Q1 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 Q1 2024 metrics.

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.

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 12/7/2021-The metric now only looks at screening status as of 2 months after enrollment.**	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	72.72%	64.26%	69.50%	60.93%			*		N/A	**70%**
CountyCare Health Plan	48.46%	41.50%	53.31%	60.99%			*		N/A	
Aetna (IlliniCare Health)	43.74%	48.36%	51.15%	52.99%			*		N/A	
Meridian Health Plan	55.56%	47.03%	55.48%	60.58%			*		N/A	
Molina Healthcare	48.32%	44.39%	52.39%	65.14%			*		N/A	

*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 Q1 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.

% of Enrollees (Seniors or Person with Disabilities) identified as Moderate (level 2) or High Risk (level 3)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	20.42%	20.29%	20.39%	20.39%			20.70%	met	1%	**20%**
CountyCare Health Plan	23.98%	24.43%	25.76%	26.56%			27.22%	met	14%	
Aetna (IlliniCare Health)	28.38%	29.73%	30.62%	30.96%			27.75%	met	-2%	
Meridian Health Plan	20.03%	20.01%	20.01%	20.03%			20.15%	met	1%	
Molina Healthcare	20.94%	27.39%	24.17%	24.45%			25.58%	met	22%	

% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	5.13%	5.06%	5.15%	5.07%			4.96%	not met	-3%	**5%**
CountyCare Health Plan	11.33%	11.26%	11.65%	11.99%			12.94%	met	14%	
Aetna (IlliniCare Health)	5.76%	5.95%	6.06%	6.30%			6.39%	met	11%	
Meridian Health Plan	5.02%	5.00%	5.00%	5.02%			5.10%	met	2%	
Molina Healthcare	9.46%	9.55%	8.05%	8.27%			8.24%	met	-13%	

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.

BCBSIL: Enhancements to the risk model include isolated Social and Structural Determinants of Health (SDOH) risk identification. Rebalancing of the model based on updates impacted the overall percentage totals. Post implementation, BCBSIL is trending within the performance threshold of 5%.

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)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	90.80%	90.26%	90.47%	91.47%			90.81%	met	0%	**90%**
CountyCare Health Plan	96.06%	95.80%	97.06%	97.43%			96.63%	met	1%	
Aetna (IlliniCare Health)	99.05%	99.43%	98.59%	97.82%			98.38%	met	-1%	
Meridian Health Plan	90.02%	90.02%	90.03%	90.02%			90.04%	met	0%	
Molina Healthcare	91.18%	95.00%	93.11%	94.15%			94.81%	met	4%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	20.33%	19.94%	20.23%	20.45%			20.63%	met	1%	**20%**
CountyCare Health Plan	17.62%	20.69%	26.28%	26.60%			24.06%	met	37%	
Aetna (IlliniCare Health)	21.21%	21.61%	21.00%	20.43%			20.88%	met	-2%	
Meridian Health Plan	20.01%	20.01%	20.01%	20.01%			20.02%	met	0%	
Molina Healthcare	19.03%	18.82%	18.27%	22.76%			20.13%	met	6%	

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.

Molina: Molina exceeded thresholds for overall MLTSS members stratified as Level 2 or Level 3, and it provides case management to all MLTSS members. The balance of Level 3 and Level 2 members in Q3 skewed slightly towards Level 2. Molina case managers completed a full review of their membership on an individual basis in 2023 to identify members that could appropriately be placed at Level 3, and Molina MLTSS thresholds are met as of Q2 2023. Molina continues to meet risk stratification thresholds in Q1 2024; as Molina continued to refine MLTSS stratification levels, Q1 2024 was closer to the 20%

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 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	2.05%	2.04%	2.04%	2.03%			2.04%	met	0%	**2%**
CountyCare Health Plan	2.54%	2.24%	2.15%	2.15%			2.14%	met	-16%	
Aetna (IlliniCare Health)	2.01%	2.00%	2.03%	2.61%			2.01%	met	0%	
Meridian Health Plan	2.01%	2.00%	2.01%	2.01%			2.37%	met	18%	
Molina Healthcare	1.73%	3.60%	3.61%	3.77%			3.89%	met	125%	

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.

County Care: CountyCare performed a one-time auto-stratification using predictive modeling at the end of 2022, which led to an increase in high acuity numbers across all populations, including FHP. Following this, the care management team carried out a clinical audit and member-level outreach for those newly identified as high acuity. After undergoing a new health risk screening, a significant portion of FHP members were reassigned to a lower acuity level. Despite this adjustment, FHP continues to meet the risk

acuity requirements for this metric. Additionally, we conduct extra health risk screenings for all members identified as pregnant.

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 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	2.12%	2.11%	2.10%	2.10%			2.11%	met	0%	**2%**
CountyCare Health Plan	3.12%	3.16%	3.33%	3.43%			3.93%	met	26%	
Aetna (IlliniCare Health)	2.01%	2.01%	2.24%	2.17%			2.09%	met	4%	
Meridian Health Plan	2.00%	2.00%	2.00%	2.01%			2.26%	met	13%	
Molina Healthcare	2.51%	3.80%	3.26%	3.22%			3.63%	met	45%	

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.

CountyCare: Due to our efforts to enhance HRS engagement, which includes texting in multiple languages, we have seen an overall increase in this population. Additionally, their needs tend to be immediate but short-term or related to chronic conditions. These factors resulted in a genuine increase in the acuity level of this population in Q1 2024.

Molina: Molina continues to exceed risk stratification requirements but is reviewing its methodology to ensure focus on the most impactable members.

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.

% **high risk** Enrollees with an IPoC completed **within 90 days** after being identified as high risk ***New threshold as of 1/1/2022.**	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	27.12%	13.90%	16.15%	15.26%			*		N/A	**60%**
CountyCare Health Plan	23.57%	26.59%	64.05%	64.28%			*		N/A	
Aetna (IlliniCare Health)	74.47%	82.53%	83.36%	82.06%			*		N/A	
Meridian Health Plan	28.17%	30.46%	34.84%	57.38%			*		N/A	
Molina Healthcare	62.25%	22.09%	56.75%	42.49%			*		N/A	

*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 Q1 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 *New threshold as of 1/1/2022.	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	60.91%	42.26%	39.45%	38.47%			40.03%	not met	-34%	**60%**
CountyCare Health Plan	50.50%	49.10%	53.77%	58.38%			56.06%	not met	11%	
Aetna (IlliniCare Health)	55.92%	66.93%	68.68%	71.80%			57.19%	not met	2%	
Meridian Health Plan	34.08%	41.76%	53.15%	72.46%			80.35%	met	136%	
Molina Healthcare	75.70%	56.55%	83.18%	72.16%			71.80%	met	-5%	

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.

BCBSIL: BCBSIL is focused on improving overall care plan completions for newly moderate-risk members. Through analysis of the largest impact areas of opportunity, based on population demographics, refocused outreach efforts are underway in alignment with its enhanced risk model to improve outcomes for Q2 2024. BCBSIL includes all members in the denominator, including members who have refused and members who have not been reached despite contact attempts.

CountyCare: CountyCare implemented interventions to increase this metric. Recent analysis shows the last 2 months of Q2 2024 at the 60% threshold.

Meridian: Meridian is currently meeting expectations for implementing an IPOC for Moderate Risk populations within 90 Days at the rate of 80.35% for Q1 2024. Improved reporting and tracking tools have been instrumental. Meridian expects to continue into Q2 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.

% 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 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	83.80%	73.02%	79.45%	81.61%			85.17%	not met	2%	**90%**
CountyCare Health Plan	78.26%	81.75%	82.93%	83.23%			86.17%	not met	10%	
Aetna (IlliniCare Health)	60.98%	72.14%	82.06%	82.00%			80.90%	not met	33%	
Meridian Health Plan	86.11%	88.00%	88.97%	89.98%			86.01%	not met	0%	
Molina Healthcare	68.44%	71.21%	71.49%	69.88%			62.31%	not met	-9%	

Aetna Better Health of Illinois: Aetna continues to demonstrate material improvements due to increased capacity for outreach and engagement via expanded staffing, restructuring, and face-to-face contact; enhanced reporting capabilities; and overall end-to-end operational improvements to ensure compliance with this metric and all Waiver metrics.

BCBSIL: BCBSIL has been performing above the stated industry average of 80% since Q2 2023 and continues to push towards the 90% performance threshold. Through ongoing data analysis, we have implemented a face-to-face attempt or door knock within a 15-day period to engage members who are unable to reach. We also restructured our team to have dedicated resources who outreach and engage newly eligible members. BCBSIL continues to reinforce and provide refresher trainings with our teams related to the importance of outreach and timely engagement to ensure appropriate service delivery to our members.

CountyCare: CountyCare has continued to make steady improvements on this important 15-day metric. It monitors the activity, data, and workflows tied to this metric very closely to help get the plan to the 90% threshold. CountyCare has continued to make steady improvements on this important 15-day metric. The observed improvement is attributed to several strategies including: continuous monitoring of activity, data and workflows designed to ensure timely outreach and successful face-to-face contacts; the development and refinement of automated care management processes; and an increased emphasis on leveraging formal/informal member support networks to address key barriers to meeting the 90% threshold.

Meridian: At 86.0% for Q1 2024 Meridian was just short of expectations. Meridian has implemented improvements in reporting to capture outliers in a timelier manner and expects to improve in Q2 2024. Meridian enhanced reporting to refresh daily for added oversight and monitoring of due dates and completions. In addition, improvements in reporting include pulling in additional address and phone number information received, such as from the ADT feeds, to assist our case managers in contacting hard to reach members within the 15-day timeframe. The plan continues to collaborate with the state agency to get in touch with members who are unreachable to the plan during the 15-day timeframe as well.

Molina: Molina has improved the success rate for 15-day service plans for HCBS members since 2021 and saw higher performance throughout 2023. Molina continues to push for higher performance in this area in 2024. Molina notes the majority of rate decrease is due to unable to reach member referrals. Molina notes this trend has increased since last year in order to improve contact and engagement we have been confirming contact information from referral agency and/or non-waiver CM. We have also enhanced our communication efforts by including text/email as able/available.

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 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Trend	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	99.42%	99.51%	99.44%	99.94%			99.89%	Increasing	0.5%	**Monitor**
CountyCare Health Plan	100.00%	99.91%	100.00%	100.00%			100.00%	No Change	0.0%	
Aetna (IlliniCare Health)	100.00%	100.00%	100.00%	100.00%			100.00%	No Change	0.0%	
Meridian Health Plan	100.00%	99.85%	100.00%	100.00%			99.29%	Decreasing	-0.7%	
Molina Healthcare	100.00%	100.00%	100.00%	100.00%			100.00%	No Change	0.0%	

Aetna Better Health of Illinois: Aetna is fully compliant with required Grievance Turn Around Times (TATs) through a robust end-to-end intake, review, and resolution process.

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

Meridian: Meridian saw a slight decrease (-0.7%) regarding timely resolution of grievances however throughout Q1, positive steps have been made to close the small gap and attain 100% timeliness. Through daily monitoring of inventory, as well as 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. For Q1, the average turnaround time was 39 days. This is significantly below the 90-day contractual turnaround time. Overall, the volume of grievances per 1,000 enrollees remains comparatively low, indicating a positive enrollee experience with Meridian.

Some of Meridian's successes have included decreasing balance billing complaints 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 is now being completed to provide support on "how to bill the plan." This is an ongoing effort into Q2 2024; however, between Q4 2023 and Q1 2024, there was a 28% decrease in the number of complaints against par providers. We attribute this decrease to sending "cease" letters where providers refused to stop billing the members while also engaging the provider networking team when the participating providers are not adhering to their contracts. To further support better ongoing outcomes for our members, Meridian has increased the number of internal audits to ensure that the grievances are being handled appropriately and all requirements are being followed. This is an ongoing initiative. In Q1 2024 the Meridian grievances team also partnered with its internal systems team and the enrollment team when it was identified that the member's preference for PCP wasn't updating in the system correctly. A deep dive was completed as to why there were errors with PCP assignments. Through this partnership, Meridian was able to resolve the issue with the PCP updates and overcome this obstacle for the members. Meridian's grievance department continues to work closely with the case management team to decrease care gaps for the members and increase assignments to a Care Manager. The team is inviting more members to Care Management versus the members waiting for referrals for Care Managers. All the above initiatives continue into Q2 2024.

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 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Trend	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	98.57%	99.20%	97.96%	97.60%			97.58%	Decreasing	-1.0%	**Monitor**
CountyCare Health Plan	100.00%	99.38%	100.00%	97.76%			95.97%	Decreasing	-4.0%	
Aetna (IlliniCare Health)	99.67%	100.00%	100.00%	99.86%			100.00%	Increasing	0.3%	
Meridian Health Plan	99.85%	100.00%	99.87%	99.76%			99.71%	Decreasing	-0.1%	
Molina Healthcare	100.00%	100.00%	100.00%	99.73%			100.00%	No Change	0.0%	

Aetna Better Health of Illinois: Aetna is fully compliant with required Appeals Turn Around Times (TATs) through a robust end-to-end intake, review, and resolution process.

Meridian: Meridian saw a slight decrease in timeliness (-0.05%) from the last time this metric was reported. The decrease is attributed to onboarding new staff as well as an increase in the number of appeals received. Leadership initiated frequent refresher trainings and daily discussion huddles to assist with sharing best practices for navigating systems, processing appeals and working with supporting vendors. Cross-training was provided to more experienced supporting staff to address gaps within staffing. Root cause analysis was performed by leadership to identify and address contributing factors into the few appeals that missed the 15-day window for resolution. All initiatives have continued into Q2 in support of ongoing efforts to increase timeliness.

CountyCare: The decrease observed in Q1 2024 was due to a single member appeal that exceeded the 15-day window because of a one-time human error. This issue has been resolved through coaching and reinforced staffing coverage. CountyCare will continue to monitor and address appeals promptly.

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 Management										
% of total **Approved** (all services requested were approved)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Trend	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	85.60%	83.20%	82.49%	85.90%			85.76%	Increasing	0.2%	**Monitor**
CountyCare Health Plan	93.87%	94.15%	94.50%	93.92%			95.55%	Increasing	1.8%	
Aetna (IlliniCare Health)	80.34%	79.45%	88.08%	89.57%			89.61%	Increasing	11.5%	
Meridian Health Plan	85.82%	85.61%	83.32%	83.42%			77.31%	Decreasing	-9.9%	
Molina Healthcare	88.46%	80.67%	81.96%	88.12%			89.30%	Increasing	1.0%	

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, resulting in an auto approval rate in Q1 2024 of 40%. Aetna continues its quarterly review of PA services, refining the list of services requiring PA; currently, 25% of all pre-service procedures on the HFS fee schedule require 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 ongoing 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 is evaluating prior authorization requests based on medical necessity using its clinical criteria guidelines or clinical policies. CountyCare has a <1% denial rate due to a lack of medical necessity or insufficient information. CountyCare works with provider relations to assist in engaging providers to include all necessary information with the initial request.

Meridian: Meridian saw an increase in denials during Q1 due to the ending of adjusted services (e.g. home health) that may have been previously authorized through the end of 2023. Beginning 2024 those services received a full review, resulting in increased denials. Meridian also observed an increase in incomplete information submitted. The Meridian "request for information" rate was 3.45%, and this yielded a "return of information" rate of 31.20%. Meridian is committed to ensuring that its members receive the appropriate care, at the right level, and at the right time. To achieve this, Meridian will partner with its provider relations team to update providers on the impact of 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.

Prior Authorization (Behavioral Health Only)										
% of total **Approved** (all services requested were approved)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Trend	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	99.56%	99.67%	99.80%	99.78%			99.48%	Decreasing	-0.1%	**Monitor**
CountyCare Health Plan	95.11%	96.64%	97.40%	97.92%			99.48%	Increasing	4.6%	
Aetna (IlliniCare Health)	94.35%	95.47%	96.61%	95.90%			95.92%	Increasing	1.7%	
Meridian Health Plan	100.00%	98.31%	100.00%	97.32%			93.33%	Decreasing	-6.7%	
Molina Healthcare	93.87%	98.51%	97.49%	93.78%			88.97%	Decreasing	-5.2%	

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: 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 ongoing 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 is currently evaluating prior authorization requests based on medical necessity using its clinical criteria guidelines or clinical policies. CountyCare has a <1% denial rate due to lack of medical necessity or insufficient information. CountyCare works with provider relations to assist in engaging providers to include all necessary information with the initial request. CountyCare has monthly meetings with its high-utilizing providers to educate them on what is required to reduce errors/denial rates.

Meridian: The Behavioral Health UM team receives a low number of prior authorization requests in Q1, so the denominator is relatively low for the Q1 2024 reporting. There are very few authorizations for which the BH UM team issued a full denial, but for those that were fully denied, the majority did not meet medical necessity criteria. In Q1 2024, Meridian did a re-training with its OP UM staff on the InterQual

medical necessity criteria for the IOP level of care and began staffing more cases with its BH Medical Directors when IOP authorizations reached a long length of stay threshold. These efforts resulted in more cases being pended to BH Medical Directors for advisor review and resulted in more medical necessity criteria denials.

Molina: Molina continues to support prior authorization reviews based on medical necessity and review of Medicaid-covered benefits and providers. In the first part of 2024, Molina reported a decrease in BH approvals, a change attributable to a subset of reviews that were originally not approved but later were moved to approved status. Accounting for those approvals moves the approval rate over 93%. These denials are due primarily to non-covered benefits and not-Medicaid-certified providers. Only 4 BH authorizations were denied in Q2 2024 due to medical necessity not being met.

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.

# of disputes **(per 1,000 Member Months)**	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Trend	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	0.09	0.09	0.09	0.06			0.06	Decreasing	-36%	**Monitor**
CountyCare Health Plan	0.06	0.03	0.08	0.04			0.06	Increasing	9%	
Aetna (IlliniCare Health)	0.13	0.12	0.17	0.14			0.15	Increasing	17%	
Meridian Health Plan	0.24	0.20	0.13	0.08			0.10	Decreasing	-59%	
Molina Healthcare	0.06	0.06	0.09	0.08			0.14	Increasing	122%	

Aetna Better Health of Illinois: Aetna's disputes per thousand member months have increased for Q1 2024 due to a material reduction in membership resulting from redetermination reinstatement following the end of the Public Health Emergency in 2023. Overall dispute volume is down over 20% 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: CountyCare has consistently remained the MCO with the lowest 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. CountyCare also meets regularly with provider groups to address any potential issues before escalation to the state complaint portal occurs. Through proactive provider communication and addressing known issues for all impacted claims, CountyCare expects to maintain complaint numbers well below the industry average.

Molina: Molina experienced a decrease in overall membership during 2023 which led to an increase in the received provider dispute rate for Q1 2024. Molina continues to support its providers by assigning dedicated Provider Relations Managers who conduct regular and recurring billing/JOC meetings, town halls, webinars, etc., to assist providers within the network. Molina also offers additional means of resolution to its providers via the Availity Essentials Provider Portal and its standard Appeals and Grievances process.

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)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	96.73%	96.44%	96.53%	94.99%			96.68%	met	0%	80% in 30 seconds or less
CountyCare Health Plan	83.95%	82.26%	79.98%	92.43%			86.02%	met	2%	
Aetna (IlliniCare Health)	93.93%	94.43%	95.77%	90.74%			89.25%	met	-5%	
Meridian Health Plan	83.36%	90.33%	88.12%	92.76%			95.89%	met	15%	
Molina Healthcare	81.39%	70.46%	85.67%	92.24%			91.09%	met	12%	

CountyCare: CountyCare saw a slight decrease in Q1 2024. Moving into Q2 2024, CountyCare is currently trending closer to the industry standard of 92%. This is due to increasing bilingual CSRs and implementing a strong retention strategy.

Meridian: The Meridian Member and Provider Services team is proud to report an 82% retention rate of staff supporting the Medicaid line of business throughout Q1 2024. Staff retention has been a driving force behind ensuring Meridian has the needed resources to service its members and providers.

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)	Q3 2022	Q4 2022	Q1 2023	Q2 2023	Q3 2023	Q4 2023	Q1 2024	met/not met	% change from Q3 2022	Threshold:
Blue Cross Community Health Plan	1.38%	0.81%	0.88%	0.89%			0.69%	met	-50%	5% or less
CountyCare Health Plan	1.80%	2.91%	3.17%	0.66%			1.60%	met	-11%	
Aetna (IlliniCare Health)	1.09%	0.58%	0.53%	1.20%			1.21%	met	11%	
Meridian Health Plan	2.67%	1.38%	1.56%	1.77%			1.20%	met	-55%	
Molina Healthcare	2.07%	6.01%	1.48%	0.60%			0.50%	met	-76%	

Aetna Better Health of Illinois: Aetna monitors call service levels on an hourly basis to ensure full compliance.

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.