health** 163 **Molina HealthCare** 709 **YouthCare** 0
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should	**Aetna Better Health** 4 **Blue Cross Community Health Plans** 185 **CountyCare Health Plan** 5 **Meridian Health** 0 **Molina HealthCare** 44 **YouthCare** 0

	enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Aetna Better Health** 1,764 **Blue Cross Community Health Plans** 21,121 **CountyCare Health Plan** 4,009 **Meridian Health** 2,841 **Molina HealthCare** 7,111 **YouthCare** 125

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 54 **Blue Cross Community Health Plans** 15 **CountyCare Health Plan** 45 **Meridian Health** 0 **Molina HealthCare** 131 **YouthCare** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 1,671 **Blue Cross Community Health Plans** 428 **CountyCare Health Plan** 1,867 **Meridian Health** 88 **Molina HealthCare** 248 **YouthCare** 20

D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 1 **Blue Cross Community Health Plans** 36 **CountyCare Health Plan** 1 **Meridian Health** 0 **Molina HealthCare** 10 **YouthCare** 0
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 20 **Blue Cross Community Health Plans** 13 **CountyCare Health Plan** 0 **Meridian Health** 1 **Molina HealthCare** 45 **YouthCare** 0
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs**	**Aetna Better Health** 150

	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Blue Cross Community Health Plans** 1,735 **CountyCare Health Plan** 12 **Meridian Health** 18 **Molina HealthCare** 1,117 **YouthCare** 20
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 224 **Blue Cross Community Health Plans** 20 **CountyCare Health Plan** 3 **Meridian Health** 1 **Molina HealthCare** 19 **YouthCare** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional	**Aetna Better Health** 167 **Blue Cross Community Health Plans**

	LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	98 **CountyCare Health Plan** 116 **Meridian Health** 163 **Molina HealthCare** 301 **YouthCare** 0
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 160 **Blue Cross Community Health Plans** 1,000 **CountyCare Health Plan** 86 **Meridian Health** 185 **Molina HealthCare** 418 **YouthCare** 3

D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Aetna Better Health** 739 **Blue Cross Community Health Plans** 2,447 **CountyCare Health Plan** 800 **Meridian Health** 1,682 **Molina HealthCare** 1,167 **YouthCare** 33
D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i paid primarily by Medicaid, enter "N/A".	**Aetna Better Health** 841 **Blue Cross Community Health Plans** 15,347 **CountyCare Health Plan** 2,114 **Meridian Health** 501 **Molina HealthCare** 4,169 **YouthCare** 49

Grievances by Reason

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

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Aetna Better Health** 785 **Blue Cross Community Health Plans** 9,722 **CountyCare Health Plan** 542 **Meridian Health** 405 **Molina HealthCare** 528 **YouthCare** 7
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Aetna Better Health** 43 **Blue Cross Community Health Plans** 350 **CountyCare Health Plan** 47 **Meridian Health** 69 **Molina HealthCare** 164 **YouthCare** 0

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Aetna Better Health** 324 **Blue Cross Community Health Plans** 4,986 **CountyCare Health Plan** 6 **Meridian Health** 316 **Molina HealthCare** 3,263 **YouthCare** 2
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Aetna Better Health** 111 **Blue Cross Community Health Plans** 92 **CountyCare Health Plan** 27 **Meridian Health** 83 **Molina HealthCare** 222 **YouthCare** 0
D1IV.16e	**Resolved grievances related to plan communications**	**Aetna Better Health** 9

	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Blue Cross Community Health Plans** 491 **CountyCare Health Plan** 141 **Meridian Health** 2 **Molina HealthCare** 492 **YouthCare** 0
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Aetna Better Health** 157 **Blue Cross Community Health Plans** 6,330 **CountyCare Health Plan** 2,468 **Meridian Health** 168 **Molina HealthCare** 1,609 **YouthCare** 17
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health** 0 **Blue Cross Community Health Plans**

	were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	96 **CountyCare Health Plan** 4 **Meridian Health** 1 **Molina HealthCare** 26 **YouthCare** 0
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 19 **CountyCare Health Plan** 5 **Meridian Health** 4 **Molina HealthCare** 58 **YouthCare** 0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 1 **CountyCare Health Plan**

	were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	0 **Meridian Health** 0 **Molina HealthCare** 884 **YouthCare** 0
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 4 **CountyCare Health Plan** 0 **Meridian Health** 0 **Molina HealthCare** 0 **YouthCare** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Aetna Better Health** 752 **Blue Cross Community Health Plans** 21 **CountyCare Health Plan** 22 **Meridian Health**

1

Molina HealthCare

1,725

YouthCare

99

Topic VII: Quality & Performance Measures

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

Quality & performance measure total count: 106

Complete

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

1 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.12%

Blue Cross Community Health Plans

73.48%

CountyCare Health Plan

69.56%

Meridian Health

73.09%

Molina HealthCare

70.00%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Ambulatory Care: ED Visits—Total

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

631.16

Blue Cross Community Health Plans

BR (Health Plan rate was materially biased)

CountyCare Health Plan

594.11

Meridian Health

581.05

Molina HealthCare

635.83

YouthCare

546.61

Complete

D2.VII.1 Measure Name: Ambulatory Care: Outpatient Visits—Total

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

3322.84

Blue Cross Community Health Plans

BR (Health Plan rate was materially biased)

CountyCare Health Plan

3381.92

Meridian Health

3655.18

Molina HealthCare

3460.29

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Annual Dental Visits—Total

D2.VII.2 Measure Domain

Dental and oral health services

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

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

N/A

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.10%

Blue Cross Community Health Plans

51.91%

CountyCare Health Plan

55.00%

Meridian Health

52.00%

Molina HealthCare

48.70%

YouthCare

57.14%

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits — Total 5 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

43.62%

Blue Cross Community Health Plans

52.32%

CountyCare Health Plan

50.73%

Meridian Health

51.04%

Molina HealthCare

47.91%

YouthCare

59.17%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status—Combination 3

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

58.64%

Blue Cross Community Health Plans

60.83%

CountyCare Health Plan

60.58%

Meridian Health

60.34%

Molina HealthCare

58.39%

YouthCare

67.88%

Complete

D2.VII.1 Measure Name: Childhood Immunization Status—Combination 10

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0038

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

20.92%

Blue Cross Community Health Plans

27.74%

CountyCare Health Plan

32.36%

Meridian Health

24.33%

Molina HealthCare

21.17%

YouthCare

34.31%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents—Combination 1

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

85.16%

Blue Cross Community Health Plans

89.09%

CountyCare Health Plan

83.94%

Meridian Health

90.27%

Molina HealthCare

86.70%

YouthCare

86.86%

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents—Combination 2

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1407

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

27.25%

Blue Cross Community Health Plans

36.14%

CountyCare Health Plan

38.69%

Meridian Health

28.22%

Molina HealthCare

31.24%

YouthCare

38.20%

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

64.72%

Blue Cross Community Health Plans

74.21%

CountyCare Health Plan

85.14%

Meridian Health

66.67%

Molina HealthCare

78.10%

YouthCare

70.56%

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

65.21%

Blue Cross Community Health Plans

65.94%

CountyCare Health Plan

81.08%

Meridian Health

63.02%

Molina HealthCare

61.31%

YouthCare

67.40%

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0024

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.07%

Blue Cross Community Health Plans

63.05%

CountyCare Health Plan

78.72%

Meridian Health

57.91%

Molina HealthCare

60.50%

YouthCare

62.53%

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 15 Months-Six or More Visits

13 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

58.90%

Blue Cross Community Health Plans

66.22%

CountyCare Health Plan

54.96%

Meridian Health

58.64%

Molina HealthCare

61.64%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months-Two or More Visits

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

59.59%

Blue Cross Community Health Plans

67.87%

CountyCare Health Plan

60.38%

Meridian Health

64.07%

Molina HealthCare

61.37%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Breast Cancer Screening

15 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

43.89%

Blue Cross Community Health Plans

53.11%

CountyCare Health Plan

53.11%

Meridian Health

48.57%

Molina HealthCare

48.06%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

16 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

49.64%

Blue Cross Community Health Plans

59.85%

CountyCare Health Plan

60.51%

Meridian Health

56.45%

Molina HealthCare

55.72%

YouthCare

N/A

Complete

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

17 / 106

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

55.32%

Blue Cross Community Health Plans

56.01%

CountyCare Health Plan

65.08%

Meridian Health

46.13%

Molina HealthCare

57.21%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care - Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.51%

Blue Cross Community Health Plans

89.78%

CountyCare Health Plan

84.23%

Meridian Health

89.29%

Molina HealthCare

89.78%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care - Timeliness of Postpartum Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

77.37%

Blue Cross Community Health Plans

79.08%

CountyCare Health Plan

76.70%

Meridian Health

81.51%

Molina HealthCare

77.86%

YouthCare

N/A

Complete

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

20 / 106

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

49.88%

Blue Cross Community Health Plans

63.75%

CountyCare Health Plan

58.15%

Meridian Health

61.80%

Molina HealthCare

61.56%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0018

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

53.77%

Blue Cross Community Health Plans

61.56%

CountyCare Health Plan

53.53%

Meridian Health

58.39%

Molina HealthCare

61.31%

YouthCare

N/A

Complete

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

22 / 106

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

46.47%

Blue Cross Community Health Plans

45.01%

CountyCare Health Plan

52.31%

Meridian Health

51.09%

Molina HealthCare

44.28%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients with Diabetes: HbA1c Control (<8.0%)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

57.18%

Blue Cross Community Health Plans

51.58%

CountyCare Health Plan

48.91%

Meridian Health

49.64%

Molina HealthCare

44.04%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9.0%)

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0061

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

34.31%

Blue Cross Community Health Plans

42.09%

CountyCare Health Plan

44.77%

Meridian Health

40.88%

Molina HealthCare

46.47%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

66.88%

Blue Cross Community Health Plans

70.06%

CountyCare Health Plan

70.34%

Meridian Health

67.14%

Molina HealthCare

66.77%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

70.14%

Blue Cross Community Health Plans

66.77%

CountyCare Health Plan

71.56%

Meridian Health

67.45%

Molina HealthCare

87.52%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders: Ages 18–64 Years

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

28.76%

Blue Cross Community Health Plans

25.48%

CountyCare Health Plan

20.74%

Meridian Health

28.43%

Molina HealthCare

28.69%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

31.29%

Blue Cross Community Health Plans

27.69%

CountyCare Health Plan

26.87%

Meridian Health

28.49%

Molina HealthCare

35.11%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up—Ages 18–64

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.79%

Blue Cross Community Health Plans

43.72%

CountyCare Health Plan

33.18%

Meridian Health

47.38%

Molina HealthCare

44.71%

YouthCare

71.97%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

NA (denominator too small to report)

Meridian Health

NA (denominator too small to report)

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up—Ages 18–64

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

56.12%

Blue Cross Community Health Plans

54.01%

CountyCare Health Plan

43.23%

Meridian Health

56.48%

Molina HealthCare

55.62%

YouthCare

77.07%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

NA (denominator too small to report)

Meridian Health

NA (denominator too small to report)

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

24.62%

Blue Cross Community Health Plans

27.72%

CountyCare Health Plan

19.20%

Meridian Health

26.92%

Molina HealthCare

28.64%

YouthCare

26.67%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up—Ages 18+

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

34.83%

Blue Cross Community Health Plans

38.02%

CountyCare Health Plan

27.11%

Meridian Health

37.31%

Molina HealthCare

41.16%

YouthCare

40.00%

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 7-Day Follow-Up—Ages 18–64

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

38.44%

Blue Cross Community Health Plans

37.55%

CountyCare Health Plan

38.58%

Meridian Health

37.74%

Molina HealthCare

40.19%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 7-Day Follow-Up—Ages 65+

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

26.32%

Meridian Health

22.58%

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 30-Day Follow-Up—Ages 18–64

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

55.34%

Blue Cross Community Health Plans

53.68%

CountyCare Health Plan

54.04%

Meridian Health

55.43%

Molina HealthCare

57.54%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 30-Day Follow-Up—Ages 65+

38 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

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

Program-specific rate

0576

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

38.60%

Meridian Health

38.71%

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

27.69%

Blue Cross Community Health Plans

23.99%

CountyCare Health Plan

18.93%

Meridian Health

25.50%

Molina HealthCare

24.48%

YouthCare

39.44%

Complete

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

40 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

19.35%

CountyCare Health Plan

19.57%

Meridian Health

12.96%

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

46.99%

Blue Cross Community Health Plans

42.18%

CountyCare Health Plan

34.17%

Meridian Health

44.55%

Molina HealthCare

46.16%

YouthCare

58.69%

Complete

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

42 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

35.48%

CountyCare Health Plan

36.96%

Meridian Health

37.04%

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Initiation of Substance Use Treatment—18–64 Years

43 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

39.91%

Blue Cross Community Health Plans

48.30%

CountyCare Health Plan

39.03%

Meridian Health

43.86%

Molina HealthCare

46.60%

YouthCare

44.38%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Initiation of Substance Use Treatment—65+ Years

44 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

37.99%

Blue Cross Community Health Plans

49.78%

CountyCare Health Plan

33.88%

Meridian Health

47.84%

Molina HealthCare

41.00%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Engagement of Substance Use Treatment—18–64 Years

45 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

14.11%

Blue Cross Community Health Plans

14.40%

CountyCare Health Plan

10.50%

Meridian Health

13.34%

Molina HealthCare

12.99%

YouthCare

5.33%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Engagement of Substance Use Treatment—65+ Years 46 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

0108

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

6.12%

Blue Cross Community Health Plans

7.56%

CountyCare Health Plan

6.83%

Meridian Health

6.64%

Molina HealthCare

9.00%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Pharmacotherapy for Opioid Use Disorder

47 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

27.46%

Blue Cross Community Health Plans

24.96%

CountyCare Health Plan

22.91%

Meridian Health

25.91%

Molina HealthCare

7.56%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders: Ages 1–17 Years

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

21.27%

Blue Cross Community Health Plans

19.63%

CountyCare Health Plan

20.77%

Meridian Health

21.79%

Molina HealthCare

17.52%

YouthCare

48.38%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

47.49%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

77.45%

Blue Cross Community Health Plans

71.91%

CountyCare Health Plan

70.93%

Meridian Health

77.94%

Molina HealthCare

79.68%

YouthCare

85.07%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

83.33%

Blue Cross Community Health Plans

80.39%

CountyCare Health Plan

77.00%

Meridian Health

83.56%

Molina HealthCare

87.90%

YouthCare

90.72%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

13.68%

Blue Cross Community Health Plans

17.30%

CountyCare Health Plan

12.22%

Meridian Health

25.56%

Molina HealthCare

22.99%

YouthCare

37.29%

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up—Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

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

3488

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

20.00%

Blue Cross Community Health Plans

27.03%

CountyCare Health Plan

16.67%

Meridian Health

34.96%

Molina HealthCare

34.48%

YouthCare

54.24%

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 7-Day Follow-Up—Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

NA (denominator too small to report)

Meridian Health

NA (denominator too small to report)

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After High-Intensity Care for Substance Use Disorder: 30-Day Follow-Up—Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

NA (denominator too small to report)

CountyCare Health Plan

NA (denominator too small to report)

Meridian Health

NA (denominator too small to report)

Molina HealthCare

NA (denominator too small to report)

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

46.27%

Blue Cross Community Health Plans

48.42%

CountyCare Health Plan

37.74%

Meridian Health

42.28%

Molina HealthCare

43.27%

YouthCare

44.52%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

0576

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

70.58%

Blue Cross Community Health Plans

74.46%

CountyCare Health Plan

62.37%

Meridian Health

68.65%

Molina HealthCare

69.54%

YouthCare

69.52%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Initiation of Substance Use Treatment—Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

47.81%

Blue Cross Community Health Plans

50.00%

CountyCare Health Plan

46.20%

Meridian Health

49.22%

Molina HealthCare

49.51%

YouthCare

55.61%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Substance Use Treatment: Engagement of Substance Use Treatment—Ages 13–17

D2.VII.2 Measure Domain

Behavioral health care

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

0004

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

9.63%

Blue Cross Community Health Plans

13.84%

CountyCare Health Plan

10.33%

Meridian Health

13.06%

Molina HealthCare

6.55%

YouthCare

9.73%

Complete

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

60 / 106

D2.VII.2 Measure Domain

Behavioral health care

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

2801

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

62.35%

Blue Cross Community Health Plans

64.90%

CountyCare Health Plan

58.28%

Meridian Health

59.32%

Molina HealthCare

58.15%

YouthCare

73.43%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

32.46%

Blue Cross Community Health Plans

39.78%

CountyCare Health Plan

34.70%

Meridian Health

32.29%

Molina HealthCare

31.01%

YouthCare

54.06%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

31.76%

Blue Cross Community Health Plans

38.75%

CountyCare Health Plan

33.51%

Meridian Health

31.51%

Molina HealthCare

30.34%

YouthCare

53.38%

Complete

D2.VII.1 Measure Name: Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Percentage of members receiving mobile crisis response services that result in a hospitalization for children and adolescents (ages 0-20).

Measure results

Aetna Better Health

23.48%

Blue Cross Community Health Plans

41.80%

CountyCare Health Plan

23.77%

Meridian Health

25.22%

Molina HealthCare

13.42%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Total number of repeat behavioral health hospitalizations for children and adolescents (ages 0-20)

Measure results

Aetna Better Health

104

Blue Cross Community Health Plans

663

CountyCare Health Plan

209

Meridian Health

558

Molina HealthCare

238

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Average number of repeat behavioral health hospitalizations for children and adolescents (ages 0-20)

Measure results

Aetna Better Health

0.19

Blue Cross Community Health Plans

0.37

CountyCare Health Plan

0.26

Meridian Health

0.30

Molina HealthCare

0.33

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Total percentage of children and adolescent members (ages 0-20) with repeat behavioral health hospitalizations.

Measure results

Aetna Better Health

14.41%

Blue Cross Community Health Plans

22.09%

CountyCare Health Plan

16.86%

Meridian Health

19.09%

Molina HealthCare

19.23%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Inpatient Utilization—Behavioral Health Hospitalizations for Children and Adolescents: Discharges per 1000 Member Months—Total

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Total number of inpatient behavioral health discharges for children and adolescents (ages 0-20) per 1000 member months.

Measure results

Aetna Better Health

0.43

Blue Cross Community Health Plans

0.72

CountyCare Health Plan

0.49

Meridian Health

0.50

Molina HealthCare

0.61

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Total average length of stay for inpatient behavioral hospitalizations for children and adolescents (ages 0-20)

Measure results

Aetna Better Health

7.08

Blue Cross Community Health Plans

8.16

CountyCare Health Plan

9.14

Meridian Health

8.73

Molina HealthCare

9.39

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Emergency Department (ED) Visits that Result in an Inpatient Admission for Children and Adolescents

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

Percentage of emergency department visits that resulted in an inpatient admission for children and adolescents (ages 0-20).

Measure results

Aetna Better Health

17.41%

Blue Cross Community Health Plans

48.11%

CountyCare Health Plan

14.24%

Meridian Health

21.37%

Molina HealthCare

14.49%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Gap in Human Immunodeficiency Virus (HIV) Medical Visits 70 / 106

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HRSA

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

Yes

D2.VII.8 Measure Description

Percentage of patients, regardless of age, with a diagnosis of Human Immunodeficiency Virus (HIV) who did not have a medical visit in the last six months of the measurement year.

Measure results

Aetna Better Health

21.06%

Blue Cross Community Health Plans

24.77%

CountyCare Health Plan

29.50%

Meridian Health

20.43%

Molina HealthCare

13.61%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HRSA

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

Yes

D2.VII.8 Measure Description

Percentage of Beneficiaries with HIV Viral Load <200 Copies/mL—Total

Measure results

Aetna Better Health

14.79%

Blue Cross Community Health Plans

49.86%

CountyCare Health Plan

23.68%

Meridian Health

40.23%

Molina HealthCare

58.03%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression: Percentage of Beneficiaries with Valid Viral Load Lab Result—Total

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HRSA

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

Yes

D2.VII.8 Measure Description

Percentage of Beneficiaries with Valid Viral Load Lab Result—Total

Measure results

Aetna Better Health

41.26%

Blue Cross Community Health Plans

57.91%

CountyCare Health Plan

28.82%

Meridian Health

43.52%

Molina HealthCare

62.47%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression: Percentage of Beneficiaries with Valid Viral Load Lab Result and Viral Load <200 Copies/mL—Total

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3489

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

Program-specific rate

D2.VII.6 Measure Set

HRSA

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

Yes

D2.VII.8 Measure Description

Percentage of beneficiaries who had a valid HIV viral load lab result and viral load less than 200 copies/mL during the measurement period.

Measure results

Aetna Better Health

35.85%

Blue Cross Community Health Plans

86.11%

CountyCare Health Plan

82.17%

Meridian Health

92.46%

Molina HealthCare

92.88%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Prescription of HIV Antiretroviral Therapy

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

3488

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

Program-specific rate

D2.VII.6 Measure Set

HRSA

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

Yes

D2.VII.8 Measure Description

Percentage of patients, regardless of age, with a diagnosis of HIV prescribed antiretroviral therapy[1] for the treatment of HIV infection during the measurement period.

Measure results

Aetna Better Health

88.10%

Blue Cross Community Health Plans

90.90%

CountyCare Health Plan

88.02%

Meridian Health

89.04%

Molina HealthCare

92.02%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Managed Long-Term Services and Supports (MLTSS) Comprehensive Care Plan and Update: Care Plan with Core Elements—Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

94.79%

Blue Cross Community Health Plans

53.13%

CountyCare Health Plan

53.13%

Meridian Health

56.25%

Molina HealthCare

88.54%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Managed Long-Term Services and Supports (MLTSS) Comprehensive Care Plan and Update: Participant Could Not Be Contacted—Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

0.00%

Blue Cross Community Health Plans

4.74%

CountyCare Health Plan

0.00%

Meridian Health

0.00%

Molina HealthCare

0.02%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Managed Long-Term Services and Supports (MLTSS) Comprehensive Care Plan and Update: Participant Refused Care Planning—Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

0.00%

Blue Cross Community Health Plans

0.26%

CountyCare Health Plan

0.25%

Meridian Health

0.00%

Molina HealthCare

0.00%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: LTSS Successful Transition After Long-Term Facility Stay: Observed— Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

20.33%

CountyCare Health Plan

12.18%

Meridian Health

12.71%

Molina HealthCare

22.03%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: LTSS Successful Transition After Long-Term Facility Stay: Expected—Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

74.46%

CountyCare Health Plan

69.19%

Meridian Health

46.72%

Molina HealthCare

54.88%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: LTSS Successful Transition After Long-Term Facility Stay: Observed to Expected Ratio—Total

D2.VII.2 Measure Domain

Long-term services and supports

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

CMS MLTSS Measure

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

NA (denominator too small to report)

Blue Cross Community Health Plans

0.27

CountyCare Health Plan

0.18

Meridian Health

0.27

Molina HealthCare

0.40

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Childhood Immunization Status—Combination 7

D2.VII.2 Measure Domain

Primary care access and preventative care

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

38

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

54.74%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

56.23%

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication: Continuance and Maintenance Phase

D2.VII.2 Measure Domain

Behavioral health care

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

2800

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

62.70%

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

67.14%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

3.8

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

2082

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

22.68

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

2080

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

26.95%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

2083/3211e

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

0.44

Complete

D2.VII.1 Measure Name: Mobile Crisis Response Services that Result in Hospitalization for Children and Adolescents

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

The percentage of mobile crisis response (MCR) services for members ages 0 through 20 years who had a subsequent inpatient admission within three days of the MCR service.

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

26.47%

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

N/A

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

Cross-program rate: Medicaid (HealthChoice Illinois), Youth/Former Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

Yes

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

N/A

Blue Cross Community Health Plans

N/A

CountyCare Health Plan

N/A

Meridian Health

N/A

Molina HealthCare

N/A

YouthCare

17.51%

Complete

D2.VII.1 Measure Name: Getting Needed Care

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

80.7%

Blue Cross Community Health Plans

82.6%

CountyCare Health Plan

76.2%

Meridian Health

84.1%

Molina HealthCare

81.4%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Getting Care Quickly

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

77.8%

Blue Cross Community Health Plans

80.2%

CountyCare Health Plan

77.7%

Meridian Health

83.8%

Molina HealthCare

82.4%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

92.0%

Blue Cross Community Health Plans

93.0%

CountyCare Health Plan

92.6%

Meridian Health

90.7%

Molina HealthCare

92.9%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Customer Service

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

87.0%

Blue Cross Community Health Plans

89.1%

CountyCare Health Plan

91.1%

Meridian Health

92.7%

Molina HealthCare

86.7%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

47.9%

Blue Cross Community Health Plans

54.7%

CountyCare Health Plan

61.3%

Meridian Health

56.8%

Molina HealthCare

57.6%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

64.1%

Blue Cross Community Health Plans

71.1%

CountyCare Health Plan

73.9%

Meridian Health

64.4%

Molina HealthCare

67.0%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.9%

Blue Cross Community Health Plans

69.7%

CountyCare Health Plan

63.8%

Meridian Health

62.5%

Molina HealthCare

72.5%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Adult CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

51.1%

Blue Cross Community Health Plans

66.2%

CountyCare Health Plan

67.8%

Meridian Health

56.0%

Molina HealthCare

58.7%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Getting Needed Care

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

83.4%

Blue Cross Community Health Plans

73.1%

CountyCare Health Plan

74.4%

Meridian Health

86.5%

Molina HealthCare

82.1%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Getting Care Quickly

100 / 106

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.5%

Blue Cross Community Health Plans

79.0%

CountyCare Health Plan

82.3%

Meridian Health

86.0%

Molina HealthCare

85.8%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

94.8%

Blue Cross Community Health Plans

92.6%

CountyCare Health Plan

94.5%

Meridian Health

93.0%

Molina HealthCare

94.1%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Customer Service

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.2%

Blue Cross Community Health Plans

87.7%

CountyCare Health Plan

86.2%

Meridian Health

86.7%

Molina HealthCare

87.8%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.3%

Blue Cross Community Health Plans

66.0%

CountyCare Health Plan

68.8%

Meridian Health

71.2%

Molina HealthCare

70.0%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

73.8%

Blue Cross Community Health Plans

72.5%

CountyCare Health Plan

77.1%

Meridian Health

75.9%

Molina HealthCare

78.1%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often

105 / 106

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

72.3%

Blue Cross Community Health Plans

60.6%

CountyCare Health Plan

68.6%

Meridian Health

76.2%

Molina HealthCare

73.6%

YouthCare

N/A

Complete

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

106 / 106

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

Program-specific rate

D2.VII.6 Measure Set

Child CAHPS

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

58.1%

Blue Cross Community Health Plans

72.1%

CountyCare Health Plan

75.5%

Meridian Health

71.4%

Molina HealthCare

63.8%

YouthCare

N/A

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

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

Sanction total count: 22

Complete

D3.VIII.1 Intervention type: Fine

1 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

06/28/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

2 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

06/28/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

3 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

06/28/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

4 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$200,000

D3.VIII.7 Date assessed

06/28/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

5 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

04/25/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

6 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

04/25/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$200,000

D3.VIII.7 Date assessed

01/19/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$200,000

D3.VIII.7 Date assessed

01/19/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

9 / 22

D3.VIII.2 Intervention topic

Missed Encounter Data Submission Threshold

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

01/19/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

10 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$5,000

1

D3.VIII.7 Date assessed

10/12/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

11 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/09/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

12 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$50,000

1

D3.VIII.7 Date assessed

09/25/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

13 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

05/12/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

14 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$5,000

1

D3.VIII.7 Date assessed

02/01/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

15 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

03/20/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

16 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$265,000

1

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

17 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

09/25/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

18 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$145,000

1

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

19 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$300,000

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

20 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$85,000

1

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

21 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Fine

22 / 22

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

N/A

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

$5,000

1

D3.VIII.7 Date assessed

06/05/2023

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Aetna Better Health** 4 **Blue Cross Community Health Plans** 8 **CountyCare Health Plan** 11 **Meridian Health** 6 **Molina HealthCare** 4 **YouthCare** 6
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Aetna Better Health** 124 **Blue Cross Community Health Plans** 241 **CountyCare Health Plan** 195 **Meridian Health** 403 **Molina HealthCare** 41 **YouthCare** 25

D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health** 0.31:1,000 **Blue Cross Community Health Plans** 0.03:1,000 **CountyCare Health Plan** 0.45:1,000 **Meridian Health** 0.44:1,000 **Molina HealthCare** 0.12:1,000 **YouthCare** 0.68:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Aetna Better Health** 57 **Blue Cross Community Health Plans** 121 **CountyCare Health Plan** 99 **Meridian Health** 163 **Molina HealthCare** 28 **YouthCare** 10
D1X.5	**Ratio of resolved program integrity investigations to enrollees**	**Aetna Better Health** 0.14:1,000

What is the ratio of program integrity investigations resolved by the plan in the past year to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.

Blue Cross Community Health Plans

0.06:1,000

CountyCare Health Plan

0.26:1,000

Meridian Health

0.18:1,000

Molina HealthCare

0.08:1,000

YouthCare

0.27:1,000

D1X.6

Referral path for program integrity referrals to the state

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

Aetna Better Health

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Blue Cross Community Health Plans

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

CountyCare Health Plan

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Meridian Health

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Molina HealthCare

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

YouthCare

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Aetna Better Health** 36 **Blue Cross Community Health Plans** 73 **CountyCare Health Plan** 96 **Meridian Health** 107 **Molina HealthCare** 46 **YouthCare** 107
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Aetna Better Health** 0.09:1,000 **Blue Cross Community Health Plans** 0.11:1,000 **CountyCare Health Plan** 0.22:1,000 **Meridian Health** 0.12:1,000 **Molina HealthCare** 0.13:1,000 **YouthCare** 0.289:1,000
D1X.9	**Plan overpayment reporting to the state**	**Aetna Better Health** CY2023 $40,914,759 1.4%

	Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Blue Cross Community Health Plans** CY2023 Recovered $58,217.21 0% **CountyCare Health Plan** CY2023 $509,986 recovered 0.000149008% **Meridian Health** CY2023 Recovered $16,387,582 0.3252% **Molina HealthCare** CY2023 Recovered $63,335.48 0.003% **YouthCare** CY2023 Recovered $687,197 0.2762%
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Aetna Better Health** Monthly **Blue Cross Community Health Plans** Monthly **CountyCare Health Plan** Monthly **Meridian Health** Monthly **Molina HealthCare** Monthly **YouthCare** Monthly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Illinois Client Enrollment Broker (ICEB) - Maximus** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Illinois Client Enrollment Broker (ICEB) - Maximus** Enrollment Broker/Choice Counseling