Managed Care Program Annual Report (MCPAR) for Illinois: HealthChoice Illinois (HCI) 06/26/2025

Due date	Last edited	Edited by	Status
06/29/2025	06/13/2025	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.	Amy Roberts
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	amy.roberts@illinois.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Amy Harris Roberts
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	amy.roberts@illinois.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/27/2025

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2024
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2024
A6	**Program name** Auto-populated from report dashboard.	HealthChoice Illinois (HCI) 06/26/2025

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 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for 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

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

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

	Indicator	Response
	ILOS name	

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.	3,468,330
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.	2,668,861

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 OIG conducts 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 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 2024, the MCO SIUs worked on 432 audits and 266 investigations, referred 578 cases to the OIG, and established over $80,209,609.15 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 State sends the MCPs a daily HIPAA Compliant 834 file that contains any enrollments and disnerollments 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 State sends the MCPs a reconciliation HIPAA Compliant 834 Audit file that contians 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 State on the customer, such as contact information, address, case updates, and the capitation payment that the State 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 State's eligibility and enrollment team if there are questions and also utilize tools that the State has made available, such as enrollment error files that are exchanged between the State's record and the MCPs record. The State systematically closes recipients who become ineligible for MCO coverage weekly and on the last system day of the month. Results of the disenrollments are

		analyzed and reviewed by State staff for accuracy and ensure any enrollment changes made are in compliance with State Statutes, Contract requirements and Program Policy.
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 42 CFR 438.602(g)(3) and 455.104.	No
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy,	No such audits were conducted during the reporting year.

	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.	

Topic XIII. Prior Authorization

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

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

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
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	2,587,472

	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.	Beginning in January of 2024, the Department enrolled managed care eligible Health Benefits for Immigrant Adults and Seniors into managed care plans. Approximately 60,000 customers were initially enrolled. Largely the services provided to these customers were paid for with only state dollars.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Use of correct file formats Overall data accuracy (as determined through data validation) Other, specify – The State implemented a Quarterly EUM process to evaluate the MCPs for the completeness of data submissions for HCI. The State reviews and evaluates the MCPs based on data submissions for completeness on 4 rolling quarters. HCI MCPs are required to meet minimum 98% of overall completeness and 92% of the category level completeness to avoid monetary sanctions (financial penalties). In addition, other includes: Medical Record Procurement Rate, Second Date of Service Submission Rate, Medical Record Omission Rate, Encounter Data Omission Rate, Diagnosis Code Accuracy, Procedure Code Accuracy, Procedure Code Modifier Accuracy, and All-Element Accuracy Rate.
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Contract Sections 1.1.73 and 5.27.3; and Attachment XI, Attachment XIII, and Attachment XXIII
C1III.4	**Financial penalties contract language**	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 state is not able to process all encounter data received by the health plans due to system issues with identifying provider license requirements. Due to this issue, some encounters were not processed and that portion of the system was suspended.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	A Critical Incident is identified in the HCI Contract in Section 1.1.5 as any event that is indicated in Attachment XVII. Contract Section 5.23.2 and Attachment XVII outline specific critical incident definitions.
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	Timely resolution of appeals is defined in the HCI Contract Section 5.30.3.4, and says "If an Enrollee does not request an expedited Appeal, Contractor shall make its decision on the Appeal within fifteen (15) Business Days after submission of the Appeal. Contractor may extend this time frame for up to fourteen (14) days if the Enrollee requests an extension, or if Contractor demonstrates to the satisfaction of the appropriate State Agency's hearing office that there is a need for additional information and the delay is in the Enrollees interest."
C1IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Expedited resolution of appeals is defined in the HCI Contract Section 5.30.3.3 and says "If an Enrollee requests an expedited Appeal pursuant to 42 CFR §438.410, Contractor shall notify the Enrollee within twenty-four (24) hours after the submission of the Appeal, of all information from the Enrollee that Contractor requires to evaluate the Appeal. Contractor shall render a decision on an expedited Appeal within twenty-four (24) hours after receipt of the required information. Contractor shall not 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.	The Department contracted its EQRO to conduct a Network Adequacy Validation (NAV) and Time and Distance Study (TDS), with results presented in December 2024. The results demonstrated that the health plans met time and distance standards for all enrollees and counties in all provider categories assessed except pharmacies and oral surgeons. The Department holds access to pharmacies at a higher standard than other provider categories, requiring that 100 percent of enrollees have access within 15 minutes or 15 miles in urban counties, or within 60 minutes or 60 miles in rural counties. All health plans met the standard in all rural counties, but in some urban counties, between 97.3 and 99.9 percent of enrollees had access within the standard. When access to oral surgeon results were analyzed by county and region, each of the statewide health plans failed to provide the required access in some areas, predominately in rural counties in three regions. The findings were consistent with previous years' results, although improvements were also identified. Additionally, the Department contracted its EQRO to conduct a revealed Access and Availability Survey (AAS) in 2024, which evaluated the accuracy of provider information and appointment availability for enrollees with a behavioral health or prenatal provider. Results of the AAS indicated that health plan provider information data was poor, which impacted access to care due to the inability of members to find a provider that delivered the requested services. However, due to the nature of the survey, several limitations should be considered when generalizing results, including: 1) Survey calls were conducted at least four weeks following receipt of the health plans' provider data, resulting in the possibility that provider locations updated their contact information with the health plan prior to survey calls; 2) Time to first available appointment is based on appointments requested within the sampled provider location; offers to schedule at a different location were not counted therefore, survey results may underrepresent timely appointments if enrollees are willing to travel to an alternate location; 3) Survey findings were compiled from self-reported provider office

		personnel responses; therefore, survey responses may vary from information obtained at other times or using other methods of communication; and 4) Health plans are responsible for ensuring that enrollees have access to a provider within the contract standards, rather than requiring that each provider offer appointments within the defined time frames. Since this was a revealed survey, responses may not accurately reflect an enrollee's experience when seeking an appointment.
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 CAP 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 may also collaborate with MCPs to address barriers related to provider acceptance of Medicaid rates and/or MCP contracting.

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 or Revealed 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 or Revealed 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

Secret or 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

Secret or Revealed Shopper Calls

C2.V.8 Frequency of oversight methods

As needed

Complete

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

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

Annually

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

Annually

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 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 state, and with input from the Health Plans, develops and maintains educational materials designed to provide Potential Enrollees and Enrollees with clear, concise, and accurate information about the Health Plans. Written materials are available in English and Spanish, and other prevalent languages determined by the agency. 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?	HFS 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. • Average abandonment rate is no more than 7 percent. • Average time on hold after initial interaction with Call Center staff is 3 minutes or less. • Sufficient number of qualified staff are available on-site to communicate with callers who speak • English or Spanish. • Interpretive services are available via telephone 100 percent of the time when requested by callers who speak languages other than English or Spanish. • TDD/TTY capabilities are available 100 percent of the time when requested. The state 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 An state Bureau of Managed Care staff member randomly reviews several ICEB calls daily to ensure compliance with HFS 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. The ICEB also prepares and presents to the state A Year in Review Power Point presentation which highlights their performance and accomplishments and details completed initiatives.

Topic X: Program Integrity

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

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the most recent parity analysis(es)?**	MCO
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	12/01/2023
C1XII.9	**When was the last parity analysis(es) for this program**	12/31/2018

	submitted to CMS? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/il20232024mentalhealthparitysummaryreport.pdf

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** 371,300 **Blue Cross Community Health Plans** 727,132 **CountyCare Health Plan** 428,091 **Meridian Health** 765,869 **Molina HealthCare** 310,312 **YouthCare** 35,520
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** 21% **CountyCare Health Plan** 12.3% **Meridian Health** 22.1% **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	**Aetna Better Health** 13.9% **Blue Cross Community Health Plans** 27.2% **CountyCare Health Plan** 16% **Meridian Health**

enrollment (B.I.2)	28.7% **Molina HealthCare** 11.6% **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** 91% **Blue Cross Community Health Plans** 95% **CountyCare Health Plan** 97% **Meridian Health** 96% **Molina HealthCare** 90% **YouthCare** 96%
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	**Aetna Better Health** N/A **Blue Cross Community Health Plans**

	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.	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 submissions that were compliant out of the file submissions it has 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%

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

Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter "N/A".

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Aetna Better Health** 3,155 **Blue Cross Community Health Plans** 4,590 **CountyCare Health Plan** 2,933 **Meridian Health** 7,108 **Molina HealthCare** 1,221 **YouthCare** 303
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Aetna Better Health** 2,682 **Blue Cross Community Health Plans** 2,548 **CountyCare Health Plan** 1,276 **Meridian Health** 3,819 **Molina HealthCare** 635 **YouthCare** 113
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter "N/A".	**Aetna Better Health** 24 **Blue Cross Community Health Plans** 65 **CountyCare Health Plan** 24 **Meridian Health**

78

Molina HealthCare

16

YouthCare

4

D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Aetna Better Health** 449 **Blue Cross Community Health Plans** 1,977 **CountyCare Health Plan** 1,632 **Meridian Health** 3,211 **Molina HealthCare** 500 **YouthCare** 186
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** 160 **Blue Cross Community Health Plans** 73 **CountyCare Health Plan** 44 **Meridian Health** 0 **Molina HealthCare** 35 **YouthCare** 0
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf	**Aetna Better Health** 143 **Blue Cross Community Health Plans** 310

	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).	**CountyCare Health Plan** 0 **Meridian Health** 106 **Molina HealthCare** 139 **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 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	**Aetna Better Health** 56 **Blue Cross Community Health Plans** 7 **CountyCare Health Plan** 0 **Meridian Health** 109 **Molina HealthCare** 10 **YouthCare** 2

	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** 3,090 **Blue Cross Community Health Plans** 2,879 **CountyCare Health Plan** 2,019 **Meridian Health** 6,788 **Molina HealthCare** 1,125 **YouthCare** 252
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** 61 **Blue Cross Community Health Plans** 1,609 **CountyCare Health Plan** 852 **Meridian Health** 64 **Molina HealthCare** 89 **YouthCare** 5
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	**Aetna Better Health** 2,945 **Blue Cross Community Health Plans** 4,469 **CountyCare Health Plan** 1,293

	limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Meridian Health** 6,382 **Molina HealthCare** 99 **YouthCare** 187
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** 66 **Blue Cross Community Health Plans** 13 **CountyCare Health Plan** 2 **Meridian Health** 0 **Molina HealthCare** 0 **YouthCare** 0
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Aetna Better Health** 144 **Blue Cross Community Health Plans** 108 **CountyCare Health Plan** 0 **Meridian Health** 2,318 **Molina HealthCare** 2 **YouthCare** 87
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan	**Aetna Better Health** 0 **Blue Cross Community Health Plans**

	during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	0 **CountyCare Health Plan** 0 **Meridian Health** 0 **Molina HealthCare** 629 **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** 3 **Meridian Health** 0 **Molina HealthCare** 7 **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** 0 **CountyCare Health Plan** 1 **Meridian Health** 0 **Molina HealthCare** 484 **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** 0 **Blue Cross Community Health Plans** 0 **CountyCare Health Plan** 0 **Meridian Health** 0 **Molina HealthCare** 0 **YouthCare** 0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Aetna Better Health** 166 **Blue Cross Community Health Plans** 162 **CountyCare Health Plan** 12 **Meridian Health** 1,443 **Molina HealthCare** 30 **YouthCare** 62
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** 2,858 **Blue Cross Community Health Plans** 237 **CountyCare Health Plan** 260 **Meridian Health** 4,182 **Molina HealthCare** 4 **YouthCare** 209
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** 65 **Blue Cross Community Health Plans** 58 **CountyCare Health Plan** 1 **Meridian Health**

994

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

66

Blue Cross Community Health Plans

18

CountyCare Health Plan

125

Meridian Health

115

Molina HealthCare

2

YouthCare

0

D1IV.7e

Resolved appeals related to covered outpatient prescription drugs

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

Aetna Better Health

1,878

Blue Cross Community Health Plans

2,977

CountyCare Health Plan

1,672

Meridian Health

4,450

Molina HealthCare

476

YouthCare

0

D1IV.7f

Resolved appeals related to skilled nursing facility (SNF) services

Enter the total number of appeals resolved by the plan

Aetna Better Health

0

Blue Cross Community Health Plans

1

	during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter “N/A”.	**CountyCare Health Plan** 3 **Meridian Health** 23 **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 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”.	**Aetna Better Health** 85 **Blue Cross Community Health Plans** 22 **CountyCare Health Plan** 0 **Meridian Health** 106 **Molina HealthCare** 42 **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** 314 **Blue Cross Community Health Plans** 1,043 **CountyCare Health Plan** 921 **Meridian Health** 921 **Molina HealthCare** 315 **YouthCare** 32

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** 0 **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** 779 **Blue Cross Community Health Plans** 82 **CountyCare Health Plan** 14 **Meridian Health** 527 **Molina HealthCare** 345 **YouthCare** 16

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** 39 **Blue Cross Community Health Plans** 66 **CountyCare Health Plan** 11 **Meridian Health** 70 **Molina HealthCare** 41 **YouthCare** 4
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** 14 **CountyCare Health Plan** 1 **Meridian Health** 8 **Molina HealthCare** 8 **YouthCare** 2
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** 4 **Blue Cross Community Health Plans** 22 **CountyCare Health Plan** 0 **Meridian Health**

		11 **Molina HealthCare** 5 **YouthCare** 0
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Aetna Better Health** 9 **Blue Cross Community Health Plans** 52 **CountyCare Health Plan** 10 **Meridian Health** 29 **Molina HealthCare** 23 **YouthCare** 2
D1IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter “N/A”. External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Aetna Better Health** 25 **Blue Cross Community Health Plans** 129 **CountyCare Health Plan** 47 **Meridian Health** 52 **Molina HealthCare** 23 **YouthCare** 2
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review	**Aetna Better Health** 61 **Blue Cross Community Health Plans** 128

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).

CountyCare Health Plan

59

Meridian Health

82

Molina HealthCare

22

YouthCare

5

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** 1,368 **Blue Cross Community Health Plans** 18,227 **CountyCare Health Plan** 3,613 **Meridian Health** 1,281 **Molina HealthCare** 5,828 **YouthCare** 167
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** 211 **Blue Cross Community Health Plans** 401 **CountyCare Health Plan** 230 **Meridian Health** 0 **Molina HealthCare** 116 **YouthCare** 0
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	**Aetna Better Health** 208 **Blue Cross Community Health Plans** 1,827 **CountyCare Health Plan** 138 **Meridian Health**

	actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	0 **Molina HealthCare** 627 **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 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	**Aetna Better Health** 68 **Blue Cross Community Health Plans** 66 **CountyCare Health Plan** 32 **Meridian Health** 0 **Molina HealthCare** 71 **YouthCare** 1

	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** 1,368 **Blue Cross Community Health Plans** 18,219 **CountyCare Health Plan** 3,583 **Meridian Health** 1,281 **Molina HealthCare** 5,823 **YouthCare** 167

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** 18 **Blue Cross Community Health Plans** 41 **CountyCare Health Plan** 59 **Meridian Health** 8 **Molina HealthCare** 105 **YouthCare** 2
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** 1,338 **Blue Cross Community Health Plans** 207 **CountyCare Health Plan** 1,589 **Meridian Health** 172 **Molina HealthCare** 164 **YouthCare** 13
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** 2 **Blue Cross Community Health Plans** 18 **CountyCare Health Plan** 1 **Meridian Health**

		0 **Molina HealthCare** 9 **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** 10 **Blue Cross Community Health Plans** 8 **CountyCare Health Plan** 1 **Meridian Health** 0 **Molina HealthCare** 52 **YouthCare** 1
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health** 103 **Blue Cross Community Health Plans** 1,657 **CountyCare Health Plan** 11 **Meridian Health** 77 **Molina HealthCare** 992 **YouthCare** 13
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** Enter the total number of grievances resolved by the plan	**Aetna Better Health** 20 **Blue Cross Community Health Plans** 26

	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”.	**CountyCare Health Plan** 4 **Meridian Health** 1 **Molina HealthCare** 7 **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 LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter “N/A”.	**Aetna Better Health** 31 **Blue Cross Community Health Plans** 109 **CountyCare Health Plan** 148 **Meridian Health** 0 **Molina HealthCare** 279 **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** 136 **Blue Cross Community Health Plans** 1,006 **CountyCare Health Plan** 135 **Meridian Health** 2 **Molina HealthCare** 313 **YouthCare** 24

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** 474 **Blue Cross Community Health Plans** 2,207 **CountyCare Health Plan** 740 **Meridian Health** 908 **Molina HealthCare** 908 **YouthCare** 67
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** 745 **Blue Cross Community Health Plans** 12,962 **CountyCare Health Plan** 2,491 **Meridian Health** 113 **Molina HealthCare** 3,312 **YouthCare** 47

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** 126 **Blue Cross Community Health Plans** 9,038 **CountyCare Health Plan** 405 **Meridian Health** 43 **Molina HealthCare** 561 **YouthCare** 6
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** 35 **Blue Cross Community Health Plans** 381 **CountyCare Health Plan** 43 **Meridian Health** 8 **Molina HealthCare** 232 **YouthCare** 1
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	**Aetna Better Health** 210 **Blue Cross Community Health Plans** 3,044 **CountyCare Health Plan** 8 **Meridian Health**

	travel or wait times, or other access issues.	158 **Molina HealthCare** 2,462 **YouthCare** 5
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** 78 **Blue Cross Community Health Plans** 181 **CountyCare Health Plan** 50 **Meridian Health** 49 **Molina HealthCare** 203 **YouthCare** 4
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	**Aetna Better Health** 2 **Blue Cross Community Health Plans** 2,496 **CountyCare Health Plan** 147 **Meridian Health** 11 **Molina HealthCare** 456 **YouthCare** 10
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	**Aetna Better Health** 54 **Blue Cross Community Health Plans** 5,947

	were filed for a reason related to payment or billing issues.	**CountyCare Health Plan** 1,985 **Meridian Health** 83 **Molina HealthCare** 1,464 **YouthCare** 57
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 150 **CountyCare Health Plan** 2 **Meridian Health** 5 **Molina HealthCare** 49 **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** 3 **Blue Cross Community Health Plans** 21 **CountyCare Health Plan** 2 **Meridian Health** 5 **Molina HealthCare** 65 **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 were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 90 **CountyCare Health Plan** 0 **Meridian Health** 27 **Molina HealthCare** 684 **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	**Aetna Better Health** 0 **Blue Cross Community Health Plans** 0 **CountyCare Health Plan** 0 **Meridian Health** 0

	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.	**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** 773 **Blue Cross Community Health Plans** 17 **CountyCare Health Plan** 2 **Meridian Health** 892 **Molina HealthCare** 951 **YouthCare** 3

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: 104

Complete

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

1 / 104

D2.VII.2 Measure Domain

Primary care access and preventative care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

69.06

Blue Cross Community Health Plans

74.65

CountyCare Health Plan

70.76

Meridian Health

74.70

Molina HealthCare

71.27

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

612.44

Blue Cross Community Health Plans

535.76

CountyCare Health Plan

580.13

Meridian Health

573.45

Molina HealthCare

603.38

YouthCare

46.35

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

3432.89

Blue Cross Community Health Plans

4869.17

CountyCare Health Plan

3518.56

Meridian Health

3845.31

Molina HealthCare

3421.45

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

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

59.33

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits — Total 5 / 104

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

46.3

Blue Cross Community Health Plans

55.10

CountyCare Health Plan

54.36

Meridian Health

54.59

Molina HealthCare

49.96

YouthCare

62.26

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.02

Blue Cross Community Health Plans

60.16

CountyCare Health Plan

63.99

Meridian Health

58.64

Molina HealthCare

59.37

YouthCare

N/A

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

23.84

Blue Cross Community Health Plans

25.69

CountyCare Health Plan

30.41

Meridian Health

24.33

Molina HealthCare

20.68

YouthCare

32.83

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

85.76

Blue Cross Community Health Plans

88.44

CountyCare Health Plan

88.32

Meridian Health

88.81

Molina HealthCare

86.72

YouthCare

N/A

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

26.96

Blue Cross Community Health Plans

35.20

CountyCare Health Plan

45.26

Meridian Health

32.36

Molina HealthCare

32.02

YouthCare

39.28

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

73.72

Blue Cross Community Health Plans

75.18

CountyCare Health Plan

87.85

Meridian Health

72.02

Molina HealthCare

80.78

YouthCare

33.22

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

65.45

Blue Cross Community Health Plans

64.45

CountyCare Health Plan

83.33

Meridian Health

67.15

Molina HealthCare

65.94

YouthCare

23.08

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.99

Blue Cross Community Health Plans

63.02

CountyCare Health Plan

82.29

Meridian Health

65.69

Molina HealthCare

64.72

YouthCare

22.5

Complete

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

13 / 104

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.59

Blue Cross Community Health Plans

64.12

CountyCare Health Plan

63.40

Meridian Health

66.60

Molina HealthCare

63.94

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

1392

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

63.49

Blue Cross Community Health Plans

69.51

CountyCare Health Plan

68.11

Meridian Health

68.76

Molina HealthCare

65.57

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Breast Cancer Screening

D2.VII.2 Measure Domain

Primary care access and preventative care

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

2372

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.76

Blue Cross Community Health Plans

53.90

CountyCare Health Plan

55.25

Meridian Health

50.21

Molina HealthCare

49.73

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening

16 / 104

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0032

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

49.88

Blue Cross Community Health Plans

58.64

CountyCare Health Plan

62.28

Meridian Health

54.60

Molina HealthCare

53.77

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0033

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

55.32

Blue Cross Community Health Plans

56.58

CountyCare Health Plan

64.42

Meridian Health

47.03

Molina HealthCare

56.12

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

85.64

Blue Cross Community Health Plans

89.05

CountyCare Health Plan

86.89

Meridian Health

83.21

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.02

Blue Cross Community Health Plans

85.40

CountyCare Health Plan

81.64

Meridian Health

86.36

Molina HealthCare

82.73

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

0063

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.07

Blue Cross Community Health Plans

66.67

CountyCare Health Plan

65.45

Meridian Health

63.75

Molina HealthCare

68.13

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

57.18

Blue Cross Community Health Plans

63.99

CountyCare Health Plan

54.63

Meridian Health

62.04

Molina HealthCare

59.37

YouthCare

N/A

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

52.31

Blue Cross Community Health Plans

56.69

CountyCare Health Plan

56.45

Meridian Health

52.80

Molina HealthCare

39.28

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

58.15

Blue Cross Community Health Plans

61.07

CountyCare Health Plan

58.15

Meridian Health

54.99

Molina HealthCare

54.50

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

33.58

Blue Cross Community Health Plans

29.93

CountyCare Health Plan

32.36

Meridian Health

39.17

Molina HealthCare

37.96

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

66.79

Blue Cross Community Health Plans

70.57

CountyCare Health Plan

70.04

Meridian Health

67.05

Molina HealthCare

66.45

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

71.91

Blue Cross Community Health Plans

67.56

CountyCare Health Plan

72.93

Meridian Health

69.65

Molina HealthCare

65.95

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

Cross-program rate: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

30.35

Blue Cross Community Health Plans

26.66

CountyCare Health Plan

21.36

Meridian Health

29.68

Molina HealthCare

29.95

YouthCare

50.19

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

Cross-program rate: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

31.86

Blue Cross Community Health Plans

27.84

CountyCare Health Plan

26.96

Meridian Health

29.87

Molina HealthCare

40.20

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 7-Days 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

45.29

Blue Cross Community Health Plans

45.04

CountyCare Health Plan

31.77

Meridian Health

50.22

Molina HealthCare

50.12

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 7-Days 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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

74.90

Blue Cross Community Health Plans

73.45

CountyCare Health Plan

62.58

Meridian Health

76.78

Molina HealthCare

77.75

YouthCare

77.68

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 30-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

54.71

Blue Cross Community Health Plans

56.11

CountyCare Health Plan

40.30

Meridian Health

59.63

Molina HealthCare

60.25

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness: 30-Day 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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.18

Blue Cross Community Health Plans

79.76

CountyCare Health Plan

72.33

Meridian Health

83.97

Molina HealthCare

83.80

YouthCare

87.39

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 7-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

25.47

Blue Cross Community Health Plans

27.51

CountyCare Health Plan

24.22

Meridian Health

23.76

Molina HealthCare

25.96

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 30-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

35.10

Blue Cross Community Health Plans

37.27

CountyCare Health Plan

32.76

Meridian Health

33.67

Molina HealthCare

39.43

YouthCare

N/A

Complete

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

36.51

Blue Cross Community Health Plans

38.05

CountyCare Health Plan

35.57

Meridian Health

36.41

Molina HealthCare

36.93

YouthCare

N/A

Complete

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

54.03

Blue Cross Community Health Plans

56.67

CountyCare Health Plan

54.10

Meridian Health

53.93

Molina HealthCare

55.04

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 7-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

36.51

Blue Cross Community Health Plans

38.05

CountyCare Health Plan

35.57

Meridian Health

36.41

Molina HealthCare

36.93

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 7-Day 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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

49.21

Blue Cross Community Health Plans

47.50

CountyCare Health Plan

36.81

Meridian Health

41.47

Molina HealthCare

44.09

YouthCare

48.88

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

54.03

Blue Cross Community Health Plans

56.67

CountyCare Health Plan

54.10

Meridian Health

53.93

Molina HealthCare

55.04

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness: 30-Day 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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

78.02

Blue Cross Community Health Plans

72.19

CountyCare Health Plan

61.90

Meridian Health

67.96

Molina HealthCare

74.19

YouthCare

71.47

Complete

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

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

38.66

Blue Cross Community Health Plans

50.26

CountyCare Health Plan

40.47

Meridian Health

46.59

Molina HealthCare

43.55

YouthCare

47.39

Complete

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

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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

5.38

Blue Cross Community Health Plans

15.15

CountyCare Health Plan

4.90

Meridian Health

7.61

Molina HealthCare

7.71

YouthCare

10.63

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

22.81

Blue Cross Community Health Plans

26.83

CountyCare Health Plan

19.01

Meridian Health

21.45

Molina HealthCare

7.27

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 7-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

20.30

Blue Cross Community Health Plans

24.27

CountyCare Health Plan

19.50

Meridian Health

26.01

Molina HealthCare

19.13

YouthCare

52.25

Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use: 30-Day 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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/01/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

25.56

Blue Cross Community Health Plans

31.55

CountyCare Health Plan

27.67

Meridian Health

33.75

Molina HealthCare

34.78

YouthCare

62.16

Complete

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

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 in Care (YouthCare)

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.28

Blue Cross Community Health Plans

60.60

CountyCare Health Plan

59.42

Meridian Health

59.88

Molina HealthCare

58.64

YouthCare

70.79

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

2801

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

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

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

29.44

Blue Cross Community Health Plans

36.58

CountyCare Health Plan

38.82

Meridian Health

32.24

Molina HealthCare

32.44

YouthCare

51.57

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

2801

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

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

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

28.72

Blue Cross Community Health Plans

35.67

CountyCare Health Plan

37.06

Meridian Health

31.75

Molina HealthCare

31.49

YouthCare

50.94

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

25.77

Complete

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

No, 01/01/2023 - 12/31/2023

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

0.49

Complete

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

Cross-program rate: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

29.78

Complete

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

4.38

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

20.00

Complete

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

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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

17.76

Complete

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

55 / 104

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

20.33

Blue Cross Community Health Plans

24.66

CountyCare Health Plan

34.91

Meridian Health

20.51

Molina HealthCare

12.31

YouthCare

N/A

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression—Percentage of Members with a Viral Load Less Than 200 Copies/mL 56 / 104

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

8.03

Blue Cross Community Health Plans

49.83

CountyCare Health Plan

43.57

Meridian Health

38.01

Molina HealthCare

52.45

YouthCare

N/A

Complete

D2.VII.1 Measure Name: HIV Viral Load Suppression—Percentage of Members with a Valid Lab Result and a Viral Load Less Than 200 Copies/mL

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

HIV Viral Load Suppression—Percentage of Members with a Valid Lab Result and a Viral Load Less Than 200 Copies/mL

Measure results

Aetna Better Health

26.29

Blue Cross Community Health Plans

87.33

CountyCare Health Plan

88.15

Meridian Health

90.94

Molina HealthCare

95.81

YouthCare

N/A

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

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

Measure results

Aetna Better Health

90.33

Blue Cross Community Health Plans

94.65

CountyCare Health Plan

95.84

Meridian Health

91.96

Molina HealthCare

93.16

YouthCare

N/A

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

83.33

Blue Cross Community Health Plans

54.17

CountyCare Health Plan

71.88

Meridian Health

76.04

Molina HealthCare

82.29

YouthCare

N/A

Complete

D2.VII.1 Measure Name: MMP IL 3.6: Movement of Members In LTC: Percentage of members who were classified as being in LTC as of the

first day of the reporting period

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Percentage of members who were classified as being in LTC as of the first day of the reporting period.

Measure results

Aetna Better Health

7.00

Blue Cross Community Health Plans

4.40

CountyCare Health Plan

5.40

Meridian Health

8.60

Molina HealthCare

7.70

YouthCare

N/A

Complete

D2.VII.1 Measure Name: MMP IL 3.6: Movement of Members In LTC: Percentage of members who were not classified as being in LTC as of the first day of the reporting period

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Percentage of members who were not classified as being in LTC as of the first day of the reporting period.

Measure results

Aetna Better Health

93.00

Blue Cross Community Health Plans

95.60

CountyCare Health Plan

94.60

Meridian Health

91.40

Molina HealthCare

92.30

YouthCare

N/A

Complete

D2.VII.1 Measure Name: MMP IL 3.6: Movement of Members In LTC: Percentage of members who were not classified as being in LTC as of the last day of the reporting period

62 / 104

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

State-specific

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

Percentage of members who were not classified as being in LTC as of the last day of the reporting period.

Measure results

Aetna Better Health

93.00

Blue Cross Community Health Plans

95.50

CountyCare Health Plan

96.90

Meridian Health

92.00

Molina HealthCare

91.70

YouthCare

N/A

Complete

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

63 / 104

D2.VII.2 Measure Domain

Behavioral health care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

HEDIS

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

No, 01/01/2023 - 12/31/2023

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

68.69

Complete

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

64 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

75.52%

Blue Cross Community Health Plans

82.41%

CountyCare Health Plan

80.02%

Meridian Health

83.71%

Molina HealthCare

86.12%

YouthCare

N/A

Complete

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

65 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

77.42%

Blue Cross Community Health Plans

81.63%

CountyCare Health Plan

78.17%

Meridian Health

82.61%

Molina HealthCare

78.62%

YouthCare

N/A

Complete

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

66 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

92.38%

Blue Cross Community Health Plans

93.65%

CountyCare Health Plan

91.23%

Meridian Health

95.90%

Molina HealthCare

95.32%

YouthCare

N/A

Complete

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

67 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

87.49%

Blue Cross Community Health Plans

91.16%

CountyCare Health Plan

90.15%

Meridian Health

92.08%

Molina HealthCare

87.07%

YouthCare

N/A

Complete

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

68 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

50.84%

Blue Cross Community Health Plans

56.06%

CountyCare Health Plan

61.14%

Meridian Health

60.32%

Molina HealthCare

69.50%

YouthCare

N/A

Complete

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

69 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

65.70%

Blue Cross Community Health Plans

74.78%

CountyCare Health Plan

70.82%

Meridian Health

70.99%

Molina HealthCare

76.22%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often - Adult 70 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

64.68%

Blue Cross Community Health Plans

67.77%

CountyCare Health Plan

73.55%

Meridian Health

66.91%

Molina HealthCare

70.10%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

49.83%

Blue Cross Community Health Plans

67.76%

CountyCare Health Plan

68.15%

Meridian Health

62.26%

Molina HealthCare

63.64%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

81.82%

Blue Cross Community Health Plans

73.32%

CountyCare Health Plan

79.36%

Meridian Health

83.06%

Molina HealthCare

81.41%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.50%

Blue Cross Community Health Plans

75.28%

CountyCare Health Plan

82.03%

Meridian Health

85.93%

Molina HealthCare

79.83%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

93.73%

Blue Cross Community Health Plans

92.38%

CountyCare Health Plan

93.00%

Meridian Health

94.05%

Molina HealthCare

94.21%

YouthCare

N/A

Complete

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

75 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.09%

Blue Cross Community Health Plans

84.80%

CountyCare Health Plan

87.87%

Meridian Health

84.07%

Molina HealthCare

84.41%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

67.12%

Blue Cross Community Health Plans

67.97%

CountyCare Health Plan

77.16%

Meridian Health

65.98%

Molina HealthCare

63.21%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

70.57%

Blue Cross Community Health Plans

74.35%

CountyCare Health Plan

75.59%

Meridian Health

75.89%

Molina HealthCare

75.00%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.53%

Blue Cross Community Health Plans

63.16%

CountyCare Health Plan

75.26%

Meridian Health

69.44%

Molina HealthCare

75.47%

YouthCare

N/A

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

61.39%

Blue Cross Community Health Plans

73.50%

CountyCare Health Plan

78.56%

Meridian Health

67.21%

Molina HealthCare

61.31%

YouthCare

N/A

Complete

D2.VII.1 Measure Name: Getting Needed Care: Special Needs Children 80 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.60%

Blue Cross Community Health Plans

77.59%

CountyCare Health Plan

78.90%

Meridian Health

84.37%

Molina HealthCare

89.18%

YouthCare

89.22%

Complete

D2.VII.1 Measure Name: Getting Care Quickly: Special Needs Children 81 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

87.06%

Blue Cross Community Health Plans

80.71%

CountyCare Health Plan

84.58%

Meridian Health

87.16%

Molina HealthCare

91.01%

YouthCare

93.16%

Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: Special Needs Children

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

89.75%

Blue Cross Community Health Plans

93.09%

CountyCare Health Plan

88.92%

Meridian Health

92.04%

Molina HealthCare

91.37%

YouthCare

96.70%

Complete

D2.VII.1 Measure Name: Customer Service: Special Needs Children

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.22%

Blue Cross Community Health Plans

86.81%

CountyCare Health Plan

85.44%

Meridian Health

89.84%

Molina HealthCare

88.19%

YouthCare

85.34%

Complete

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

84 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

66.47%

Blue Cross Community Health Plans

65.63%

CountyCare Health Plan

65.84%

Meridian Health

63.64%

Molina HealthCare

69.57%

YouthCare

70.37%

Complete

D2.VII.1 Measure Name: Rating of Personal Doctor: Special Needs Children

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.61%

Blue Cross Community Health Plans

76.12%

CountyCare Health Plan

75.28%

Meridian Health

74.90%

Molina HealthCare

74.37%

YouthCare

76.70%

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

75.21%

Blue Cross Community Health Plans

78.79%

CountyCare Health Plan

77.60%

Meridian Health

81.36%

Molina HealthCare

80.00%

YouthCare

76.79%

Complete

D2.VII.1 Measure Name: Rating of Health Plan: Special Needs Children

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

59.76%

Blue Cross Community Health Plans

65.45%

CountyCare Health Plan

69.58%

Meridian Health

62.73%

Molina HealthCare

59.45%

YouthCare

59.90%

Complete

D2.VII.1 Measure Name: Getting Needed Care: Special Needs Children CCC

88 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

86.01%

Blue Cross Community Health Plans

79.14%

CountyCare Health Plan

81.40%

Meridian Health

83.90%

Molina HealthCare

87.35%

YouthCare

83.11%

Complete

D2.VII.1 Measure Name: Getting Care Quickly: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

87.74%

Blue Cross Community Health Plans

81.80%

CountyCare Health Plan

84.05%

Meridian Health

86.66%

Molina HealthCare

89.99%

YouthCare

92.29%

Complete

D2.VII.1 Measure Name: How Well Doctors Communicate: Special Needs Children CCC

90 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

91.54%

Blue Cross Community Health Plans

92.23%

CountyCare Health Plan

89.76%

Meridian Health

91.18%

Molina HealthCare

92.11%

YouthCare

96.24%

Complete

D2.VII.1 Measure Name: Customer Service: Special Needs Children CCO

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.71%

Blue Cross Community Health Plans

87.72%

CountyCare Health Plan

86.83%

Meridian Health

90.49%

Molina HealthCare

89.20%

YouthCare

83.94%

Complete

D2.VII.1 Measure Name: Rating of All Health Care: Special Needs Children CCC

92 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

65.92%

Blue Cross Community Health Plans

67.76%

CountyCare Health Plan

68.86%

Meridian Health

61.84%

Molina HealthCare

65.19%

YouthCare

60.62%

Complete

D2.VII.1 Measure Name: Rating of Personal Doctor: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

69.34%

Blue Cross Community Health Plans

76.26%

CountyCare Health Plan

73.85%

Meridian Health

71.40%

Molina HealthCare

72.76%

YouthCare

74.14%

Complete

D2.VII.1 Measure Name: Rating of Specialist Seen Most Often: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

74.34%

Blue Cross Community Health Plans

81.53%

CountyCare Health Plan

78.41%

Meridian Health

74.23%

Molina HealthCare

76.39%

YouthCare

64.49%

Complete

D2.VII.1 Measure Name: Rating of Health Plan: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

60.27%

Blue Cross Community Health Plans

66.53%

CountyCare Health Plan

67.73%

Meridian Health

60.12%

Molina HealthCare

56.60%

YouthCare

54.09%

Complete

D2.VII.1 Measure Name: Access to Specialized Services: Special Needs Children CCC 96 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

68.49%

Blue Cross Community Health Plans

62.95%

CountyCare Health Plan

63.93%

Meridian Health

64.32%

Molina HealthCare

71.13%

YouthCare

68.21%

Complete

D2.VII.1 Measure Name: FCC: Personal Doctor Who Knows Child: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

89.20%

Blue Cross Community Health Plans

91.49%

CountyCare Health Plan

91.36%

Meridian Health

89.21%

Molina HealthCare

88.80%

YouthCare

89.71%

Complete

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

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

84.67%

Blue Cross Community Health Plans

80.02%

CountyCare Health Plan

87.16%

Meridian Health

78.84%

Molina HealthCare

84.65%

YouthCare

72.27%

Complete

D2.VII.1 Measure Name: Access to Prescription Medicines: Special Needs Children CCC

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

90.74%

Blue Cross Community Health Plans

85.42%

CountyCare Health Plan

89.31%

Meridian Health

86.85%

Molina HealthCare

89.29%

YouthCare

77.68%

Complete

D2.VII.1 Measure Name: FCC: Getting Needed Information: Special Needs Children CCC

100 / 104

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

N/A

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

Program-specific rate

D2.VII.6 Measure Set

Medicaid Child Core Set

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

Yes

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

89.73%

Blue Cross Community Health Plans

89.05%

CountyCare Health Plan

89.42%

Meridian Health

90.28%

Molina HealthCare

92.27%

YouthCare

90.79%

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services: 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: HealthChoice Illinois (HCI), Youth in Care (YouthCare)

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2023 - 12/31/2023

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

40.70

Blue Cross Community Health Plans

31.52

CountyCare Health Plan

53.70

Meridian Health

48.61

Molina HealthCare

41.33

YouthCare

N/A

Complete

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

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

22.75

Blue Cross Community Health Plans

26.74

CountyCare Health Plan

18.71

Meridian Health

21.46

Molina HealthCare

7.35

YouthCare

N/A

Complete

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

103 / 104

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

25.71

Blue Cross Community Health Plans

31.82

CountyCare Health Plan

28.40

Meridian Health

20.93

Molina HealthCare

2.27

YouthCare

N/A

Complete

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

104 / 104

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

No, 01/01/2023 - 12/31/2023

D2.VII.8 Measure Description

N/A

Measure results

Aetna Better Health

22.81

Blue Cross Community Health Plans

26.83

CountyCare Health Plan

19.01

Meridian Health

21.45

Molina HealthCare

7.27

YouthCare

19.17

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: 21

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

1 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Untimely Provider Resolution Portal Response

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

01/22/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

2 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Untimely Provider Resolution Portal Response

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

09/09/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

3 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Untimely Provider Resolution Portal Response

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

01/12/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

4 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

EUM Missed Thresholds for Q4 2023

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

01/12/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

5 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

EUM Missed Thresholds for Q1 2024

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

04/10/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

6 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

EUM Missed Thresholds for Q3 2024

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$50,000

D3.VIII.7 Date assessed

11/20/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

7 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

EUM Missed Thresholds for Q2 2024

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$100,000

D3.VIII.7 Date assessed

11/20/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

8 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Untimely PDL Attestation Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

04/30/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

9 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

Untimely April 2024 Lock-In Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

06/24/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

10 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

YouthCare

D3.VIII.4 Reason for intervention

Untimely April 2024 Lock-In Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

D3.VIII.6 Sanction amount

1

$5,000

D3.VIII.7 Date assessed

06/24/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

11 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Untimely Annual DUR Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/06/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

12 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

Untimely Annual DUR Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/06/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

13 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Untimely Ad-Hoc Research Request Response

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/27/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

14 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Untimely Transporation Ad-Hoc Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/08/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

15 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Aetna Better Health

D3.VIII.4 Reason for intervention

Untimely P4R Q4 Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/09/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

16 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

Untimely Review and Remediation Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/09/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

17 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Molina HealthCare

D3.VIII.4 Reason for intervention

Untimely Quarterly Quality Presentation Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

08/06/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

18 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CountyCare Health Plan

D3.VIII.4 Reason for intervention

Untimely Ad-Hoc Technical Assistance Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/06/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

19 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Meridian Health

D3.VIII.4 Reason for intervention

Incomplete Report Data Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/06/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

20 / 21

D3.VIII.2 Plan performance issue

D3.VIII.3 Plan name

Aetna Better Health

Reporting

D3.VIII.4 Reason for intervention

Untimely Lock-In Report Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/15/2024

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

No, no remediation

D3.VIII.9 Corrective action plan

No

Complete

D3.VIII.1 Intervention type: Civil monetary penalty

21 / 21

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Blue Cross Community Health Plans

D3.VIII.4 Reason for intervention

Incomplete Report Data Submission

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$5,000

D3.VIII.7 Date assessed

11/19/2024

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** 6 **Blue Cross Community Health Plans** 7 **CountyCare Health Plan** 12 **Meridian Health** 6 **Molina HealthCare** 5 **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** 164 **Blue Cross Community Health Plans** 192 **CountyCare Health Plan** 111 **Meridian Health** 244 **Molina HealthCare** 156 **YouthCare** 48
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** 0.44:1,000 **Blue Cross Community Health Plans** 0.2566:1,000 **CountyCare Health Plan** 0.26:1,000 **Meridian Health**

		0.51:1,000 **Molina HealthCare** 0.52:1,000 **YouthCare** 1.12:1,000
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** 108 **Blue Cross Community Health Plans** 162 **CountyCare Health Plan** 136 **Meridian Health** 289 **Molina HealthCare** 122 **YouthCare** 29
D1X.5	**Ratio of resolved program integrity investigations to enrollees** 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.	**Aetna Better Health** 0.29:1,000 **Blue Cross Community Health Plans** 0.2165:1,000 **CountyCare Health Plan** 0.32:1,000 **Meridian Health** 0.6:1,000 **Molina HealthCare** 0.41:1,000 **YouthCare** 0.68:1,000
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program	**Aetna Better Health** Makes referrals to the State Medicaid Agency (SMA) only

	integrity referrals to the state? Select one.	**Blue Cross Community Health Plans** Makes referrals to the State Medicaid Agency (SMA) only **CountyCare Health Plan** Makes referrals to the State Medicaid Agency (SMA) only **Meridian Health** Makes referrals to the State Medicaid Agency (SMA) only **Molina HealthCare** Makes referrals to the State Medicaid Agency (SMA) only **YouthCare** Makes referrals to the State Medicaid Agency (SMA) only
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**Aetna Better Health** 77 **Blue Cross Community Health Plans** 90 **CountyCare Health Plan** 69 **Meridian Health** 135 **Molina HealthCare** 136 **YouthCare** 8
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	**Aetna Better Health** 0.21:1,000 **Blue Cross Community Health Plans** 0.1203:1,000 **CountyCare Health Plan**

	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.	0.16:1,000 **Meridian Health** 0.28:1,000 **Molina HealthCare** 0.45:1,000 **YouthCare** 0.19:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Aetna Better Health** 01/01/2024 **Blue Cross Community Health Plans** 01/01/2024 **CountyCare Health Plan** 01/01/2024 **Meridian Health** 01/01/2024 **Molina HealthCare** 01/01/2024 **YouthCare** 01/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Aetna Better Health** 12/31/2024 **Blue Cross Community Health Plans** 12/31/2024 **CountyCare Health Plan** 12/31/2024 **Meridian Health** 12/31/2024 **Molina HealthCare** 12/31/2024 **YouthCare** 12/31/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount**	**Aetna Better Health** $43,424,584

	From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Blue Cross Community Health Plans** $459,146.19 **CountyCare Health Plan** $304,915.62 **Meridian Health** $444,919.23 **Molina HealthCare** $792,910.16 **YouthCare** $25,108.32
D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Aetna Better Health** $2,968,022,518.61 **Blue Cross Community Health Plans** $5,492,072,178 **CountyCare Health Plan** $3,864,475,979 **Meridian Health** $5,337,061,189 **Molina HealthCare** $2,253,513,732 **YouthCare** $297,151,619
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

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

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

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Aetna Better Health** No ILOSs were offered by this plan **Blue Cross Community Health Plans** No ILOSs were offered by this plan **CountyCare Health Plan** No ILOSs were offered by this plan **Meridian Health** No ILOSs were offered by this plan **Molina HealthCare** No ILOSs were offered by this plan **YouthCare** No ILOSs were offered by this plan

Topic XIII. Prior Authorization

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

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

Topic XIV. Patient Access API Usage

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

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

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

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

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