Q4 2024 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 for the Illinois Managed Care Plans. All thresholds and requirements reflected here were developed based on best practices nationally and were shaped by 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 metric category below, the report offers (1) an explanation of the metrics overarching goals, (2) data showing changes over time (by quarter), and (3) where appropriate, highlights from individual plans.

Note: MCO data entry for Q3 and Q4 2023 metrics were temporarily suspended by the Department due to alignment concerns across the MCOs. The Department reinstated data entry into the MCO Performance Reporting System for most metrics for Q1 2024 and beyond.

Care Coordination:

New Enrollee Screening & Assessments:

Health Plans contact 100% of members to complete Health Risk Screenings and Health Risk Assessments. 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. Also, it should be noted that HRSs and HRAs are not completed for members in the fee-for-service program. This service is only available through managed care.

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 12/7/2021-The metric now only looks at screening status as of 2 months after enrollment**	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	Threshold: **70%**
Blue Cross Community Health Plan			*	*	*	*	*	
CountyCare Health Plan			*	*	*	*	*	
Aetna (IliniCare Health)			*	*	*	*	*	
Meridian Health Plan			*	*	*	*	*	
Molina Healthcare			*	*	*	*	*	

***HFS is auditing alignment of the application, of the performance metric definitions across plans to ensure future reporting outcomes are consistent and reflect the same interpretation of guidance provided. MCO metric data continues to be suspended and was not required for the Q4 2024 reporting period.**

Risk Stratification: Overview

HFS requires risk stratification to help ensure that care strategies consider differing needs. HFS requires that 20% of a plan's seniors and members with disabilities are identified as moderate or high risk. Further, HFS requires that 5% of seniors and members with disabilities be categorized as high risk. When a customer is classified as high or moderate risk, they are enrolled in specific care coordination programs. Risk stratification is based on predictive modeling algorithms and manual clinical reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. It is important to note that there may be a fluctuation in members stratified as a high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

Enrollee Engagement, Risk Stratification									
% of Enrollees (Seniors or Person with Disabilities) identified as Moderate (level 2) or High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **20%**
Blue Cross Community Health Plan			20.70%	21.70%	20.62%	20.96%	met	*	
CountyCare Health Plan			27.22%	27.20%	26.56%	26.69%	met	*	
Aetna (IliniCare Health)			27.75%	27.86%	28.15%	29.44%	met	*	
Meridian Health Plan			20.15%	20.01%	20.00%	20.04%	met	*	
Molina Healthcare			25.58%	26.22%	25.14%	24.83%	met	*	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **5%**
Blue Cross Community Health Plan			4.96%	5.02%	5.06%	5.04%	met	*	
CountyCare Health Plan			12.94%	13.14%	12.63%	12.58%	met	*	
Aetna (IliniCare Health)			6.39%	6.59%	6.45%	6.49%	met	*	
Meridian Health Plan			5.10%	5.01%	5.00%	5.02%	met	*	
Molina Healthcare			8.24%	7.88%	7.84%	7.42%	met	*	

Aetna Better Health of Illinois: Aetna employs a comprehensive approach to stratify the population, utilizing multiple modalities such as predictive modeling, health risk assessments, and referrals. These methods enable Aetna to identify and address the needs of high-risk members effectively. Aetna consistently meets or exceeds the risk stratification targets set by the Illinois Department of Healthcare and Family Services (HFS) across all product lines. This achievement is facilitated by rigorous oversight and continuous monitoring of performance metrics. The use of advanced data analytics and close collaboration with healthcare providers ensures that Aetna can deliver targeted interventions and support to improve health outcomes for its members.

Meridian: Meridian continues to meet expectations regarding High and Medium Risk Stratification for Persons with Disabilities. Enhancements are projected to be in place Q1 2025 for one of Meridian's predictive monitoring tools, Care Management Priority Report, which is expected to maximize available data in efforts to continually review and ensure timely and effective outreach, engagement and enrollment of the appropriate members into Care Management.

Risk Stratification Dual Eligible:

HFS requires that 90% of dual eligible adults be identified as moderate or high risk. Further, HFS requires that 20% of dual eligible members be categorized as high risk. Risk stratification is based on predictive modeling algorithms and manual clinical review that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high or moderate risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in members stratified as high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (Dual Eligible Adults) identified as Moderate (level 2) or High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **90%**
Blue Cross Community Health Plan			90.81%	89.79%	90.26%	90.32%	met	*	
CountyCare Health Plan			96.63%	96.35%	96.38%	96.54%	met	*	
Aetna (IliniCare Health)			98.38%	99.10%	98.95%	99.24%	met	*	
Meridian Health Plan			90.04%	90.04%	90.03%	90.11%	met	*	
Molina Healthcare			94.81%	94.35%	94.33%	94.46%	met	*	
% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **20%**
Blue Cross Community Health Plan			20.63%	19.99%	20.14%	20.22%	met	*	
CountyCare Health Plan			24.06%	23.90%	23.95%	23.95%	met	*	
Aetna (IliniCare Health)			20.88%	21.45%	22.73%	23.84%	met	*	
Meridian Health Plan			20.02%	20.02%	20.02%	20.03%	met	*	
Molina Healthcare			20.13%	17.47%	22.40%	21.13%	met	*	

Meridian: Meridian continues to meet expectations regarding High and Medium Risk Stratification for Dual Eligible Adults. Enhancements are projected to be in place Q1 2025 for one of Meridian's predictive monitoring tools, Care Management Priority Report, which is expected to maximize available data in efforts to continually review and ensure timely and effective outreach, engagement and enrollment of the appropriate members into Care Management.

Risk Stratification Families & Children:

HFS requires that 2% of enrollees within the family and children eligibility category be identified as high-risk. Risk stratification is based on predictive modeling algorithms and manual clinical reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in members stratified as a high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (Families and Children) identified as High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **2%**
Blue Cross Community Health Plan			2.04%	1.99%	2.08%	2.04%	met	*	
CountyCare Health Plan			2.14%	2.14%	1.80%	1.73%	not met	*	
Aetna (IliniCare Health)			2.01%	2.08%	2.39%	2.10%	met	*	
Meridian Health Plan			2.37%	2.05%	2.04%	2.06%	met	*	
Molina Healthcare			3.89%	3.86%	3.24%	3.39%	met	*	

CountyCare: CountyCare performed an analysis of the downward trend and will implement remediation within the next monthly cycle to expand acuity setting parameters to meet this metric. This includes a deep dive into each case management team's practices using all available data to determine acuity. Additionally, we will be setting corrective performance plans with each team as appropriate until the metric sustains the 2% threshold requirement.

Meridian: Meridian continues to meet expectations regarding High and Medium Risk Stratification for members in the Families and Children populations. Enhancements are projected to be in place Q1 2025 for one of Meridian's predictive monitoring tools, Care Management Priority Report, which is expected to maximize available data in efforts to continually review and ensure timely and effective outreach, engagement and enrollment of the appropriate members into Care Management. Additionally, for Q1 2025 Meridian expanded the catchment universe of High Stratified members from 2.0 to 2.5 to capture additional members in need of coordination.

Risk Stratification ACA adults:

HFS requires that 2% of ACA eligible adults be identified as high-risk. Risk stratification is based on predictive modeling algorithms and manual clinical reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in members stratified as a high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (ACA Adult) identified as High Risk (level 3)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **2%**
Blue Cross Community Health Plan			2.11%	2.15%	2.13%	2.09%	met	*	
CountyCare Health Plan			3.93%	3.96%	3.67%	3.52%	met	*	
Aetna (IliniCare Health)			2.09%	2.16%	2.16%	2.44%	met	*	
Meridian Health Plan			2.26%	2.00%	2.00%	2.00%	met	*	
Molina Healthcare			3.63%	4.01%	3.61%	3.67%	met	*	

Meridian: : Meridian continues to meet expectations regarding High and Medium Risk Stratification for members in the ACA populations. Enhancements are projected to be in place Q1 2025 for one of Meridian's predictive monitoring tools, Care Management Priority Report, which is expected to maximize available data in efforts to continually review and ensure timely and effective outreach, engagement and enrollment of the appropriate members into Care Management. Additionally, for Q1 2025 Meridian expanded the catchment universe of High Stratified members from 2.0 to 2.5 to capture additional members in need of coordination.

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 members goals related to medical, health, and overall well-being. When a care plan is designed, members and their health plan collaborate to create interventions and barriers allowing the members to successfully achieve their established goals.

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	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/not met	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			*	*	*	*	*	*	**Effective 01/01/22**
CountyCare Health Plan			*	*	*	*	*	*	
Aetna (IliniCare Health)			*	*	*	*	*	*	60%
Meridian Health Plan			*	*	*	*	*	*	
Molina Healthcare			*	*	*	*	*	*	

***HFS is auditing alignment of the application of the performance metric definitions across plans to ensure future reporting outcomes are consistent and reflect the same interpretation of guidance provided. MCO metric data continues to be suspended and was not required for the Q4 2024 reporting period**.

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 61% completion within 90 days.

% **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/not met	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			40.03%	42.01%	50.77%	52.97%	not met	*	**Effective 01/01/22**
CountyCare Health Plan			56.06%	56.74%	59.33%	59.39%	not met	*	
Aetna (IliniCare Health)			57.19%	56.56%	53.26%	48.03%	not met	*	60%
Meridian Health Plan			80.35%	83.79%	81.57%	88.02%	met	*	
Molina Healthcare			71.80%	70.59%	70.03%	73.14%	met	*	

Aetna Better Health of Illinois: Aetna continues to strengthen our engagement strategies through the expansion of our boots on the ground community presence utilizing Community Health Workers, as well as scaling our onsite presence in our high volume facilities and provider offices. Additional accelerators to improve IPOC completion rates include: reinforcing training for teams to enhance their skills and productivity; engagement with our Healthcare Transformation Collaborative (HTCs) partners; embedding our clinical workforce in our value based provider offices; and deploying ADT and pharmacy data to bolster our member demographic data.

Blue Cross Blue Shield of Illinois: Performance has increased quarter over quarter throughout 2024. Ongoing improvement of member engagement demonstrated by timely IPOC completions for newly moderate risk membership is a key focus area in order to facilitate improved health outcomes as changes in condition occur.

CountyCare: For two quarters, CountyCare has narrowly missed this measure by under one percentage point. A remediation strategy has been implemented during the last three consecutive months. CountyCare anticipates meeting the target of 60% within the next quarter. The remediation strategy included a report indicating members who are due for contact that month with weekly monitoring by managers. Additionally, a process has been set for re-evaluating hard-to-reach members consisting of case audits and community outreach efforts.

Meridian: For Q4 2024, Meridian continued to diligently execute best practices to ensure timely and impactful Individualized Plan of Care (IPOC) completion. Q12025 enhancements to Meridian's predictive modeling tools will allow more accurate identification of members emerging risk status and enable engagement and enrollment into Care management.

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 80% 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	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/not met	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			85.17%	82.28%	82.41%	78.82%	not met	*	**Effective 01/01/22**
CountyCare Health Plan			86.17%	86.04%	84.02%	86.89%	not met	*	
Aetna (IliniCare Health)			80.90%	82.17%	78.93%	82.73%	not met	*	90%
Meridian Health Plan			86.01%	87.75%	90.23%	92.25%	met	*	
Molina Healthcare			62.31%	61.89%	60.80%	61.20%	not met	*	

Aetna Better Health of Illinois: While Aetna continues to make progress, member-related delays remain the primary challenge affecting timely onboarding. To address this, monitoring capabilities have been enhanced through dashboard optimization and improved reporting systems. Aetna continues to leverage a lag reporting tool, which provides valuable historical data analysis to identify trends and improvement opportunities. This tool has become essential in our efforts to enhance timeliness and has had a positive impact on outcomes.

Blue Cross Blue Shield of Illinois: Performance completions were impacted in Q4 2024, however care coordinators consistently documented valid justification to identify service plans that were not completed timely. Examples of valid justification included: members that were out of the state or country, member requesting visit preference outside of the 15 day period, unable to reach, and member declining waiver services.

CountyCare: CountyCare continues to perform above the noted industry average of 80%. We are trending up from Q3 2024 and when isolating for the closed swim lane, we are meeting the target. CountyCare continues to monitor our newly waiver eligible members very closely and train care coordinators quarterly on the requirements and expectations of this metric.

Meridian: For Q4 2024, Meridian is proud to be best among HFS MCO peers re providing members with a Service Plan w/ in 15 days of notification. Meridian continued to diligently execute best practices to ensure timely and impactful Service Plan implementation. Our Service Plan implementation includes all identified needs, member input and approval resulting in the best possible short- and long-term outcomes for members. As a result, for Q4 2024, as in previous quarters, Meridian consistently exceeded expectations.

Molina: Molina has engaged in ongoing data analysis of its results in this area. The primary driver of underperformance in this area appears to be driven by member's requesting to schedule an initial assessment visit outside of the 15-day service initiation window upon the CMs reaching out to initiate within the timeframe. Molina has crafted talking points in this area to educate our members on the importance of the prompt initiation of waiver services (whenever possible) and has implemented process changes to enhance monitoring and oversight 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 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Trend	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			99.89%	99.98%	100.00%	100.00%	no change	*	**TBD**
CountyCare Health Plan			100.00%	100.00%	100.00%	99.91%	no change	*	
Aetna (IliniCare Health)			100.00%	100.00%	100.00%	100.00%	no change	*	
Meridian Health Plan			99.29%	99.50%	100.00%	100.00%	no change	*	
Molina Healthcare			100.00%	100.00%	100.00%	100.00%	no change	*	

Aetna Better Health of Illinois: Aetna continues to achieve full compliance with required Grievance Turn Around Times (TATs) through a robust end-to-end intake, review, and resolution process. Aetna tracks and trends all grievance data to identify global issues and drive remediation.

Meridian: Meridian continues to maintain exemplary performance regarding timely resolution of grievances. 100% of grievances for Q4 2024 were resolved within 90 days. The average turnaround time was 36 days in Q4. Meridian was able to achieve this through daily monitoring of inventory and timely responses from business partners. Meridian continues to work closely with the transportation vendor and the vendor managers to reduce the number of complaints received from the members. Meridian continues to have biweekly workgroups to discuss and brainstorm complicated trips and any barriers for the members.

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 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Trend	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			97.58%	97.82%	98.90%	98.41%	no change	*	**TBD**
CountyCare Health Plan			95.97%	99.57%	100.00%	99.81%	no change	*	
Aetna (IliniCare Health)			100.00%	100.00%	100.00%	100.00%	no change	*	
Meridian Health Plan			99.71%	100.00%	100.00%	99.93%	no change	*	
Molina Healthcare			100.00%	100.00%	100.00%	100.00%	no change	*	

Aetna Better Health of Illinois: Aetna is fully compliant with required Appeals Turn Around Times (TATs). The Aetna Grievances & Appeals team leverages detailed and real time tracking processes to ensure timely intake, processing, and responses for all appeals within or favorable to contractual requirements.

Meridian: Meridian continued to resolve non-expedited appeals at 99.93% timely in Q4. Our consistent performance is attributed to ongoing, frequent refresher training sessions and added support from team cross-training. Meridian expects to maintain performance into Q1 and beyond.

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 88%. 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, 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									
% of total **Approved** (all services requested were approved)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Trend	change from Q3 2023	Threshold: **TBD**
Blue Cross Community Health Plan			85.76%	83.55%	83.94%	83.42%	no change	*	
CountyCare Health Plan			95.55%	95.22%	93.90%	94.03%	no change	*	
Aetna (IliniCare Health)			89.61%	88.46%	89.69%	90.24%	increasing	*	
Meridian Health Plan			77.31%	78.13%	77.52%	78.92%	increasing	*	
Molina Healthcare			89.30%	92.35%	92.48%	92.70%	no change	*	

Aetna Better Health of Illinois: Aetna continually evaluates prior authorizations (PA) to enhance efficiency and drive industry best practices across Utilization Management (UM) activities. Statistical analysis identifies patterns that promote UM efficiency and further simplify the provider experience. Aetna continues its quarterly review of PA services, refining the list of services requiring PA. Aetna continues to promote efficiencies and strengthen capabilities in receiving clinical information via self-service access to Epic Payer Platform (EPP) and Electronic Medical Record (EMR) systems, increased use of Availity (Aetna's Provider Portal), as well as exploring additional integration opportunities into Provider clinical documentation systems.

Meridian: Meridian continually evaluates codes and procedures to determine whether prior authorization (PA) can be retired based on approval volumes. Meridian uses PA to ensure members are receiving care consistent with clinical best practices and to identify members who may be newly in need of care coordination services. Providers are encouraged to use Availity to enhance two-way communication about their PA requests. Meridian noticed a slight increase in approval rates in Q4 2024 along with corresponding decreases in denial rates during Q4 indicating that there were fewer partial approvals during this reporting period.

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 95%. 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 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Trend	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			99.48%	99.38%	99.61%	99.73%	no change	*	**TBD**
CountyCare Health Plan			99.48%	98.64%	99.04%	98.43%	decreasing	*	
Aetna (IliniCare Health)			95.92%	96.03%	94.91%	95.36%	no change	*	
Meridian Health Plan			93.33%	94.44%	91.67%	90.63%	decreasing	*	
Molina Healthcare			88.97%	92.83%	97.20%	95.48%	decreasing	*	

Aetna Better Health of Illinois: Aetna meets the industry average on approvals for Behavioral Health (BH) services; Aetna does not require Pre-Service review for members seeking outpatient BH care.

Meridian: A select number of Behavioral Health (BH) outpatient services undergo prior authorization (PA) review to ensure there is adequate capacity for members stepping down from acute care and assurance that members are receiving services at the right place and time. These services are reviewed frequently to ensure Meridian is effectively managing the levels of care most utilized and needed for our members requiring BH. PA also serves as a conduit to care coordination for our members. Our Utilization Management (UM) team collaborates closely with Care Management (CM). It is through the PA process that members are identified and discussed in UM/CM rounds to ensure care coordination occurs.

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.

Provider Disputes/ Complaints Summary **Data Source: HFS Provider Complaint Portal.**									
# of disputes **(per 1,000 Member Months)**	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	Trend	change from Q3 2023	Threshold:
Blue Cross Community Health Plan			0.06	0.03	0.04	0.04	no change	*	**TBD**
CountyCare Health Plan			0.06	0.06	0.05	0.06	no change	*	
Aetna (IliniCare Health)			0.15	0.16	0.14	0.12	no change	*	
Meridian Health Plan			0.10	0.07	0.08	0.09	no change	*	
Molina Healthcare			0.14	0.12	0.11	0.10	no change	*	

Aetna Better Health of Illinois: Aetna's HealthChoice Illinois disputes per thousand member months have decreased from Q3 2024 to Q4 2024 from .08 to .07. Overall dispute numbers have continued to decrease month over month with a 35% overall decrease from CY 2023 to CY 2024 due to a rigorous weekly monitoring, root cause, and resolution process that was instituted in early 2023. Deep dives are conducted into key drivers of portal complaints to identify global trends that can be addressed en masse. Aetna has deployed system automations to enhance payment accuracy and resolution of key volume drivers, including Share of Cost reconciliation and authorization disputes which will help reduce the number of provider disputes.

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 92% 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 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **80%** in 30 seconds or less
Blue Cross Community Health Plan			96.68%	96.92%	92.42%	96.77%	met	*	
CountyCare Health Plan			86.02%	74.34%	69.55%	91.50%	met	*	
Aetna (IliniCare Health)			89.25%	89.26%	85.65%	89.41%	met	*	
Meridian Health Plan			95.89%	95.92%	85.78%	88.74%	met	*	
Molina Healthcare			91.09%	94.81%	90.60%	88.90%	met	*	

Aetna Better Health of Illinois: Aetna continues to exceed service level thresholds. The Aetna call center team tracks all metrics on an hourly basis via automated reporting and hosts multiple workforce management huddles daily to ensure staffing levels are meeting incoming call volumes.

Meridian: Meridian met all Contact Center metrics in Q4. Service Level rebounded to prior quarters after the Q3 Healthy Rewards inquiries.

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. Every Health Plan met the fewer than 5% threshold with an industry average percentage of 1.04% for calls being abandoned.

Provider and Enrollee Service Call Center									
% of calls abandoned (combined Provider and Enrollee calls)	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Q4 2024	met/ not met	change from Q3 2023	Threshold: **5%** or less
Blue Cross Community Health Plan			0.69%	0.62%	0.91%	0.36%	met	*	
CountyCare Health Plan			1.60%	3.50%	2.89%	0.87%	met	*	
Aetna (IliniCare Health)			1.21%	1.37%	1.55%	1.10%	met	*	
Meridian Health Plan			1.20%	1.28%	2.44%	2.01%	met	*	
Molina Healthcare			0.50%	0.52%	1.22%	1.27%	met	*	

Aetna Better Health of Illinois: Aetna has maintained abandonment rates in full compliance with contractual requirements. The Aetna Member Services team tracks all call metrics on an hourly basis via automated reporting and hosts multiple workforce management huddles daily to ensure staffing levels are meeting incoming call volumes and any negative trends are addressed in real time.

Meridian: Meridian's Contact Center has continued to meet all required metrics in Q4. To ensure adequate coverage, Meridian continues to partner with our Workforce Management team to assess staffing on a weekly cadence.

MCO Provider Credentialing:

Under the HealthChoice Illinois Contract,

5.9 UNIFORM PROVIDER CREDENTIALING AND RE-CREDENTIALING

5.9.1 By 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Contractor's Provider Network, the Contractor must verify that provider is enrolled in IMPACT.

5.9.1.1 Upon receipt of a Provider's completed and accurate Universal Roster Template, Contractor shall load the Provider information into its system within thirty (30) days.

5.9.2 Continuingly, the Contractor shall monitor Enrollee Complaints and Appeals, quality-of-care and quality-of-service events, and medical record review. The contractor shall document its process for selecting and retaining Providers.

5.9.3 Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers.

5.9.4 Contractor is prohibited from requiring providers to undergo additional credentialing processes that are not a part of this Contract.

MCOs do not credential providers per Contract requirements as outlined above. Instead, HFS considers providers credentialed once they are enrolled in IMPACT. As HFS credentials the providers in IMPACT, there is no credentialing activity that the MCOs perform or report to HFS.