Q2 2024 Quarterly Business Review (QBR) Report – Performance Metrics

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**	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	Threshold: **70%**
Blue Cross Community Health Plan	69.50%	60.93%			*	*		
CountyCare Health Plan	53.31%	60.99%			*	*		
Aetna (IliniCare Health)	51.15%	52.99%			*	*		
Meridian Health Plan	55.48%	60.58%			*	*		
Molina Healthcare	52.39%	65.14%			*	*		

***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 Q2 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)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **20%**
Blue Cross Community Health Plan	20.39%	20.39%			20.70%	21.70%	met	0.06%	
CountyCare Health Plan	25.76%	26.56%			27.22%	27.20%	met	0.06%	
Aetna (IlliniCare Health)	30.62%	30.96%			27.75%	27.86%	met	-0.09%	
Meridian Health Plan	20.01%	20.03%			20.15%	20.01%	met	0.00%	
Molina Healthcare	24.17%	24.45%			25.58%	26.22%	met	0.08%	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **5%**
Blue Cross Community Health Plan	5.15%	5.07%			4.96%	5.02%	met	-0.03%	
CountyCare Health Plan	11.65%	11.99%			12.94%	13.14%	met	0.13%	
Aetna (IlliniCare Health)	6.06%	6.30%			6.39%	6.59%	met	0.09%	
Meridian Health Plan	5.00%	5.02%			5.10%	5.01%	met	0.00%	
Molina Healthcare	8.05%	8.27%			8.24%	7.88%	met	-0.02%	

Aetna Better Health of Illinois: Aetna continues to stratify the population via multiple modalities including predictive modeling, assessments, and referrals. Aetna continues to meet/exceed the risk stratification targets across all product lines as established by HFS via close oversight and monitoring.

Meridian: Meridian has and continues to consistently meet expectations for identifying Seniors or Persons with Disabilities. Meridian continues to refine its predictive modeling tools to capture members with the most need at the earliest possible time post enrollment or life-altering event. This allows Meridian Care Managers to coordinate care, educate, and advocate in the most impactful manner.

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)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **90%**
Blue Cross Community Health Plan	90.47%	91.47%			90.81%	89.79%	not met	-0.01%	
CountyCare Health Plan	97.06%	97.43%			96.63%	96.35%	met	-0.01%	
Aetna (IliniCare Health)	98.59%	97.82%			98.38%	99.10%	met	0.01%	
Meridian Health Plan	90.03%	90.02%			90.04%	90.04%	met	0.00%	
Molina Healthcare	93.11%	94.15%			94.81%	94.35%	met	0.01%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **20%**
Blue Cross Community Health Plan	20.23%	20.45%			20.63%	19.99%	not met	-0.01%	
CountyCare Health Plan	26.28%	26.60%			24.06%	23.90%	met	-0.09%	
Aetna (IliniCare Health)	21.00%	20.43%			20.88%	21.45%	met	0.02%	
Meridian Health Plan	20.01%	20.01%			20.02%	20.02%	met	0.00%	
Molina Healthcare	18.27%	22.76%			20.13%	17.47%	not met	-0.04%	

BCBSIL: The risk model has undergone ongoing improvements to the end-to-end process. New monitoring tools to identify opportunities for calibration of inputs and preliminary results have been created and are being utilized. Through the inclusion of these tools, we expect to improve our performance with the risk stratification requirements.

Meridian: Meridian has and continues to consistently meet expectations for identifying Dual Eligible Adults at High and Moderate risk levels. Meridian continues to refine its predictive modeling tools to capture members with the most need at the earliest possible time post enrollment or life-altering event. This allows Meridian Care Managers to coordinate care, educate, and advocate in the most impactful manner.

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)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **2%**
Blue Cross Community Health Plan	2.04%	2.03%			2.04%	1.99%	not met	-0.02%	
CountyCare Health Plan	2.15%	2.15%			2.14%	2.14%	met	0.00%	
Aetna (IliniCare Health)	2.03%	2.61%			2.01%	2.08%	met	0.02%	
Meridian Health Plan	2.01%	2.01%			2.37%	2.05%	met	0.02%	
Molina Healthcare	3.61%	3.77%			3.89%	3.86%	met	0.07%	

BCBSIL: The risk model has undergone ongoing improvements to the end-to-end process. New monitoring tools to identify opportunities for calibration of inputs and preliminary results have been created and are being utilized. Through the inclusion of these tools, we expect to improve our performance with the risk stratification requirements.

Meridian: Meridian has and continues to consistently meet expectations for identifying Families and Children populations at High Risk. Meridian continues to refine its predictive modeling tools to capture members with the most need at the earliest possible time post enrollment or life-altering event. This allows Meridian Care Managers to coordinate care, educate, and advocate in the most impactful manner.

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)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **2%**
Blue Cross Community Health Plan	2.10%	2.10%			2.11%	2.15%	met	0.02%	
CountyCare Health Plan	3.33%	3.43%			3.93%	3.96%	met	0.19%	
Aetna (IliniCare Health)	2.24%	2.17%			2.09%	2.16%	met	-0.04%	
Meridian Health Plan	2.00%	2.01%			2.26%	2.00%	met	0.00%	
Molina Healthcare	3.26%	3.22%			3.63%	4.01%	met	0.23%	

Meridian: Meridian continues to meet expectations for identifying, categorizing, and care-managing ACA Adult populations. Meridian recognizes timely and accurate identification of at-risk populations is the first important step towards outreach, assessment, and care planning. Meridian continues to refine its predictive modeling tools to capture members with the most need at the earliest possible time post

enrollment or life-altering event. This allows Meridian Care Managers to coordinate care, educate, and advocate in the most impactful manner.

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	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	16.15%	15.26%			*	*			**Effective 01/01/22**
CountyCare Health Plan	64.05%	64.28%			*	*			
Aetna (IlliniCare Health)	83.36%	82.06%			*	*			60%
Meridian Health Plan	34.84%	57.38%			*	*			
Molina Healthcare	56.75%	42.49%			*	*			

***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 Q2 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	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	39.45%	38.47%			40.03%	42.01%	not met	0.06%	**Effective 01/01/22**
CountyCare Health Plan	53.77%	58.38%			56.06%	56.74%	not met	0.06%	
Aetna (IlliniCare Health)	68.68%	71.80%			57.19%	56.56%	not met	-0.18%	60%
Meridian Health Plan	53.15%	72.46%			80.35%	83.79%	met	0.58%	
Molina Healthcare	83.18%	72.16%			71.80%	70.59%	met	-0.15%	

Aetna Better Health of Illinois: Aetna continues acceleration of efforts in engagement strategies with emphasis including the use of Community Health Workers and expanding onsite resources in its high-volume facilities and provider offices to improve outcomes for Q2 2024. Aetna continues to support care management initiatives with innovative technology such as the Dragon dictation system and Smart Care Recommendations that facilitate efficient communication, documentation, and care coordination. In addition, Aetna is partnering with peer coaches to conduct boots on the ground search-find-engage outreach, to refer members for care management and provider appointments.

BCBSIL: Performance improved from Q1 to Q2 2024 with steady improvements anticipated into Q3. Care Coordination regularly assesses engagement approaches for targeted populations and as such, we have evolved the engagement strategy to tailor our outreach messaging based on member demographics.

CountyCare: CountyCare Health Plan continues to focus care management practices and outreach strategies to engage moderate acuity members utilizing member rewards as an engagement tool. These members are also included in our formal performance improvement plan for call contacts.

Meridian: Meridian met expectations for implementing an IPOC for Moderate Risk populations within 90 Days at the rate of 83.79% for Q2 2024. Meridian continues to improve reporting and tracking tools which have been instrumental in the continued success. Meridian expects this performance to continue into Q3 2024 and beyond.

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	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	79.45%	81.61%			85.17%	82.28%	not met	0.04%	**Effective 01/01/22**
CountyCare Health Plan	82.93%	83.23%			86.17%	86.04%	not met	0.04%	
Aetna (IlliniCare Health)	82.06%	82.00%			80.90%	82.17%	not met	0.00%	90%
Meridian Health Plan	88.97%	89.98%			86.01%	87.75%	not met	-0.01%	
Molina Healthcare	71.49%	69.88%			62.31%	61.89%	not met	-0.13%	

Aetna Better Health of Illinois: Aetna has consistently demonstrated significant improvements, driven by an expanded capacity for outreach and engagement through increased staffing, strategic restructuring, and a greater emphasis on face-to-face interactions. These efforts, combined with enhanced reporting capabilities and comprehensive operational improvements, are ensuring compliance with this and all Waiver metrics. Additionally, Aetna is strengthening its interventions to ensure timely outreach, effectively minimizing delays caused by Care Coordinators.

BCBSIL: Continue to monitor newly eligible service plan completion on a high frequency level. Upon newly eligible notification, members are immediately assigned to a care coordinator. Outreach to members to schedule visit to complete the service plan is expedited through use of phone, letters, and visit to members residence to ensure timely completions. When members request to have the service plan completed later than 15 days, the care coordinator will work with the member for first available date and time.

CountyCare: CountyCare maintained stable performance in Q2. Quarterly trainings and reminders to staff were implemented to help ensure timely and aggressive outreach is conducted to help meet this important 15-day metric and achieve the 90% target.

Meridian: Meridian increased our performance in Q2 by 1.74%, continuing to near the expectation. Meridian continues to implement improvements to strive to meet the required metric. In June 2024, Meridian implemented additional resources on our LTSS support team to complete further investigation and attempts to contact the member and schedule an in-person visit. The health plan continues to utilize

surveillance data to locate alternate contact information, as well as working closely with the state agencies to get in touch with hard-to-reach members. As of Q3 2024, Meridian met the 90% expectation for this metric.

Molina: Molina has seen a decrease in performance on this metric that it attributes to case managers accommodating member requests to schedule their service plan appointments after the 15-day mark. We are re-educating our team that, while we should work to accommodate members as much as possible, we should make efforts to schedule within the 15-day mark.

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	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Trend	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	99.44%	99.94%			99.89%	99.98%	Increasing	0.01%	**TBD**
CountyCare Health Plan	100.00%	100.00%			100.00%	100.00%	No Change	0.00%	
Aetna (IliniCare Health)	100.00%	100.00%			100.00%	100.00%	No Change	0.00%	
Meridian Health Plan	100.00%	100.00%			99.29%	99.50%	Decreasing	-0.01%	
Molina Healthcare	100.00%	100.00%			100.00%	100.00%	No Change	0.00%	

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. The Aetna G&A team is focused on monitoring trends of grievances to identify global issues and drive remediation.

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

Meridian: Meridian maintained steady performance regarding timely resolution of grievances. Over 99% of grievances for Q1 and Q2 2024 were resolved within 90 days. Volumes remain consistent from Q1 to Q2. For Q2, the average turnaround time was 36 days, which is a 3 day decrease from Q1 (39 days).

Meridian was able to achieve this through daily monitoring of inventory and timely responses from business partners. This is significantly below the 90-day contractual turnaround time. For Q2, the grievance rate per 1000 members was 1.55. This is consistent with Q1 rates.

In Q2, Meridian received 26% less grievances for balance billing than in Q1. Due to an enhanced partnership with provider networks, Meridian has found that some providers don't know where or how to bill the plan, so more outreach was being completed to provide support on "how to bill the plan." This is an ongoing effort through 2024.

However, Meridian received an increase in complaints for "driver no-shows" for transportation in Q2 (37%). To ensure that members are picked up for their appointments, Meridian has been conducting a bi-weekly workgroup with various departments to discuss and brainstorm complicated trips and any barriers for the members. There is leadership representation from the vendor, vendor oversite team, member services, case management and grievances. This meeting will continue for the remainder of 2024 in an effort to decrease transportation complaints.

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	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Trend	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	97.96%	97.60%			97.58%	97.82%	No Change	0.00%	**TBD**
CountyCare Health Plan	100.00%	97.76%			95.97%	99.57%	No Change	0.00%	
Aetna (IliniCare Health)	100.00%	99.86%			100.00%	100.00%	No Change	0.00%	
Meridian Health Plan	99.87%	99.76%			99.71%	100.00%	No Change	0.00%	
Molina Healthcare	100.00%	99.73%			100.00%	100.00%	No Change	0.00%	

Aetna Better Health of Illinois: Aetna is fully compliant with required Appeals Turn Around Times (TATs). The Aetna G&A team has implemented optimized tracking processes to ensure timely intake, processing and responses for all appeals.

BCBSIL: BCBS will continue to implement strategies to maintain a steady performance of above 98% to ensure pre and post service appeals are processed within the required timeframe.

Meridian: Meridian increased timeliness in resolving non-expedited appeals in Q2. The improvement in turnaround time is attributed to the frequent refresher trainings that took place during Q1 and the added support from the cross-trainings. Meridian expects to maintain performance into Q3 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.

% of total **Approved** (all services requested were approved)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Trend	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	82.49%	85.90%			85.76%	83.55%	Increasing	0.01%	**TBD**
CountyCare Health Plan	94.50%	93.92%			95.55%	95.22%	Increasing	0.01%	
Aetna (IliniCare Health)	88.08%	89.57%			89.61%	88.46%	No Change	0.00%	
Meridian Health Plan	83.32%	83.42%			77.31%	78.13%	Decreasing	-0.06%	
Molina Healthcare	81.96%	88.12%			89.30%	92.35%	Increasing	0.13%	

Aetna Better Health of Illinois: Aetna continually evaluates prior authorizations (PA) to enhance efficiency and drive industry best practices across Utilization Management (UM) activities, using machine learning and artificial intelligence (AI) principles. Statistical analysis fueled by AI 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.

BCBSIL: BCBS requires prior authorization (PA) for only select services to ensure members are receiving safe, high quality, medically appropriate services. Prior authorization requirements and clinical decision-making outcomes are reviewed on an on-going basis. BCBS continues to grow its technologies and capabilities to ensure a seamless prior authorization process for members and providers to reduce administrative and technical denials.

CountyCare: CountyCare met the compliance metric for Q2 2024. CountyCare has a <1% denial rate due to a lack of medical necessity or insufficient information. CountyCare continues to focus on provider engagement, communication, and review of prior authorization processes and requirements through quarterly Strategic Partnership Reviews with provider groups and outreach from the CountyCare Provider Relations team.

Meridian: Meridian saw a decrease in denials during Q2 as continued partnerships with the Provider Relations team offered providers ongoing education and clarity on the benefit changes following the end of the PHE.

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.

% of total **Approved** (all services requested were approved)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Trend	% change from Q1 2023	Threshold:
Blue Cross Community Health Plan	99.80%	99.78%			99.48%	99.38%	No Change	0.00%	**TBD**
CountyCare Health Plan	97.40%	97.92%			99.48%	98.64%	Increasing	0.01%	
Aetna (IliniCare Health)	96.61%	95.90%			95.92%	96.03%	Decreasing	-0.01%	
Meridian Health Plan	100.00%	97.32%			93.33%	94.44%	Decreasing	-0.06%	
Molina Healthcare	97.49%	93.78%			88.97%	92.83%	Decreasing	-0.05%	

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

BCBSIL: No change for BCCHP BH Approval rates quarter over quarter in 2024.

CountyCare: CountyCare met the compliance metric for Q2 2024. CountyCare has a <1% denial rate due to a lack of medical necessity or insufficient information. CountyCare continues to focus on provider engagement, communication, and review of prior authorization processes and requirements through quarterly Strategic Partnership Reviews with provider groups and outreach from the CountyCare Provider Relations team.

Meridian: Meridian saw a decrease in denials during Q2 as continued partnerships with the Provider Relations team offered providers ongoing education and clarity on the benefit changes following the end of the PHE.

Molina: Higher denial rates for 2024 are driven by authorization requests from non-CPL and non-Medicaid-certified providers, who cannot be authorized. We review trends in these non-certified provider requests to encourage providers to become Medicaid-certified, and we support members in finding alternative care that is covered.

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									
# of disputes **(per 1,000 Member Months)**	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Trend	% change from Q1 2023	Threshold: **TBD**
Blue Cross Community Health Plan	0.09	0.06			0.06	0.03	Decreasing	-0.65%	
CountyCare Health Plan	0.08	0.04			0.06	0.06	Decreasing	-0.18%	
Aetna (IliniCare Health)	0.17	0.14			0.15	0.16	Decreasing	-0.11%	
Meridian Health Plan	0.13	0.08			0.10	0.07	Decreasing	-0.44%	
Molina Healthcare	0.09	0.08			0.14	0.12	Increasing	0.32%	

Aetna Better Health of Illinois: Aetna's HCI disputes per thousand member months have decreased quarter over quarter since Q4 2023 dropping from .12 to .08 in Q2 2024. Overall dispute volume is similarly down 28% Year over Year 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/is working on system automation to expedite resolution of key volume drivers including Share of Cost reconciliation and authorization disputes which should help reduce the number of provider disputes.

CountyCare: For Q2 2024 CountyCare saw a slight decrease in number of provider complaints per 1,000 members. CountyCare continually analyzes all claim denials and proactively addresses any adjudication issues identified, without action from providers. To improve communication and eliminate the need for providers to file a dispute, an issues tracking log is posted to the CountyCare website with the status of all known global issues. We continue to leverage our provider relations team and work directly with providers to avoid issue escalation to the HFS portal level. Through proactive provider communication and addressing known issues for all impacted claims, CountyCare expects to continue compliance with this metric.

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.

% of calls answered in 30 seconds or less (combined Provider and Enrollee calls)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **80%** in 30 seconds or less
Blue Cross Community Health Plan	96.53%	94.99%			96.68%	96.92%	met	0.00%	
CountyCare Health Plan	79.98%	92.43%			86.02%	74.34%	not met	-0.07%	
Aetna (IliniCare Health)	95.77%	90.74%			89.25%	89.26%	met	-0.07%	
Meridian Health Plan	88.12%	92.76%			95.89%	95.92%	met	0.09%	
Molina Healthcare	85.67%	92.24%			91.09%	94.81%	met	0.11%	

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.

CountyCare: CountyCare saw a decrease in this metric due to higher than usual call volumes as well as an increase in staff attrition. To improve this metric, CountyCare is actively onboarding new staff, including increasing bilingual staff to improve member experience and reduce calls that are transferred to a language line, as this increases call times. Additionally, CountyCare has instituted a call center representative retention strategy and provides incentives to retain staff.

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.

% of calls abandoned (combined Provider and Enrollee calls)	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	met/ not met	% change from Q1 2023	Threshold: **5%** or less
Blue Cross Community Health Plan	0.88%	0.89%			0.69%	0.62%	met	-0.30%	
CountyCare Health Plan	3.17%	0.66%			1.60%	3.50%	met	0.10%	
Aetna (IliniCare Health)	0.53%	1.20%			1.21%	1.37%	met	1.57%	
Meridian Health Plan	1.56%	1.77%			1.20%	1.28%	met	-0.18%	
Molina Healthcare	1.48%	0.60%			0.50%	0.52%	met	-0.65%	

Aetna Better Health of Illinois: Aetna has maintained abandonment rates in full compliance with threshold. 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.

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.