Care Coordination:

New Enrollee Screening & Assessments:

HFS has a target threshold of 70% of new enrollees have a health risk assessment or a health risk screening completed within 60 days of enrollment. To date, no health plans have reached this goal, and the industry average is 44% completion rate within 60 days. It is worth noting that the Department has seen a sizeable improvement in the completion of health risk assessments or health risk screenings since Q1 2020, with an average improvement rate of 10%. Health Plans contact 100% of members to complete a Health Risk Screenings and Health Risk Assessment. HRSs and HRAs are not completed for members in the fee for service program.

Care Coordination: New Enrollee Screening and Assessments										
% of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment ***Changed as of 12/2021-The metric now only looks at screening status as of 2 months after enrollment.**	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	31.72%	40.88%	33.27%	38.12%	42.73%	47.69%	48.11%	not met	52%	**70%**
CountyCare Health Plan	41.92%	43.55%	39.21%	51.71%	42.71%	35.50%	32.49%	not met	-22%	
Aetna (IliniCare Health)	50.84%	53.12%	44.54%	47.36%	42.54%	37.78%	41.92%	not met	-18%	
Meridian Health Plan	35.69%	49.19%	43.24%	52.30%	52.58%	50.73%	44.69%	not met	25%	
Molina Healthcare	47.19%	46.74%	40.72%	43.64%	35.88%	45.00%	52.53%	not met	11%	
	41.47%	46.70%	40.20%	46.63%	43.29%	43.34%	43.95%		9.63%	

Aetna Better Health of Illinois (ABHIL): ABHIL did not change the targets but adjusted the timeline for their attainment to realistically meet the 70% threshold. Provider execution on HRS completion rates has been slower than anticipated and the impact of the Omicron variant has hampered workforce optimization. To augment these dependencies, ABHIL has endorsed skip tracing capabilities across all workstreams and leveraged a BEP vendor to assist in HRS completions. Revitalizing our mini screener has created a material improvement. ABHIL is embarking upon a data driven, hyper-local analysis of completion rates across all zip codes. This will provide leading insights into areas that require strategic focus.

BCBSIL: BCBSIL continues to implement strategies to strengthen our data mining processes to increase timely HRS completions. BCBSIL has implemented 'skip trace' technology in late Q1 2021 to enable our care coordination team to more quickly locate accurate phone numbers for our members which continues to be one of our largest barriers in completing Health Risk Screenings timely. In Q3 we achieved our highest quarterly performance so far (48.11%) and anticipate ongoing improvement from the implementation of this technology for 2022.

CountyCare: CountyCare, like all plans, showed an increase and peak in engagement with members during Q2 2020 when the COVID-pandemic resulted in more people at home, with both the time and the need to connect with health care resources. Since that initial episode there has been a fluctuation in member engagement with community reopening depending on town or city's guidance. With community mobility there is a decline in member engagement. CountyCare continues to prioritize visits with primary care providers as a parallel strategy to engage members in clinical screening, assessment, and most importantly immediate linkage to care. Two system advancements in 2022 will support HRS completion: i) a new care management system going live 2/1/22 with both enhanced triggers and the ability to share a record with providers who perform HRSs and ii) full implementation of the State's ADT portal, Collective Medical which provides extensive member contact data from multiple provider and State sources.

Meridian: For Q3 2021, Meridian continues to strive for 100% Health Risk Screening (HRS) and Health Risk Assessment (HRA) within 60 days of new member eligibility. Strong relationships with Business Enterprise Program (BEP) certified vendors, improved tracking tools, and maintained level of urgency have resulted in significant upward trending of Meridian HRS and HRAs. Meridian has maintained or exceeded the industry average consistently since Q4 2020. Meridian is committed to making continuous improvements to existing processes as well as implement innovative ideas to meet and exceed HFS target.

Molina: Molina is proud to be the performance leader in Q3 2021 for New Enrollee Health Risk Screening and Assessments completed within 60 days of enrollment. Initial screening is only one way that Molina identifies the needs of incoming members. For all members, Molina applies predictive modeling tools based on historical medical claims and other factors to identify its most at-risk members, and it focuses outreach and interventions on those members. Molina also outreaches to members who have been hospitalized, and it works closely with providers who send referrals for case management.

YouthCare: YouthCare has made improvements in engaging new enrollees within 60 days of enrollment. The YouthCare team will continue to work closely with DCFS and other stakeholders to ensure that we are reaching all members in a timely manner.

Risk Stratification Seniors & People with Disabilities:

HFS requires that 20% of seniors and people with disabilities be identified as moderate or high risk. Further, HFS requires that 5% of seniors and people with disabilities 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 need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high or moderate risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as 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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	36.04%	34.30%	21.30%	21.08%	20.36%	20.42%	20.47%	met	-43%	**20%**
CountyCare Health Plan	32.33%	31.71%	31.14%	31.29%	32.51%	30.96%	30.96%	met	-4%	
Aetna (IlliniCare Health)	27.14%	30.70%	24.52%	22.64%	25.21%	26.91%	27.85%	met	3%	
Meridian Health Plan	24.65%	26.74%	26.18%	25.91%	26.40%	22.83%	20.85%	met	-15%	
Molina Healthcare	24.05%	18.33%	21.86%	22.02%	22.57%	21.69%	24.75%	met	3%	
	28.84%	28.36%	25.00%	24.59%	25.41%	24.56%	24.98%		-11.47%	

% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	10.63%	10.77%	6.07%	5.72%	5.29%	5.29%	5.09%	met	-52%	**5%**
CountyCare Health Plan	15.11%	14.68%	14.61%	15.04%	16.76%	15.51%	15.51%	met	3%	
Aetna (IlliniCare Health)	10.83%	14.04%	7.51%	5.22%	5.03%	5.15%	5.37%	met	-50%	
Meridian Health Plan	5.49%	6.13%	5.82%	5.63%	6.13%	5.55%	5.21%	met	-5%	
Molina Healthcare	7.40%	9.23%	10.36%	11.08%	10.83%	12.30%	10.41%	met	41%	
	9.89%	10.97%	8.87%	8.54%	8.81%	8.76%	8.32%		-12.86%	

Aetna Better Health of Illinois (ABHIL): ABHIL continues to meet/exceed the risk stratification targets as established by HFS, leveraging multiple referral streams in the identification of our highest need members.

Meridian: For Q3 2021, Meridian continues to meet or exceed the HFS requirement for 20% of seniors and people with disabilities to be identified as moderate or high risk as well as assuring at least 5% are identified in the high-risk category. Meridian understands that timely and accurate identification of at-risk populations is paramount to assure members with the highest needs are prioritized appropriately for outreach, assessment, and care planning. As the COVID-19 pandemic continues to weigh heavy on our vulnerable populations, Meridian continues to educate, encourage, and provide appointment assistance for members to get vaccinated and/or boosted as appropriate with every member contact.

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 need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high or moderate risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of 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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	95.30%	93.82%	87.28%	91.01%	89.01%	91.85%	90.23%	met	-5%	**90%**
CountyCare Health Plan	91.71%	95.73%	96.28%	96.14%	95.18%	93.74%	93.74%	met	2%	
Aetna (IlliniCare Health)	90.59%	91.38%	90.56%	93.02%	98.60%	99.30%	99.47%	met	10%	
Meridian Health Plan	98.42%	95.23%	90.02%	90.00%	90.33%	90.07%	90.08%	met	-8%	
Molina Healthcare	81.29%	90.03%	86.17%	86.28%	91.31%	92.54%	94.61%	met	16%	
	91.46%	93.24%	90.06%	91.29%	92.89%	93.50%	93.63%		2.92%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	21.07%	20.21%	18.92%	20.58%	19.64%	20.47%	20.04%	met	-5%	**20%**
CountyCare Health Plan	17.82%	16.71%	16.13%	21.50%	21.60%	20.24%	20.24%	met	14%	
Aetna (IlliniCare Health)	20.01%	21.31%	20.11%	18.51%	16.18%	21.81%	21.84%	met	9%	
Meridian Health Plan	21.88%	21.71%	20.01%	20.00%	20.00%	20.00%	20.08%	met	-8%	
Molina Healthcare	25.76%	29.69%	45.75%	38.08%	37.61%	30.08%	30.15%	met	17%	
	21.31%	21.93%	24.18%	23.73%	23.01%	22.52%	22.47%		5.32%	

CountyCare: CountyCare is meeting the HFS risk stratification thresholds for our dual-eligible members. CountyCare's dual-eligible members are enrolled in care management and are assigned to an individual care coordinator for person-centered assessment and care planning.

Meridian: For Q3 2021, Meridian continues to meet HFS' expectations for identifying, categorizing, and care managing appropriate Dual Eligible members. Risk stratification is based on predictive modeling algorithms based on historical medical claims and other factors to identify its most at-risk. At Meridian the entire Dual Eligible population is enrolled in our care coordination program.

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 review that consult medical history as well as other data, to assess member need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as 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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	2.65%	3.25%	2.05%	2.07%	2.06%	2.11%	2.06%	met	-22%	2%
CountyCare Health Plan	1.83%	1.65%	1.52%	1.49%	1.41%	1.25%	1.25%	not met	-32%	
Aetna (IlliniCare Health)	2.27%	3.28%	2.32%	2.02%	0.97%	1.17%	2.05%	met	-10%	
Meridian Health Plan	2.97%	3.01%	2.05%	2.01%	2.02%	1.94%	2.00%	met	-33%	
Molina Healthcare	2.14%	1.82%	1.92%	2.12%	2.14%	1.91%	2.56%	met	20%	
	2.37%	2.60%	1.97%	1.94%	1.72%	1.68%	1.98%		-15.25%	

Aetna Better Health of Illinois (ABHIL): ABHIL began process and program enhancements post-migration to align with standard operating practices. ABHIL is now meeting/exceeding the risk stratification metric across all products/specialty areas.

CountyCare: We have increased use of an existing specialized pediatric assessment and created a new infant screener; both will provide risk level scoring based on targeted questions. Within the FHP population, CountyCare prioritizes outreach to pregnant women and families with infants admitted to the NICU, special needs children and children with behavioral health crisis; this is a small proportion of FHP participants, but they are prioritized to receive more intensive care management services.

Meridian: For Q3 2021 Meridian continues to meet or exceed the HFS requirement for 2% of enrollees within the Family and Children eligibility category, be identified as high risk. Meridian understands that timely and accurate identification of at-risk populations such as Special Needs Children and pregnant moms is paramount to assure members with the highest needs are prioritized appropriately for outreach, assessment, and care planning. For Q3 and ongoing through Q4, Meridian has made improvements in its maternity program, Smart Start for Baby, by leveraging reporting, tracking, and monitoring tools available because of the Integration with Centene systems and platforms. In addition, Meridian has collaborated with Vheda, a BEP vendor specializing in remote monitoring to enroll high-risk maternity members, with a focus on members with heightened social determinants of health to improve health equities within our membership populations.

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 review that consult medical history as well as other data, to assess member need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as 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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	4.05%	4.87%	2.81%	2.18%	2.18%	2.24%	2.22%	met	-45%	2%
CountyCare Health Plan	5.88%	5.46%	4.77%	4.83%	5.63%	4.85%	4.85%	met	-18%	
Aetna (IliniCare Health)	2.14%	2.44%	3.09%	2.02%	1.47%	1.77%	2.07%	met	-3%	
Meridian Health Plan	3.13%	3.33%	2.17%	2.08%	2.04%	2.00%	2.00%	met	-36%	
Molina Healthcare	1.81%	2.42%	2.65%	2.72%	2.90%	2.73%	2.97%	met	64%	
	3.40%	3.70%	3.10%	2.77%	2.84%	2.72%	2.82%		-7.60%	

Meridian: For Q3 2021, Meridian continues to meet and exceed HFS' expectations for identifying, categorizing and care managing ACA Adult populations at or above the 2.0% level. Meridian recognizes timely and accurate identification of at-risk populations is the first important step towards outreach, assessment, and care planning. For Q3, Meridian has leveraged tools available because of the integration from Meridian legacy to Centene systems and platforms. This will allow for more effective identification of members in need of Care Management/Coordination.

Care Plan Assessment & Individual Plan of Care High Risk:

HFS requires that high risk enrollees have an individual plan of care completed. Health plans report on the percentage of individual care plans completed within 90 days. Care plans are created with the member to identify the member's medical and other goals and identify ways the member and the health plan can work together to help the member achieve them. The industry average is approximately 40% completion within 90 days, and this represents an industry average improvement of 27% compared to the first quarter of 2020.

Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)										
% **high risk** Enrollees with an IPoC completed **within 90 days** after being identified as high risk ***New threshold as of 1/1/2022**	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	13.79%	21.30%	22.36%	26.67%	22.86%	25.57%	27.92%	Increasing	102%	60%
CountyCare Health Plan	53.60%	57.28%	61.71%	64.15%	51.86%	42.24%	41.46%	Decreasing	-23%	
Aetna (IliniCare Health)	37.44%	60.79%	66.57%	80.76%	72.91%	55.07%	73.16%	Increasing	95%	
Meridian Health Plan	23.10%	32.50%	38.32%	48.26%	51.59%	48.13%	11.69%	Decreasing	-49%	
Molina Healthcare	42.86%	57.31%	59.20%	50.65%	61.45%	44.36%	46.96%	Increasing	10%	
	34.16%	45.84%	49.63%	54.10%	52.13%	43.07%	40.24%		27.08%	

Aetna Better Health of Illinois (ABHIL): ABHIL has solid processes in place to promote compliance to this measure through our engagement dashboards. Staff are alerted daily of impending timelines for engagement in accordance with members' level of acuity. This staff specific tracking tool has optimized our engagement enabling ABHIL to exceed the threshold established by HFS.

BCBSIL: As of Q3 2021, the BCBSIL Care Coordination team continues to work on a safe plan to fully resumed in-person engagement at facilities to better assess members and complete IPoCs. All measures have seen increased engagement quarter over quarter since at least Q1 2021. BCBSIL Care Coordination team continues to improve processes and reporting enhancements to ensure that our IPoC completions are being accurately reflected. High Risk Enrollees with Completed IPOC has focused initiative currently to further increase engagement.

CountyCare: Q3 data for IPoC for high-risk members within 90-day period at 41.46% reflects consistency within industry benchmark of 40.34%. Our most recent internal data shows an upward trend (over 50%) CountyCare's newly implemented electronic mailing system and new CM system going live 2/1/22 with enhanced triggers, will further promote the trajectory toward the target.

Meridian: For Q3 2021, Meridian continues to strive for improvement completing Individualized Plans of Care for high-risk populations. Of note-Meridian underwent significant Care Management department changes in Q3 as we transitioned from legacy Meridian to Centene systems, platforms, and procedures. The transition resulted in a decline of performance in this measure from Q2. Meridian has implemented mitigation and we expect to improve in this metric in the coming quarters.

YouthCare: YouthCare continues to make improvements completing Individualized Plans of Care for Care Management High Risk identified members within 90 Days of eligibility as evidenced by increases made. Continuous quality improvements on existing tracking and accountability along with re-education will allow YouthCare to continue to improve this metric.

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 56% completion within 90 days, and this represents an industry average improvement of 59% in relation to the first quarter of 2020.

% **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk ***New threshold as of 1/1/2022**	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	14.79%	37.48%	40.18%	32.05%	32.87%	49.96%	55.37%	Increasing	274%	**60%**
CountyCare Health Plan	55.11%	59.55%	65.43%	47.55%	41.18%	41.52%	40.86%	Decreasing	-26%	
Aetna (IlliniCare Health)	63.31%	71.58%	71.54%	73.31%	55.47%	63.24%	72.04%	Increasing	14%	
Meridian Health Plan	34.51%	48.34%	46.41%	47.01%	67.26%	75.42%	58.31%	Increasing	69%	
Molina Healthcare	83.21%	79.53%	51.64%	66.98%	76.29%	44.00%	54.49%	Decreasing	-35%	
	50.19%	59.30%	55.04%	53.38%	54.61%	54.83%	56.21%		59.35%	

Aetna Better Health of Illinois (ABHIL): ABHIL has solid processes in place to promote compliance to this measure through our engagement dashboards. Staff are alerted daily of impending timelines for engagement in accordance with members' level of acuity. This staff specific tracking tool has optimized our engagement enabling ABHIL to exceed the threshold established by HFS.

BCBSIL: BCBSIL Care Coordination team continues working on process and reporting enhancements to ensure that our IPoC completions are being accurately captured and reported. Moderate Risk Enrollees with Completed IPOC has seen the most growth in 2021.

CountyCare: After a Q1 2021 initiative to reconcile for accuracy risk levels, a bulk of members required re-engagement with care coordination. The high acuity members were prioritized over medium acuity. Our newly implemented electronic mailing system and new CM system implementation going live 2/1/22 with enhanced triggers, will further promote the trajectory toward the target.

Meridian: For Q3 2021, Meridian continues to strive for improvement completing Individualized Plans of Care for moderate-risk populations. Of note-Meridian underwent significant Care Management department changes in Q3 as we transitioned from legacy Meridian to Centene systems, platforms, and procedures. The transition resulted in a decline of performance in this measure from Q2. Meridian has implemented mitigation and we expect to improve in this metric in the coming quarters.

YouthCare: YouthCare is revising its internal processes to and oversight to ensure completion of the Individuated Plans of Care for moderate risk members. Through these process enhancements, we expect to see significant improvement in this area over the next several quarters.

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 70% completion within 15 days.

Enrollee Engagement: Service Plan										
% of Enrollees deemed newly eligible for HCBS Waiver who had a Service Plan **within 15 days** after the MCO is notified of the Enrollees HCBS Waiver eligibility ***New threshold as of 1/1/2022**	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	71.98%	72.30%	73.22%	81.25%	82.39%	83.88%	86.17%	Increasing	20%	**90%**
CountyCare Health Plan	73.82%	77.19%	78.47%	82.24%	81.18%	82.84%	80.11%	Increasing	9%	
Aetna (IliniCare Health)	72.55%	73.12%	75.79%	68.85%	55.04%	53.30%	53.10%	Decreasing	-27%	
Meridian Health Plan	78.99%	80.77%	79.00%	77.67%	81.71%	78.51%	67.81%	Decreasing	-14%	
Molina Healthcare	62.16%	73.42%	83.16%	66.67%	61.90%	67.43%	60.37%	Decreasing	-3%	
	71.90%	75.36%	77.93%	75.34%	72.44%	73.19%	69.51%		-3.12%	

Aetna Better Health of Illinois (ABHIL): ABHIL under-reported our performance on this metric for Q3. ABHIL's actual performance was 69%. Additionally, our results materially improve if the reporting metric for service plan completion excludes instances of member out-of-state relocation, member expiration, lack of member eligibility, member hospitalization, and member's refusal of the waiver. ABHIL requests consideration from HFS for these reasonable exclusions.

Meridian: Meridian strives to ensure that members have service plans in place within 15 days of eligibility notification. Meridian underwent significant Care Management department changes in Q3 as we transitioned from legacy Meridian to Centene systems, platforms, and procedures. The transition resulted in a decline of performance in this measure from Q2. Meridian has implemented mitigation, and we expect to improve in this metric in the coming quarters.

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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	99.98%	100.00%	100.00%	99.94%	100.00%	100.00%	99.87%	No Change	0%	**Monitor**
CountyCare Health Plan	99.76%	99.61%	100.00%	99.83%	99.87%	99.13%	99.86%	No Change	0%	
Aetna (IliniCare Health)	100.00%	100.00%	99.83%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	100.00%	100.00%	97.84%	100.00%	100.00%	98.77%	Decreasing	-1%	
Molina Healthcare	100.00%	100.00%	100.00%	99.96%	99.93%	100.00%	100.00%	Increasing	0%	
	99.95%	99.92%	99.97%	99.51%	99.96%	99.83%	99.70%		-0.25%	

Molina: Molina continues to place a priority on the timely resolution of member grievances, specifically related to pharmacy and access to care related grievances. Molina identified these two areas as leading indicators to ensure member satisfaction.

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 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	99.64%	99.42%	99.08%	98.01%	100.00%	99.30%	96.23%	Decreasing	-3%	**Monitor**
CountyCare Health Plan	99.43%	100.00%	98.24%	100.00%	99.39%	99.67%	99.16%	No Change	0%	
Aetna (IliniCare Health)	99.02%	100.00%	100.00%	100.00%	100.00%	99.43%	98.37%	Decreasing	-1%	
Meridian Health Plan	99.47%	100.00%	98.86%	99.62%	99.14%	98.93%	90.82%	Decreasing	-9%	
Molina Healthcare	99.27%	100.00%	100.00%	100.00%	100.00%	100.00%	99.80%	Increasing	1%	
	99.36%	99.88%	99.24%	99.53%	99.71%	99.47%	96.88%		-2.50%	

Aetna Better Health of Illinois (ABHIL): ABHIL continues to identify opportunities to streamline the appeals review and resolution process to ensure adherence. Recent improvements to the process include implementation of optimized workflows across intake, consolidated reporting, and enhanced monitoring of cases.

Molina: Molina continues to review and resolve standard pre-service appeals in a timely manner. Pre-service appeals main driver are pharmacy related appeals. Many of those appeals can be overturned based on the additional information that is submitted by the provider community.

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 85%. Health plans utilize established criteria and medical necessity guidelines when determining clinical appropriateness. Prior authorizations may be denied because the request is missing clinical information and incomplete or the service requested does not meet clinical criteria.

Prior Authorization requests for Medical (non Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging & Pain Management										
% of total **Approved** (all services requested were approved)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	81.63%	84.38%	82.76%	82.95%	82.22%	82.60%	83.19%	Increasing	2%	**Monitor**
CountyCare Health Plan	93.38%	93.18%	93.57%	93.19%	92.63%	94.31%	94.79%	Increasing	2%	
Aetna (IliniCare Health)	78.12%	75.46%	67.71%	83.34%	84.70%	84.64%	84.21%	Increasing	8%	
Meridian Health Plan	88.71%	87.24%	84.90%	84.66%	86.06%	82.90%	77.46%	Decreasing	-13%	
Molina Healthcare	85.77%	86.30%	80.78%	82.62%	83.99%	84.71%	84.05%	Decreasing	-2%	
	85.52%	85.31%	81.94%	85.35%	85.92%	85.83%	84.74%		-0.70%	

Meridian: Through its Utilization Management program, Meridian continually strives to ensure that its members are getting the right care, at the right level at the right time. Due to the COVID-19 pandemic and in accordance with HFS guidance for waiving certain prior authorizations, the total number of authorization requests received during the Q3 2021 continues to trend below the normal volume. The authorizations that were reviewed were in categories that have historically had a lower volume but a higher denial rate. This higher denial rate for those categories has been attributed primarily to missing information submitted for the initial review.

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)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	99.41%	99.71%	99.55%	99.57%	99.69%	99.63%	99.79%	No Change	0%	**Monitor**
CountyCare Health Plan	93.03%	67.76%	95.33%	88.61%	87.80%	89.97%	86.72%	Decreasing	-7%	
Aetna (IliniCare Health)	91.84%	94.44%	94.12%	99.66%	98.86%	97.76%	91.13%	Decreasing	-1%	
Meridian Health Plan	100.00%	97.53%	99.67%	100.00%	99.85%	99.68%	100.00%	No Change	0%	
Molina Healthcare	96.47%	98.54%	97.14%	95.56%	97.38%	97.27%	98.46%	Increasing	2%	
	96.15%	91.60%	97.16%	96.68%	96.72%	96.86%	95.22%		-1.02%	

CountyCare: As the need for behavioral health services has increased throughout the pandemic, CountyCare has embarked on a full review of behavioral health utilization management activities to identify opportunities to align with providers and decrease administrative burden. Over the past two quarters, our team has collaborated with providers who have barriers submitting complete clinical data to support their requests. Since CountyCare does not require prior authorization for any outpatient substance use disorder services, the overall volume of authorizations reported in this metric is relatively low.

Provider Complaints:

HFS provider complaint portal:

HFS tracks the number of provider disputes submitted through the HFS complaint portal per 1000 member months. The industry average is .09. The new HFS provider complaint portal was put in place at the end of Q1 2020, since its implementation all provider complaints have been resolved by the plans within 30 days or receipt.

Provider Disputes/Complaints Portal Summary (Data Source - HFS Provider Resolution Portal)										
# of disputes **(per 1,000 Member Months)**	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Trend	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	0.06	0.03	0.01	0.01	0.01	0.05	0.10	Increasing	82%	**Monitor**
CountyCare Health Plan	0.04	0.03	0.02	0.02	0.02	0.01	0.02	Decreasing	-51%	
Aetna (IlliniCare Health)	0.15	0.04	0.01	0.01	0.01	0.08	0.10	Decreasing	-34%	
Meridian Health Plan	0.10	0.06	0.01	0.01	0.01	0.13	0.16	Increasing	59%	
Molina Healthcare	0.11	0.04	0.02	0.02	0.01	0.04	0.06	Decreasing	-41%	
	0.09	0.04	0.01	0.01	0.01	0.06	0.09		2.98%	

Aetna Better Health of Illinois (ABHIL): ABHIL is taking a multi-pronged approach to mitigate portal complaint volume. ABHIL has: 1) increased provider education through hosted webinars and targeted outreaches based on issue trends; 2) Developed targeted processes to conduct root cause analysis and prioritize trending escalations; and 3) Increased transparency with Providers via notices and emails regarding latest plan updates, global projects, etc.

Meridian: Meridian continues to focus on improving this metric through increased provider training, enhanced provider access to Meridian's electronic dispute form, and adjustments to internal controls for tracking and distributing dispute data to ensure provider issues are resolved accurately and efficiently.

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 80% 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)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	93.35%	96.83%	90.15%	94.08%	95.95%	95.72%	95.91%	met	3%	80% in 30 seconds or less
CountyCare Health Plan	87.91%	93.62%	91.13%	89.61%	86.21%	84.74%	70.13%	not met	-20%	
Aetna (IlliniCare Health)	91.93%	83.45%	72.14%	60.72%	90.04%	83.45%	69.03%	not met	-25%	
Meridian Health Plan	89.37%	90.97%	83.04%	79.55%	92.87%	87.69%	86.46%	met	-3%	
Molina Healthcare	80.41%	96.53%	82.34%	83.78%	73.19%	68.28%	79.38%	not met	-1%	
	88.59%	92.28%	83.76%	81.55%	87.65%	83.98%	80.18%		-9.38%	

Aetna Better Health of Illinois (ABHIL): ABHIL has implemented a robust strategy to improve Call Center performance including staff augmentation, employee retention programs, provider and enrollee education, and optimization of hiring cadences.

CountyCare: CountyCare call center experienced a shortage of employees, with higher than usual call of due to sickness which impacted the performance. New hire employees must go through 3 weeks training and call handling time is longer. CountyCare was able to successfully attract, onboard and maintain employees to ensure metric compliance.

Molina: Molina is working to leverage provider portal enhancements and self-service features in IVR to give providers enhanced options. To improve future performance, Molina has implemented some programs to improve employee retention and utilized some temporary staff to support through this period.

Calls Abandoned:

Health Plans report on the percentage of calls abandoned and are required to maintain a threshold of fewer than 5% of calls being abandoned for member calls. The data published combines abandonment rate for both member and provider calls. Nearly every Health Plan met the fewer than 5% threshold and the industry average percentage is 3% for calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	met/not met	% change from Q1 2020	Threshold:
Blue Cross Community Health Plan	3.45%	1.68%	4.17%	4.06%	3.57%	1.63%	1.18%	met	-66%	5% or less
CountyCare Health Plan	2.10%	1.62%	1.71%	1.81%	2.24%	2.45%	4.83%	met	130%	
Aetna (IliniCare Health)	2.62%	3.94%	5.00%	10.92%	1.22%	1.46%	3.33%	met	27%	
Meridian Health Plan	0.78%	0.82%	1.72%	2.54%	0.71%	1.56%	1.78%	met	128%	
Molina Healthcare	3.06%	0.60%	2.69%	2.32%	5.75%	7.13%	5.45%	not met	78%	
	2.40%	1.73%	3.06%	4.33%	2.70%	2.85%	3.31%		59.50%	

Molina: Call center performance improved for both service level and abandoned call rate but remained slightly below threshold. Call center leadership have been working diligently to improve operations and staffing following recent attrition attributed to the pandemic. The benefits of that work really come to bear in Q4, where all call center statistics met MPR thresholds.