Q4 2022 Quarterly Business Review (QBR) Report

Purpose of QBR Reports

The HealthChoice Illinois Quarterly Business Review is designed to provide measures and context around key subject areas and categories. All thresholds and requirements reflected here were developed based on best practices nationally as well as the Department's managed care Quality Strategy and Pillars. Among other objectives, these include improving access to care, fostering outcome-based approaches, addressing social determinants of health and promoting equity.

For each category below, the report offers (1) an explanation of major goals, (2) data showing changes over time and (3) where appropriate, highlights from individual plans.

Care Coordination:

New Enrollee Screening & Assessments:

Health Plans contact 100% of members to complete a Health Risk Screenings and Health Risk Assessment. HFS has a target threshold of 70% of new enrollees to have a health risk assessment or a health risk screening completed within 60 days of enrollment. To vigorously promote care coordination, this threshold was set higher than the industry average, which is a 49% completion rate within 60 days. Also, it should be noted that HRSs and HRAs are not completed for members in the fee for service program. This is a service available only through managed care.

Care Coordination: New Enrollee Screening and Assessments										
% of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment ***Changed as of 12/2021-The metric now only looks at screening status as of 2 months after enrollment.**	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	47.69%	48.11%	47.71%	64.71%	63.90%	72.72%	64.26%	not met	35%	**70%**
CountyCare Health Plan	35.50%	32.49%	31.04%	27.29%	37.54%	48.46%	41.50%	not met	17%	
Aetna (IlliniCare Health)	37.78%	41.92%	43.92%	45.35%	36.04%	43.74%	48.36%	not met	28%	
Meridian Health Plan	50.73%	44.69%	37.60%	49.55%	67.29%	55.56%	47.03%	not met	-7%	
Molina Healthcare	45.00%	52.53%	66.32%	39.07%	42.84%	48.32%	44.39%	not met	-1%	

Aetna Better Health of Illinois: Process and reporting capabilities have been enhanced. All medical management, customer service and vendor work streams are all documenting in ABHIL's care management documentation system for ease and integrity of reporting; these changes streamline reporting to increase accuracy and allows for a daily trigger report to reduce redundancies. Returning to the field in 2023 has improved our HRS completion rate as well as the development of an after-hours team in our on-going pursuit to reach the 70% threshold.

BCBSIL: BCBSIL met slightly below the performance target of 70% of new enrollees to have a health risk assessment or a health risk screening completed within 60 days of enrollment for Q3 2022. BCBSIL continues to see significant improvement in 2022 in comparison to prior years. BCBS continues to focus on HRS outreach and engagement by improving member engagement, adding additional staff, training, and extending hours of operation to conduct outreach at a more convenient time for members.

CountyCare: CountyCare has implemented a multi-channel approach to improve member engagement with progress towards the goal of 70%. CountyCare's team has been identifying how to improve current outreach mechanisms to account for members' needs such as language. Additional staffing resources were allocated, and enhanced oversight was implemented. CountyCare continues to use member and

HRS data to form concentrated strategies for continued improvement in meeting and exceeding the metric goal.

Meridian: The plan has implemented improvements and innovations to existing processes in efforts to meet and exceed HFS' target. Strong relationships with Business Enterprise Program (BEP) certified vendors, exploration of provider partnerships, improved tracking tools, and maintained level of urgency will improve Meridian's HRS completion rates. We have created interdepartmental workgroups to leverage the talent across the organization and create solutions to increase our percentage of new enrollee contact rates.

Molina: Molina noted a reduction in performance pertaining to changes in outreach staffing and systems in early 2022. As new systems were emplaced, Molina enhanced its outreach efforts and modalities and began to see an increase in performance in 2022. Initial screening is only one way that Molina identifies the needs of incoming members. For all members, Molina applies predictive modeling tools based on historical medical claims and other factors to identify its most at-risk members and focuses outreach and interventions on those members. Molina also outreaches to members who have been hospitalized, and it works closely with providers who send referrals for case management.

Care Plan Assessment & Individual Plan of Care High Risk:

HFS requires that high risk enrollees have an individual plan of care completed. Health plans report on the percentage of individual care plans completed within 90 days. Care plans are created with the member to identify the member's medical and other goals and identify ways the member and the health plan can work together to help the member achieve them. The industry average is approximately 35% completion within 90 days.

Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)										
% **high risk** Enrollees with an IPoC completed **within 90 days** after being identified as high risk ***New threshold as of 1/1/2022**	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	25.57%	27.92%	38.95%	35.99%	28.73%	27.12%	13.90%	not met	-46%	**60%**
CountyCare Health Plan	42.24%	41.46%	53.24%	50.41%	58.75%	23.57%	26.59%	not met	-37%	
Aetna (IlliniCare Health)	55.07%	73.16%	66.57%	72.18%	78.02%	74.47%	82.53%	met	50%	
Meridian Health Plan	48.13%	11.69%	32.03%	34.96%	34.81%	28.17%	30.46%	not met	-37%	
Molina Healthcare	44.36%	46.96%	31.77%	35.22%	30.47%	62.25%	22.09%	not met	-50%	

Aetna Better Health of Illinois: Aetna continues to amplify our efforts in engagement strategies. Recent accelerators include: returning to the field with boots on the ground utilizing Community Health Workers and returning onsite in our high-volume facilities and provider offices. Additional accelerators to improve IPOC completion rates include engagement with our Healthcare Transformation Collaborative (HTCs) partners, frequent Motivational Interviewing, listening to the voice of our members through multiple focus groups, and assessing for Health Equity gaps in care with every engagement.

BCBSIL: BCBSIL is continuing to implement strategies to increase the volume of IPOC completions and align reporting variances between MCOs. BCBS continues to focus on member outreach by improving member engagement, adding additional staff, training, and extending hours of operation to conduct outreach at a more convenient time for members.

CountyCare: CountyCare has identified a need to make practice adjustments due to downward trend for IPoC completion rate. This downward trend is attributed to recent increases in HRS rates which have increased the number of members stratified, and therefore increasing the number of members within care management. CountyCare is pursuing multiple new strategies to increase and build meaningful member engagement, increase staffing levels, and improve IPoC completion rates.

Meridian: Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

Care Plan Assessment & Individual Plan of Care Moderate Risk:

HFS requires that moderate risk enrollees have an individual plan of care completed. Health plans report on the percentage of individual care plans completed within 90 days. Care plans are created with the member to identify the member's medical and other goals and identify ways the member and the health plan can work together to help the member achieve them. The industry average is 51% completion within 90 days.

% moderate risk Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk ***New threshold as of 1/1/2022**	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	49.96%	55.37%	63.46%	61.89%	65.78%	60.91%	42.26%	not met	-15%	**60%**
CountyCare Health Plan	41.52%	40.86%	43.65%	43.42%	41.10%	50.50%	49.10%	not met	18%	
Aetna (IlliniCare Health)	63.24%	72.04%	71.54%	66.37%	63.10%	55.92%	66.93%	met	6%	
Meridian Health Plan	75.42%	58.31%	70.41%	41.65%	40.30%	34.08%	41.76%	not met	-45%	
Molina Healthcare	44.00%	54.49%	45.03%	57.52%	59.57%	75.70%	56.55%	not met	29%	

Aetna Better Health of Illinois: Aetna continues to amplify our efforts in engagement strategies. Recent accelerators include: returning to the field with boots on the ground utilizing Community Health Workers and returning onsite in our high-volume facilities and provider offices. Additional accelerators to improve IPOC completion rates include engagement with our Healthcare Transformation Collaborative (HTCs) partners, frequent Motivational Interviewing, listening to the voice of our members through multiple focus groups, and assessing for Health Equity gaps in care with every engagement.

BCBSIL: BCBSIL continues to implement strategies to increase the volume of IPOC completions and align reporting variances between MCOs. BCBS continues to focus on member outreach by improving member engagement, adding additional staff, training, and extending hours of operation to conduct outreach at a more convenient time for members.

CountyCare: Though CountyCare has remained in the same range towards completing the 60% target, additional remediation plans have been implemented in Quarter 3 2022. Expectation is to see tracking upward in the quarter summary forthcoming.

Meridian: Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

Service Plan for HCBS members:

HFS requires that HCBS eligible members have a service plan in place. Health plans report on the percentage of individual service plans in place within 15 days after the Health Plan is notified of HCBS waiver eligibility. Health Plans also provide all members a 90-day "continuity of care" period that ensures their waiver services are not changed until they have had a chance to review their plan with health plan care managers. The industry average is 77% completion within 15 days.

Enrollee Engagement: Service Plan										
% of Enrollees deemed newly eligible for HCBS Waiver who had a Service Plan **within 15 days** after the MCO is notified of the Enrollees HCBS Waiver eligibility ***New threshold as of 1/1/2022**	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	83.88%	86.17%	80.52%	79.58%	81.44%	83.80%	73.02%	not met	-13%	**90%**
CountyCare Health Plan	82.84%	80.11%	73.02%	69.61%	73.24%	78.26%	81.75%	not met	-1%	
Aetna (IlliniCare Health)	53.30%	53.10%	53.53%	58.12%	67.96%	60.98%	72.14%	not met	35%	
Meridian Health Plan	78.51%	67.81%	71.89%	85.61%	86.36%	86.11%	88.00%	not met	12%	
Molina Healthcare	67.43%	60.37%	70.92%	71.92%	71.33%	68.44%	71.21%	not met	6%	

Aetna Better Health of Illinois: Aetna achieved a material improvement in Q4 2022 and continues to make demonstrable improvements in 2023 due to: increasing capacity for outreach and engagement via expanded staffing; and restructuring and end-to-end operational improvements to ensure compliance with this metric, and all Waiver metrics.

BCBSIL: BCBSIL is continuing to evaluate reporting logic and implement strategies to increase the number of service plans in place within 15 days of HCBS waiver eligibility. Refresher trainings are occurring quarterly with staff focusing on best practices to improve member engagement.

CountyCare: CountyCare recognizes the importance of service planning within 15 days for members with new waiver eligibility. We continually strive to improve this metric through enhancing our workflows and hiring of additional staff and resources.

Meridian: Meridian strives to ensure that members have service plans in place within 15 days of eligibility notification. Meridian Care Management returned to the field effective April 2022, and we expect this metric to increase as we increase our opportunities for member touchpoints.

Molina: Molina has improved success rate for 15-day service plans for HCBS members since 2021, and it expects the positive trend to continue as its case managers return to the field following the lifting of COVID restrictions in 2023. During Q3 2022, we were able to successfully reach and assess approximately 77% of our new waiver enrollees, with service plan development lagging shortly behind that marker. Molina plans to make some organizational changes into Q1 2023 to provide a safety net, assuring that the maximum amount of outreach be conducted to increase successful reach, assessment, and service planning within the 15-day window.

Grievance and Appeals:

Resolution of Grievances:

Health plans are required to adjudicate grievances in a timely fashion. They report on the percentage of grievances resolved in less than or equal to 90 days. Nearly all grievances across the industry are resolved within 90 days.

% of Grievances resolved in less than or equal to 90 days	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Trend	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	100.00%	99.87%	100.00%	100.00%	99.95%	99.42%	99.51%	Decreasing	0%	**Monitor**
CountyCare Health Plan	99.13%	99.86%	100.00%	99.55%	99.70%	100.00%	99.91%	Increasing	1%	
Aetna (IlliniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	98.77%	93.41%	100.00%	99.42%	100.00%	99.85%	Decreasing	0%	
Molina Healthcare	100.00%	100.00%	99.89%	99.85%	100.00%	100.00%	100.00%	No Change	0%	

BCBSIL: BCBSIL continues to maintain steady performance of above 98%.

Meridian: Meridian implemented improvements to reduce grievance resolution turnaround time. Additionally, Meridian is reviewing root causes for grievances in order to reduce the overall volume and has successfully reduced. The normalized volume of enrollee grievances per 1,000 members remains very low, indicative of a positive enrollee experience with Meridian.

Molina: Molina has met member grievance turnaround times for resolved cases as indicated. To achieve this performance, Molina monitors inventory with accelerated internal delivery dates. Molina continues to collaborate with internal partners to assess trends and takes action to mitigate obstacles to improve overall processes.

Resolution of Appeals:

Health plans are required to adjudicate appeals in a timely fashion. They report on the percentage of appeals resolved in less than or equal to 15 days. Nearly all appeals across the industry are resolved within 15 days.

% of Appeals (non-expedited) resolved in less than or equal to 15 business days	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Trend	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	99.30%	96.23%	99.36%	99.39%	99.12%	98.57%	99.20%	Decreasing	0%	**Monitor**
CountyCare Health Plan	99.67%	99.16%	90.51%	98.43%	100.00%	100.00%	99.38%	Decreasing	0%	
Aetna (IlliniCare Health)	99.43%	98.37%	97.22%	100.00%	99.79%	99.67%	100.00%	Increasing	1%	
Meridian Health Plan	98.93%	90.82%	98.52%	99.84%	100.00%	99.85%	100.00%	Increasing	1%	
Molina Healthcare	100.00%	99.80%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	

Aetna Better Health of Illinois: ABHIL's Appeals team strives to achieve full compliance for appeal turnaround times (TATs) and demonstrated an increase in performance back to 100% at year-end. In addition to continuous monitoring of the appeals review and resolution process, trend review, and improved coordination between appeals and clinical review teams, the ABHIL Appeals team has implemented a recurring review process with Provider Experience to ensure findings noted during reviews translate into provider education.

BCBSIL: BCBSIL continues to maintain steady performance of above 98%.

Meridian: Meridian identified and implemented opportunities to ensure its appeals are all processed within the allotted time.

Molina: Molina monitors to ensure timely resolution of appeals, primarily by monitoring inventory with accelerated internal delivery dates. Production continues to be monitored with automated notification of escalated cases to ensure timeliness.

Utilization Management:

Prior Authorization Medical:

Health plans are required to report on the percentage of prior authorizations that are approved for medical services. The industry average is 85%. Health plans utilize established criteria and medical necessity guidelines when determining clinical appropriateness. Prior authorizations may be denied because the request is missing clinical information and incomplete or the service requested does not meet clinical criteria.

Prior Authorization requests for Medical (non Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging & Pain Management										
% of total **Approved** (all services requested were approved)	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Trend	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	82.60%	83.19%	84.10%	84.46%	83.71%	85.60%	83.20%	Increasing	1%	**Monitor**
CountyCare Health Plan	94.31%	94.79%	94.49%	93.48%	93.88%	93.87%	94.15%	Decreasing	0%	
Aetna (IlliniCare Health)	84.64%	84.21%	83.52%	83.31%	78.93%	80.34%	79.45%	Decreasing	-6%	
Meridian Health Plan	82.90%	77.46%	75.57%	84.41%	83.42%	85.82%	85.61%	Increasing	3%	
Molina Healthcare	84.71%	84.05%	83.56%	84.17%	88.49%	88.46%	80.67%	Decreasing	-5%	

Aetna Better Health of Illinois: Aetna is strengthening its capabilities in receiving clinical information via increased use of Provider portal, EMR access, as well as exploring additional integration opportunities into the Provider clinical documentation systems. It is important to note that Aetna continues its strong attention to appropriateness of care, as evidenced by the top two denial reasons being: (1) 'Does Not Meet Medical Necessity' at ~93.1%; (2) 'Not a covered benefit/benefit exhausted' at ~4.9%.

Meridian: Through its Utilization Management program, Meridian continually strives to ensure that its members are getting the right care, at the right level and at the right time. Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

Prior Authorization Behavioral Health:

Health plans are required to report on the percentage of prior authorizations that are approved for medical services. The industry average is 98%. Health plans utilize established criteria and medical necessity guidelines when determining clinical appropriateness. Prior authorizations may be denied because the request is missing clinical information and incomplete or the service requested does not meet clinical criteria.

Prior Authorization (Behavioral Health Only)										
% of total **Approved** (all services requested were approved)	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Trend	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	99.63%	99.79%	99.73%	99.72%	99.66%	99.56%	99.67%	Increasing	0%	**Monitor**
CountyCare Health Plan	89.97%	86.72%	90.76%	89.32%	91.69%	95.11%	96.64%	Increasing	7%	
Aetna (IlliniCare Health)	97.76%	91.13%	95.01%	94.37%	93.20%	94.35%	95.47%	Decreasing	-2%	
Meridian Health Plan	99.68%	100.00%	N/A	98.59%	100.00%	100.00%	98.31%	Decreasing	-1%	
Molina Healthcare	97.27%	98.46%	98.25%	98.30%	95.63%	93.87%	98.51%	Increasing	1%	

Provider Complaints:

HFS Provider Complaint Portal:

HFS tracks the number of provider disputes submitted through the HFS complaint portal per 1,000 member months. The industry average is .10. The new HFS provider complaint portal was put in place at the end of Q1 2020, since its implementation all provider complaints have been resolved by the plans within 30 days or receipt.

Provider Disputes/Complaints Portal Summary (Data Source - HFS Provider Resolution Portal)										
# of disputes **(per 1,000 Member Months)**	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Trend	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	0.05	0.10	0.11	0.13	0.09	0.09	0.09	Increasing	55%	**Monitor**
CountyCare Health Plan	0.01	0.02	0.03	0.06	0.04	0.06	0.03	Increasing	268%	
Aetna (IlliniCare Health)	0.08	0.10	0.12	0.15	0.14	0.13	0.12	Increasing	57%	
Meridian Health Plan	0.13	0.16	0.17	0.21	0.16	0.24	0.20	Increasing	50%	
Molina Healthcare	0.04	0.06	0.05	0.08	0.06	0.06	0.06	Increasing	45%	

Aetna Better Health of Illinois: The ABHIL Claims team has maintained full compliance to Complaints Portal required review and resolution timeframes since the portal launch in 2019. Throughout 2022, the team focused on identifying trends by analyzing the complaint data by provider, complaint type, etc. to identify root causes and remediation steps. This review contributed to a downward trend in complaints from Q1 to Q4 2022. The Claims team has implemented weekly proactive operational reviews to mitigate volume from escalating to the portal and is actively partnering with Provider Experience on provider feedback and education where applicable.

Meridian: Meridian has seen consistent improvement by taking the approach of meeting with provider groups and trade associations on a regular cadence. During our meetings, we identify trends and root causes, and discuss paths to sustain resolution. In addition, through the complaints we received, we have taken a proactive approach of notifying providers via our Meridian Website on global issues and proactively reprocessing claims when required. Meridian will continue to track and trend root causes to ensure member and provider satisfaction, and an overall reduction of dispute numbers.

Call Center:

Calls Answered:

Health Plans report on the percentage of calls answered within 30 seconds or less separately for members and providers and are required to maintain a threshold of 80% of calls being answered within 30 seconds for members. The data reported by the state combines both member and provider call times. The industry average is 87% of calls being answered within 30 seconds.

Provider and Enrollee Service Call Center										
% of calls answered in 30 seconds or less (combined Provider and Enrollee calls)	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	95.72%	95.91%	97.69%	96.44%	96.46%	96.73%	96.44%	met	1%	80% in 30 seconds or less
CountyCare Health Plan	84.74%	70.13%	85.56%	85.80%	84.75%	83.95%	82.26%	met	-3%	
Aetna (IlliniCare Health)	83.45%	69.03%	92.91%	96.08%	96.85%	93.93%	94.43%	met	13%	
Meridian Health Plan	87.69%	86.46%	88.88%	88.48%	91.73%	83.36%	90.33%	met	3%	
Molina Healthcare	68.28%	79.38%	89.41%	72.90%	84.38%	81.39%	70.46%	met	3%	

Molina: Molina experienced some staffing transitions in the Provider Call Center during the 4th quarter. The member percentage of calls answered within 30 seconds was 88.8%.

Calls Abandoned:

Health Plans report on the percentage of calls abandoned and are required to maintain a threshold of fewer than 5% of calls being abandoned for member calls. The data published combines abandonment rate for both member and provider calls. Nearly every Health Plan met the fewer than 5% threshold and the industry average percentage is approximately 2% for calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	met/not met	% change from Q2 2021	Threshold:
Blue Cross Community Health Plan	1.63%	1.18%	1.00%	1.04%	1.07%	1.38%	0.81%	met	-50%	5% or less
CountyCare Health Plan	2.45%	4.83%	1.90%	2.20%	2.00%	1.80%	2.91%	met	19%	
Aetna (IlliniCare Health)	1.46%	3.33%	0.68%	0.68%	0.60%	1.09%	0.58%	met	-60%	
Meridian Health Plan	1.56%	1.78%	2.04%	3.31%	2.16%	2.67%	1.38%	met	-12%	
Molina Healthcare	7.13%	5.45%	1.08%	12.41%	1.97%	2.07%	6.01%	not met	-16%	

Molina: The abandoned call rate for member calls was 1.38% in Q4.