Q1 2023 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. The target for plans to meet most of the thresholds is January 1, 2023.

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 56% 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.**	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	48.11%	47.71%	64.71%	63.90%	72.72%	64.26%	69.50%	not met	44%	**70%**
CountyCare Health Plan	32.49%	31.04%	27.29%	37.54%	48.46%	41.50%	53.31%	not met	64%	
Aetna (IlliniCare Health)	41.92%	43.92%	45.35%	36.04%	43.74%	48.36%	51.15%	not met	22%	
Meridian Health Plan	44.69%	37.60%	49.55%	67.29%	55.56%	47.03%	55.48%	not met	24%	
Molina Healthcare	52.53%	66.32%	39.07%	42.84%	48.32%	44.39%	52.39%	not met	0%	

Aetna Better Health of Illinois: In Aetna's ongoing pursuit to reach the 70% threshold, Aetna has accelerated our capabilities across internal and external work streams inclusive of expansion of the Community Health Worker (CHW) workforce and the After-Hours team. Furthermore, Aetna has engaged with an additional vendor partner, known for their strength in engaging members, which also supported the improved results. Aetna's enhanced texting campaign has been developed and will be implemented effective Q2 2023.

BCBSIL: BCBSIL is within 1% of the 70% performance target of new enrollees to have a health risk assessment or a health risk screening completed within 60 days of enrollment. BCBSIL continues to see significant improvement in 2023 in comparison to prior quarters. 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%. In Q1, CountyCare saw growth and continues to see the growth moving into Q2. 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 the 70% 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 that continued into the start of 2023. 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 51% 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**	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	27.92%	38.95%	35.99%	28.73%	27.12%	13.90%	16.15%	not met	-42%	**60%**
CountyCare Health Plan	41.46%	53.24%	50.41%	58.75%	23.57%	26.59%	64.05%	met	54%	
Aetna (IlliniCare Health)	73.16%	66.57%	72.18%	78.02%	74.47%	82.53%	83.36%	met	14%	
Meridian Health Plan	11.69%	32.03%	34.96%	34.81%	28.17%	30.46%	34.84%	not met	198%	
Molina Healthcare	46.96%	31.77%	35.22%	30.47%	62.25%	22.09%	56.75%	not met	21%	

Aetna Better Health of Illinois: Aetna continues acceleration of efforts in engagement strategies with emphasis, including 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 Healthcare Transformation Collaborative (HTC) partners, frequent Motivational Interviewing, listening to the voice of Aetna members through multiple focus groups, and assessing for Health Equity gaps in care with every engagement. Aetna's persistent outreach strategy has capitalized on Aetna's ability to engage members across the ecosystem of care over time.

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 identified a need to make practice adjustments due to downward trend for IPOC completion rate. With these adjustments, we saw an increase in our Q1 measure trending up to 64%.

Meridian: Meridian has implemented more efficient and effective engagement strategies and expects to attain significantly improved outcomes going forward.

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 60% 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**	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	55.37%	63.46%	61.89%	65.78%	60.91%	42.26%	39.45%	not met	-29%	**60%**
CountyCare Health Plan	40.86%	43.65%	43.42%	41.10%	50.50%	49.10%	53.77%	not met	32%	
Aetna (IlliniCare Health)	72.04%	71.54%	66.37%	63.10%	55.92%	66.93%	68.68%	met	-5%	
Meridian Health Plan	58.31%	70.41%	41.65%	40.30%	34.08%	41.76%	53.15%	not met	-9%	
Molina Healthcare	54.49%	45.03%	57.52%	59.57%	75.70%	56.55%	83.18%	met	53%	

Aetna Better Health of Illinois: Aetna continues acceleration of efforts in engagement strategies with emphasis including 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 Healthcare Transformation Collaborative (HTC) partners, frequent Motivational Interviewing, listening to the voice of Aetna 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: CountyCare implemented interventions which resulted in Q1 2023 increase. CountyCare continues to push new strategies to improve the measure.

Meridian: Meridian has implemented more efficient and effective engagement strategies and expects to attain significantly improved outcomes going forward.

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 81% 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**	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	86.17%	80.52%	79.58%	81.44%	83.80%	73.02%	79.45%	not met	-8%	**90%**
CountyCare Health Plan	80.11%	73.02%	69.61%	73.24%	78.26%	81.75%	82.93%	not met	4%	
Aetna (IlliniCare Health)	53.10%	53.53%	58.12%	67.96%	60.98%	72.14%	82.06%	not met	55%	
Meridian Health Plan	67.81%	71.89%	85.61%	86.36%	86.11%	88.00%	88.97%	not met	31%	
Molina Healthcare	60.37%	70.92%	71.92%	71.33%	68.44%	71.21%	71.49%	not met	18%	

Aetna Better Health of Illinois: Aetna continues to demonstrate incremental and material improvements over the last two quarters. Improvements are due to: increasing capacity for outreach and engagement via expanded staffing and restructuring; enhanced reporting capabilities; and overall end-to-end operational improvements to ensure compliance with this metric and all Waiver metrics.

BCBSIL: BCBSIL improved performance in comparison to prior quarters and continues 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 continues to make steady improvement on this important 15-day metric. We monitor the activity tied to this metric very closely and conduct ongoing training and reminders to care coordination staff to reinforce the expectations.

Meridian: Meridian will continue to implement quality improvements to achieve and exceed 90% to assure members get timely and effective service plans.

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 continues to push for higher performance in this area.

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	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Trend	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	99.87%	100.00%	100.00%	99.95%	99.42%	99.51%	99.44%	Decreasing	0%	**Monitor**
CountyCare Health Plan	99.86%	100.00%	99.55%	99.70%	100.00%	99.91%	100.00%	Increasing	0%	
Aetna (IlliniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	98.77%	93.41%	100.00%	99.42%	100.00%	99.85%	100.00%	Increasing	1%	
Molina Healthcare	100.00%	99.89%	99.85%	100.00%	100.00%	100.00%	100.00%	No Change	0%	

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

Meridian: Meridian continues to maintain steady performance regarding timely resolution of grievances. Through daily monitoring of inventory, as well analysis of root causes for grievances, the overall volume has reduced along with a significant reduction in the number of days to resolve a grievance. Overall, the volume of grievances per 1,000 enrollees remains comparatively low, indicating a positive enrollee experience with Meridian.

Some of our successes have included staffing changes, such as adding a supervisor position and increasing the number of Grievance Coordinators during Q4 2022. We also implemented a QA review process which has helped to ensure the quality of the resolutions for grievances, as well as reducing TAT as the review process previously fell to the Team Lead and/or Manager. While we have consistently maintained performance above 98% for resolving grievances within 90 days over the past year, we have also seen tremendous reduction in the number of days to resolve a grievance, decreasing from an average of 70 days in January to 64 days in March (and an average of 60.15 days YTD).

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	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Trend	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	96.23%	99.36%	99.39%	99.12%	98.57%	99.20%	97.96%	Increasing	2%	**Monitor**
CountyCare Health Plan	99.16%	90.51%	98.43%	100.00%	100.00%	99.38%	100.00%	Increasing	1%	
Aetna (IlliniCare Health)	98.37%	97.22%	100.00%	99.79%	99.67%	100.00%	100.00%	Increasing	2%	
Meridian Health Plan	90.82%	98.52%	99.84%	100.00%	99.85%	100.00%	99.87%	Increasing	10%	
Molina Healthcare	99.80%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	Increasing	0%	

BCBSIL: BCBSIL is continuing to implement strategies to maintain a steady performance of above 98% to ensure appeals are processed within the required timeframe.

Meridian: Meridian identified and implemented opportunities to ensure its appeals are all processed within the allotted time. We also created a committee to review our pre and post service appeals metrics and discuss any identified trends and proposed improvements in processes.

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 86%. 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)	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Trend	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	83.19%	84.10%	84.46%	83.71%	85.60%	83.20%	82.49%	Decreasing	-1%	**Monitor**
CountyCare Health Plan	94.79%	94.49%	93.48%	93.88%	93.87%	94.15%	94.50%	Decreasing	0%	
Aetna (IlliniCare Health)	84.21%	83.52%	83.31%	78.93%	80.34%	79.45%	88.08%	Increasing	5%	
Meridian Health Plan	77.46%	75.57%	84.41%	83.42%	85.82%	85.61%	83.32%	Increasing	8%	
Molina Healthcare	84.05%	83.56%	84.17%	88.49%	88.46%	80.67%	81.96%	Decreasing	-2%	

Aetna Better Health of Illinois: Aetna continues its quarterly review of Prior Authorization services, refining the list of services requiring Prior Authorization. Aetna continues to strengthen 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.

CountyCare: CountyCare continues to review prior authorization requests based on medical necessity through our clinical criteria guidelines or clinical policies. We have a 5% denial rate due to lack of medical necessity or insufficient information. We work with provider relations to assist in engaging providers to include all necessary information with the initial request.

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)	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Trend	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	99.79%	99.73%	99.72%	99.66%	99.56%	99.67%	99.80%	Increasing	0%	**Monitor**
CountyCare Health Plan	86.72%	90.76%	89.32%	91.69%	95.11%	96.64%	97.40%	Increasing	12%	
Aetna (IlliniCare Health)	91.13%	95.01%	94.37%	93.20%	94.35%	95.47%	96.61%	Increasing	6%	
Meridian Health Plan	100.00%	N/A	98.59%	100.00%	100.00%	98.31%	100.00%	No Change	0%	
Molina Healthcare	98.46%	98.25%	98.30%	95.63%	93.87%	98.51%	97.49%	Decreasing	-1%	

CountyCare: CountyCare continues to review prior authorization requests based on medical necessity through our clinical criteria guidelines or clinical policies. We have a 3% denial rate due to lack of medical necessity or insufficient information. We work with provider relations to assist in engaging providers to include all necessary information with the initial request.

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 .11. 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)**	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	Trend	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	0.10	0.11	0.13	0.09	0.09	0.09	0.09	Decreasing	-15%	**Monitor**
CountyCare Health Plan	0.02	0.03	0.06	0.04	0.06	0.03	0.08	Increasing	247%	
Aetna (IlliniCare Health)	0.10	0.12	0.15	0.14	0.13	0.12	0.17	Increasing	73%	
Meridian Health Plan	0.16	0.17	0.21	0.16	0.24	0.20	0.13	Decreasing	-18%	
Molina Healthcare	0.06	0.05	0.08	0.06	0.06	0.06	0.09	Increasing	46%	

Aetna Better Health of Illinois: Aetna's Claims team has maintained full compliance to Complaints Portal required review and resolution timeframes since the portal launch in 2019. Deep dives are conducted into key drivers of portal complaints on a regular cadence to identify global trends that can be addressed en masse. Q1 2023 experienced an increase in portal complaints, with primary drivers attributed to non-par provider education and DME billing. Root cause and remediation has been implemented for these areas with an expectation that complaint volume will normalize in the coming quarters.

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 through weekly reporting of our State Complaint inventory to ensure member and provider satisfaction, and an overall reduction of dispute numbers moving forward.

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 89% 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)	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	95.91%	97.69%	96.44%	96.46%	96.73%	96.44%	96.53%	met	1%	80% in 30 seconds or less
CountyCare Health Plan	70.13%	85.56%	85.80%	84.75%	83.95%	82.26%	79.98%	not met	14%	
Aetna (IlliniCare Health)	69.03%	92.91%	96.08%	96.85%	93.93%	94.43%	95.77%	met	39%	
Meridian Health Plan	86.46%	88.88%	88.48%	91.73%	83.36%	90.33%	88.12%	met	2%	
Molina Healthcare	79.38%	89.41%	72.90%	84.38%	81.39%	70.46%	85.67%	met	8%	

CountyCare: CountyCare transitioned call center services as of 4/1 which significantly increased speed of answer and quality of information provided to members.

Meridian: Meridian has hired and trained staff to prepare for influx of redetermination calls from members.

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 less than 2% for calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Q3 2022	Q4 2022	Q1 2023	met/not met	% change from Q3 2021	Threshold:
Blue Cross Community Health Plan	1.18%	1.00%	1.04%	1.07%	1.38%	0.81%	0.88%	met	-25%	5% or less
CountyCare Health Plan	4.83%	1.90%	2.20%	2.00%	1.80%	2.91%	3.17%	met	-34%	
Aetna (IlliniCare Health)	3.33%	0.68%	0.68%	0.60%	1.09%	0.58%	0.53%	met	-84%	
Meridian Health Plan	1.78%	2.04%	3.31%	2.16%	2.67%	1.38%	1.56%	met	-12%	
Molina Healthcare	5.45%	1.08%	12.41%	1.97%	2.07%	6.01%	1.48%	met	-73%	