Q3 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 Assessments. HFS has a target threshold of 70% of new enrollees having a health risk assessment or 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**	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	Threshold: **70%**
Blue Cross Community Health Plan	60.93%			*	*	*		
CountyCare Health Plan	60.99%			*	*	*		
Aetna	52.99%			*	*	*		
Meridian Health Plan	60.58%			*	*	*		
Molina Healthcare	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 be 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)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	change from Q2 2023	Threshold: 20%
Blue Cross Community Health Plan	20.39%			20.70%	21.70%	20.62%	met	0.01%	
CountyCare Health Plan	26.56%			27.22%	27.20%	26.56%	met	0.00%	
Aetna	30.96%			27.75%	27.86%	28.15%	met	-0.09%	
Meridian Health Plan	20.03%			20.15%	20.01%	20.00%	met	0.00%	
Molina Healthcare	24.45%			25.58%	26.22%	25.14%	met	0.03%	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	change from Q2 2023	Threshold: 5%
Blue Cross Community Health Plan	5.07%			4.96%	5.02%	5.06%	met	0.00%	
CountyCare Health Plan	11.99%			12.94%	13.14%	12.63%	met	0.05%	
Aetna	6.30%			6.39%	6.59%	6.45%	met	0.02%	
Meridian Health Plan	5.02%			5.10%	5.01%	5.00%	met	0.00%	
Molina Healthcare	8.27%			8.24%	7.88%	7.84%	met	-0.05%	

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 continually reviews and monitors our policies and procedures to ensure timely and effective outreach, engagement, and enrollment of members identified as high or moderate risk into Care Management programs. For Q3 2024, Meridian enhanced our Diabetes and Congestive Heart Failure programs, including more targeted data mining. Our risk stratification model enables the identification and enrollment of members with the most care needs, gaps in care, and opportunities for impact. For Q3 2024, Meridian met the target for Seniors or People with Disabilities population.

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 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 or moderate risk, they are enrolled in specific care coordination programs.

% of Enrollees (Dual Eligible Adults) identified as Moderate (level 2) or High Risk (level 3)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **90%**
Blue Cross Community Health Plan	91.47%			90.81%	89.79%	90.26%	met	-0.01%	
CountyCare Health Plan	97.43%			96.63%	96.35%	96.38%	met	-0.01%	
Aetna	97.82%			98.38%	99.10%	98.95%	met	0.01%	
Meridian Health Plan	90.02%			90.04%	90.04%	90.03%	met	0.00%	
Molina Healthcare	94.15%			94.81%	94.35%	94.33%	met	0.00%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **20%**
Blue Cross Community Health Plan	20.45%			20.63%	19.99%	20.14%	met	-0.02%	
CountyCare Health Plan	26.60%			24.06%	23.90%	23.95%	met	-0.10%	
Aetna	20.43%			20.88%	21.45%	22.73%	met	0.11%	
Meridian Health Plan	20.01%			20.02%	20.02%	20.02%	met	0.00%	
Molina Healthcare	22.76%			20.13%	17.47%	22.40%	met	-0.02%	

Meridian: In Q3 2024, Meridian underwent the Health Services Advisory Group's audit, which confirmed Meridian's member mining, identification, and stratification of the Dual Eligible Adults population, as appropriate and effective. For Q3 2024, Meridian met expectations for Dual Eligible Adults. Our risk stratification model is designed to identify members who are most in need of care coordination to address all health-related needs.

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.

% of Enrollees (Families and Children) identified as High Risk (level 3)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **2%**
Blue Cross Community Health Plan	2.03%			2.04%	1.99%	2.08%	met	0.02%	
CountyCare Health Plan	2.15%			2.14%	2.14%	1.80%	not met	-0.16%	
Aetna	2.61%			2.01%	2.08%	2.39%	met	-0.08%	
Meridian Health Plan	2.01%			2.37%	2.05%	2.04%	met	0.01%	
Molina Healthcare	3.77%			3.89%	3.86%	3.24%	met	-0.14%	

Meridian: Meridian's risk stratification demonstrates approximately 48% of engaged members in care management are in Disproportionally Impacted Areas, which are areas where member care is needed most and being identified. For Q3 2024, Meridian met expectations for the Families and Children population. As mentioned previously, our current risk stratification model is designed to identify the highest-risk members who have multiple care gaps, high clinical acuity, social needs, and who could benefit from care coordination.

<u>CountyCare Health Plan:</u> CountyCare identifies high-acuity families and children through screening tools, surveillance data, and predictive analytics. CountyCare experienced an influx of immigrant children within this population which contributed to a downward trend in its high-risk stratification in quarter 3. However, CountyCare will be identifying and executing on additional opportunities for engagement, leveraging our rewards program to incentivize participation in health risk screenings.

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.

% of Enrollees (ACA Adult) identified as High Risk (level 3)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **2%**
Blue Cross Community Health Plan	2.10%			2.11%	2.15%	2.13%	met	0.01%	
CountyCare Health Plan	3.43%			3.93%	3.96%	3.67%	met	0.07%	
Aetna	2.17%			2.09%	2.16%	2.16%	met	0.00%	
Meridian Health Plan	2.01%			2.26%	2.00%	2.00%	met	0.00%	
Molina Healthcare	3.22%			3.63%	4.01%	3.61%	met	0.12%	

<u>Meridian:</u> For Q3 2024, Meridian continues to meet expectations for the ACA Adult population. Our risk stratification model identifies individuals with the most health-related needs. Our results demonstrate positive member engagement rates, demonstrating we are targeting the appropriate populations.

Care Plan Assessment & Individual Plan of Care High Risk:

HFS requires that high-risk enrollees have an individual plan of care completed. Health plans report on the percentage of individual care plans completed within 90 days. Care plans are created with the member's 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	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	15.26%			*	*	*			**Effective 01/01/22**
CountyCare Health Plan	64.28%			*	*	*			
Aetna	82.06%			*	*	*			60%
Meridian Health Plan	57.38%			*	*	*			
Molina Healthcare	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	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	38.47%			40.03%	42.01%	50.77%	not met	0.32%	**Effective 01/01/22**
CountyCare Health Plan	58.38%			56.06%	56.74%	59.33%	not met	0.02%	
Aetna	71.80%			57.19%	56.56%	53.26%	not met	-0.26%	60%
Meridian Health Plan	72.46%			80.35%	83.79%	81.57%	met	0.13%	
Molina Healthcare	72.16%			71.80%	70.59%	70.03%	met	-0.03%	

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 Q3 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. Further refinement of the measurement methodology indicated that actual performance is above the industry average. Aetna will work with HFS to properly update past performance reporting.

BCBSIL: Performance saw significant improvement from Q2 to Q3 2024 with continued anticipated improvement in Q4. Care Coordination is maintaining consistent engagement approaches with high-intensity oversight to ensure improved outcomes.

CountyCare Health Plan: CountyCare has established a performance improvement program to improve this metric. Quarter over quarter, CountyCare is seeing an upward trend of ~3% (from 56% to 59%) and is anticipating ongoing improvement attributed to a targeted community outreach campaign for members that have been traditionally hard to reach via telephonic methods. The goal of this campaign is to engage members who have been deemed high acuity but are reluctant to actively participate in care planning.

Meridian: For Q3 2024, Meridian continued to diligently execute best practices to ensure timely and impactful Individualized Plan of Care (IPOC) completion. Prompt and aggressive IPOC implementation that includes member input and approval results in the best possible outcomes and care gap closure for members. As a result, for Q3 2024, as in previous quarters, Meridian has consistently exceeded expectations.

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	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	81.61%			85.17%	82.28%	82.41%	not met	0.01%	**Effective 01/01/22**
CountyCare Health Plan	83.23%			86.17%	86.04%	84.02%	not met	0.01%	
Aetna	82.00%			80.90%	82.17%	78.93%	not met	-0.04%	90%
Meridian Health Plan	89.98%			86.01%	87.75%	90.23%	met	0.00%	
Molina Healthcare	69.88%			62.31%	61.89%	60.80%	not met	-0.13%	

Aetna Better Health of Illinois: Aetna is working toward improvement but continues to see member-driven delays as a primary barrier in this measure, impacting successful timely onboarding. Efforts continue prioritizing timely Care Coordinator outreach and assignment using dashboards and enhanced reporting. In September 2024, Aetna launched a lag reporting tool that allows retrospective insights to identify patterns and areas of opportunity, which has proven to be instrumental in efforts to address timeliness.

BCBSIL: Performance remained consistent from Q2 to Q3 2024, with anticipated improvement for Q4. In Q4, Care Coordination was provided a refresher training ensuring that service plan activities have been completed timely and/or valid justification for any service plans completed after 15 days.

CountyCare Health Plan: CountyCare continues to perform above the stated 80% industry average for service plan completion within 15 days of the notification date. When reviewing this metric for the closed swim lane, our performance is above the 90% target, however, the health plan is shy of this goal due to timeliness. CountyCare trains care coordination teams quarterly on the newly waiver-eligible member requirements and expectations. We are further refining our data and reporting processes, ensuring we are capturing and reporting all successful activity that will support compliance with this metric, expected in Q1 2025.

Meridian: For Q3 2024, 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 Q3 2024, as in previous quarters, Meridian consistently exceeded expectations.

Molina: Members are opting out of the 15-day visit. CMs educated to encourage timely visits will be staff level goal for 2025.

Grievance and Appeals:

Resolution of Grievances:

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

% of Grievances **resolved** in less than or equal to 90 days	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Trend	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	99.94%			99.89%	99.98%	100.00%	Increasing	0.00%	**TBD**
CountyCare Health Plan	100.00%			100.00%	100.00%	100.00%	No Change	0.00%	
Aetna	100.00%			100.00%	100.00%	100.00%	No Change	0.00%	
Meridian Health Plan	100.00%			99.29%	99.50%	100.00%	Increasing	0.00%	
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. Aetna tracks and trends all grievance data to identify global issues and drive remediation.

BCBSIL: Our timeliness in grievance resolution has remained stable and consistent from quarter to quarter.

Meridian: Meridian continues to maintain exemplary performance regarding timely resolution of grievances. 100% of grievances for Q3 2024 were resolved within 90 days. Meridian was able to achieve this through daily monitoring of inventory and timely responses from business partners.
In Q3 2024, Meridian received 18% fewer grievances regarding transportation overall. Meridian continues to work closely with the transportation vendor and the vendor managers to reduce the number of complaints received from the members. We continue 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	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Trend	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	97.60%			97.58%	97.82%	98.90%	Increasing	0.01%	**TBD**
CountyCare Health Plan	97.76%			95.97%	99.57%	100.00%	Increasing	0.02%	
Aetna	99.86%			100.00%	100.00%	100.00%	No change	0.00%	
Meridian Health Plan	99.76%			99.71%	100.00%	100.00%	No change	0.00%	
Molina Healthcare	99.73%			100.00%	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 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.

BCBSIL: Industry-wide, most appeals are resolved within this period.

Meridian: Meridian continued to resolve non-expedited appeals at 100% timely in Q3. Our consistent performance is attributed to ongoing, frequent refresher training sessions and added support from team cross-training. Meridian expects to maintain performance into Q4 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)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Trend	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	85.90%			85.76%	83.55%	83.94%	Increasing	-0.02%	**TBD**
CountyCare Health Plan	93.92%			95.55%	95.22%	93.90%	Decreasing	0.00%	
Aetna	89.57%			89.61%	88.46%	89.69%	Increasing	0.00%	
Meridian Health Plan	83.42%			77.31%	78.13%	77.52%	Decreasing	-0.07%	
Molina Healthcare	88.12%			89.30%	92.35%	92.48%	Increasing	0.05%	

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.

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.

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 decline in approval rates along with corresponding decreases in denial rates during Q3 indicating that there were more 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)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Trend	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	99.78%			99.48%	99.38%	99.61%	Increasing	0.00%	**TBD**
CountyCare Health Plan	97.92%			99.48%	98.64%	99.04%	Increasing	0.01%	
Aetna	95.90%			95.92%	96.03%	94.91%	Decreasing	-0.01%	
Meridian Health Plan	97.32%			93.33%	94.44%	91.67%	Decreasing	-0.06%	
Molina Healthcare	93.78%			88.97%	92.83%	97.20%	Increasing	0.04%	

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

BCBSIL: Health plans are required to report on the percentage of prior authorizations that are approved for Behavioral Health Services. The industry average for approved services for Q3 2024 is 96%. BCCHP is above the average.

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 for 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)**	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	Trend	% change from Q2 2023	Threshold:
Blue Cross Community Health Plan	0.06			0.06	0.03	0.04	Increasing	-0.43%	**TBD**
CountyCare Health Plan	0.04			0.06	0.06	0.05	Decreasing	0.32%	
Aetna	0.14			0.15	0.16	0.14	Decreasing	-0.02%	
Meridian Health Plan	0.08			0.10	0.07	0.08	Increasing	0.04%	
Molina Healthcare	0.08			0.14	0.12	0.11	Decreasing	0.39%	

Aetna Better Health of Illinois: Aetna's HealthChoice Illinois disputes per thousand member months have remained consistent from Q2 2024 to Q3 2024 at .08. 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 in masse. Aetna has deployed system automation 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.

BCBSIL: In Q4 2024, we have implemented several measures to reduce complaints and enhance provider engagement. For LTC providers, we issued a public notice on common billing denials, with a one-page reference for solutions, and established direct communication with HFS for LTC Retro Rate letter validation. For hospitals, we have introduced a process where network consultants proactively contact facilities facing high-dollar claim denials to maintain transparency and support. For physicians and specialists, BCBS increased monthly claim audits to align with HFS expectations and improve both systemic and manual processes.

Meridian: Provider disputes and provider resolution portal trends are relatively flat. Meridian continues to have minimal administrative burden to its network. Meridian is currently working to reduce overturns by educating providers on what is needed for accurate disposition of first-time disputes, as well as enhancing training and education for Meridian's claims analysts.

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)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **80%** in 30 seconds or less
Blue Cross Community Health Plan	94.99%			96.68%	96.92%	92.42%	met	-0.03%	
CountyCare Health Plan	92.43%			86.02%	74.34%	69.55%	not met	-0.25%	
Aetna	90.74%			89.25%	89.26%	85.65%	met	-0.06%	
Meridian Health Plan	92.76%			95.89%	95.92%	85.78%	met	-0.08%	
Molina Healthcare	92.24%			91.09%	94.81%	90.60%	met	-0.02%	

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 Health Plan: Higher than usual staff attrition and call volumes contributed to member and provider call center performance in Q2 and Q3 of 2024. CountyCare does not expect this to continue as it has put a performance improvement plan in place. Thirty-six new call center representatives were hired and trained and began taking calls in January. Additionally, call volumes are projected, measured against the actual number of calls, and are reviewed in alignment with key performance indicators weekly. CountyCare prioritizes its members' experience with the health plan and is dedicated to meeting all required call center service levels.

Meridian: Meridian met all contact center metrics in Q3. Service Level was slightly lower than Q2 as we managed a higher number of member rewards inquiries related to the success of the program. We were able to flex staffing to ensure that the service level agreement was still met.

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 rates 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)	Q2 2023	Q3 2023	Q4 2023	Q1 2024	Q2 2024	Q3 2024	met/ not met	% change from Q2 2023	Threshold: **5%** or less
Blue Cross Community Health Plan	0.89%			0.69%	0.62%	0.91%	met	0.02%	
CountyCare Health Plan	0.66%			1.60%	3.50%	2.89%	met	3.37%	
Aetna	1.20%			1.21%	1.37%	1.55%	met	0.29%	
Meridian Health Plan	1.77%			1.20%	1.28%	2.44%	met	0.38%	
Molina Healthcare	0.60%			0.50%	0.52%	1.22%	met	1.04%	

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 Q3. 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 the 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.