Q1 2022 Quarterly Business Review (QBR) Report

Purpose of QBR Reports

The HealthChoice Illinois Quarterly Business Review is designed to provide measures and context around key subject areas and categories. All thresholds and requirements reflected here were developed based on best practices nationally as well as 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. The target for plans to meet most of the thresholds is January 1, 2023.

For each category below, the report offers (1) an explanation of major goals, (2) data showing changes over time and (3) where appropriate, highlights from individual plans.

Care Coordination:

New Enrollee Screening & Assessments:

Health Plans contact 100% of members to complete a Health Risk Screenings and Health Risk Assessment. 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. To vigorously promote care coordination, this threshold was set higher than the industry average, which is a 45% completion rate within 60 days. Also, it should be noted that HRSs and HRAs are not completed for members in the fee for service program. This is a service available only 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 12/2021-The metric now only looks at screening status as of 2 months after enrollment.**	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	33.27%	38.12%	42.73%	47.69%	48.11%	47.71%	64.71%	not met	94%	**70%**
CountyCare Health Plan	39.21%	51.71%	42.71%	35.50%	32.49%	31.04%	27.29%	not met	-30%	
Aetna (IlliniCare Health)	44.54%	47.36%	42.54%	37.78%	41.92%	43.92%	45.35%	not met	2%	
Meridian Health Plan	43.24%	52.30%	52.58%	50.73%	44.69%	37.60%	49.55%	not met	15%	
Molina Healthcare	40.72%	43.64%	35.88%	45.00%	52.53%	66.32%	39.07%	not met	-4%	

<u>Aetna Better Health of Illinois:</u> Aetna continues its on-going improvement efforts that focus on HRS success while strengthening our provider and vendor partnerships by creating and improving processes to support various workstreams completing the HRS. Aetna remains diligent in its education of community partners and providers regarding the benefits of participating in the HRS completion process and scheduling appointments early in member's eligibility to improve member, provider, and community engagement. Aetna takes all opportunities to further the use of the HRS mini screener across our providers, vendors, and call center teams. Aetna has analyzed completion rates across different ZIP Codes and identified hyperlocal opportunities to target stakeholder engagement that will optimize HRS completion rates. In addition, Aetna is leveraging our relationship with CVS Retail Pharmacies as well as our digital capabilities to amplify completion rates.

<u>BCBSIL:</u> BCBSIL had its highest performance increase within one quarter are trending towards the performance target of 70%. BCBSIL is proud to be the performance leader for Q1 2022 but continues to identify methods to increase member engagement and meet member needs. BCBSIL is currently evaluating the addition of social risks scores within the overall risk model to better address social determinants of health.

CountyCare: Two system advancements in 2022 have been implemented which with full engagement as of April 2022, noted increase of HRS rate month over month with April and May coming in at 34% and 39%, respectively. Though an incremental trend upward, CountyCare recognizes the need for improvement and has launched a Health Risk Screening Improvement Initiative which includes expanded outreach efforts to engage members. This effort, formally initiated in June, includes quadrupling the number of members receiving the HRS by text message, HRS completion during the welcome call, mailed paper health risk screenings, and a 75 % increase in agents strictly dedicated to improving screening outcomes.

Meridian: Meridian continues to increase the number of members who complete a Health Risk Screening (HRS) within 60 days of new member enrollment. The plan has implemented improvements and innovations to existing processes in efforts to meet and exceed HFS' target. Strong relationships with Business Enterprise Program (BEP) certified vendors, exploration of provider partnerships, improved tracking tools, and maintained level of urgency will improve Meridian's HRS and HRA completion rates. Our efforts have greatly impacted our Q2 2022 HRS/HRA completion rate.

Molina: Molina was the performance leader in Q4 2021 for New Enrollee Health Risk Screening and Assessments completed within 60 days of enrollment, but changes in outreach staffing and systems had a temporary impact in early 2022. 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 conducting health risk screenings of new enrollees within 60 days of enrollment in 2022. 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: Overview

HFS requires risk stratification to help ensure that care strategies take into account differing needs. HFS requires that 20% of a plan's senior members and members 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. When a customer is stratified 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 need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. 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.

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)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	21.30%	21.08%	20.36%	20.42%	20.47%	20.38%	20.51%	met	-4%	20%
CountyCare Health Plan	31.14%	31.29%	32.51%	30.96%	30.96%	26.59%	25.59%	met	-18%	
Aetna (IlliniCare Health)	24.52%	22.64%	25.21%	26.91%	27.85%	27.83%	27.82%	met	13%	
Meridian Health Plan	26.18%	25.91%	26.40%	22.83%	20.85%	20.00%	19.98%	not met	-24%	
Molina Healthcare	21.86%	22.02%	22.57%	21.69%	24.75%	24.82%	29.90%	met	37%	

% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	6.07%	5.72%	5.29%	5.29%	5.09%	5.12%	5.30%	met	-13%	5%
CountyCare Health Plan	14.61%	15.04%	16.76%	15.51%	15.51%	12.55%	11.94%	met	-18%	
Aetna (IlliniCare Health)	7.51%	5.22%	5.03%	5.15%	5.37%	5.21%	5.04%	met	-33%	
Meridian Health Plan	5.82%	5.63%	6.13%	5.55%	5.21%	5.00%	5.00%	met	-14%	
Molina Healthcare	10.36%	11.08%	10.83%	12.30%	10.41%	10.20%	16.32%	met	58%	

Aetna Better Health of Illinois: Aetna 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: 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. We continue to review our processes for risk stratification and have met the goal of 20% for Seniors or Person with Disabilities identified as Moderate or High for Q2 2022.

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)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	87.28%	91.01%	89.01%	91.85%	90.23%	90.54%	89.62%	not met	3%	90%
CountyCare Health Plan	96.28%	96.14%	95.18%	93.74%	93.74%	90.72%	88.38%	not met	-8%	
Aetna (IlliniCare Health)	90.56%	93.02%	98.60%	99.30%	99.47%	99.33%	99.28%	met	10%	
Meridian Health Plan	90.02%	90.00%	90.33%	90.07%	90.08%	90.01%	90.01%	met	0%	
Molina Healthcare	86.17%	86.28%	91.31%	92.54%	94.61%	95.37%	93.13%	met	8%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	18.92%	20.58%	19.64%	20.47%	20.04%	20.00%	19.87%	not met	5%	20%
CountyCare Health Plan	16.13%	21.50%	21.60%	20.24%	20.24%	20.61%	19.80%	not met	23%	
Aetna (IlliniCare Health)	20.11%	18.51%	16.18%	21.81%	21.84%	21.22%	21.12%	met	5%	
Meridian Health Plan	20.01%	20.00%	20.00%	20.00%	20.08%	20.00%	20.00%	met	0%	
Molina Healthcare	45.75%	38.08%	37.61%	30.08%	30.15%	24.87%	24.88%	met	-46%	

BCBSIL: BCBSIL is evaluating the timing of the dual eligible adults risk model since fluctuations in new members impact the set monthly risk.

CountyCare: CountyCare identified an issue with unexpected conversions to low risk for a portion of this population. Our risk stratification logic has been updated and June 2022 data reflects the following:

moderate/high at 98.6% and high at 26.18% which meets the risk stratification requirements for the dual eligible membership.

Meridian: Meridian continues to meet HFS' expectations for identifying, categorizing, and care managing appropriate Dual Eligible members. Risk stratification is based on predictive modeling algorithms using historical medical claims and other factors to identify its most at-risk members. 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)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	2.05%	2.07%	2.06%	2.11%	2.06%	2.05%	2.04%	met	0%	2%
CountyCare Health Plan	1.52%	1.49%	1.41%	1.25%	1.25%	1.12%	1.03%	not met	-32%	
Aetna (IlliniCare Health)	2.32%	2.02%	0.97%	1.17%	2.05%	2.18%	2.00%	met	-14%	
Meridian Health Plan	2.05%	2.01%	2.02%	1.94%	2.00%	2.00%	2.03%	met	-1%	
Molina Healthcare	1.92%	2.12%	2.14%	1.91%	2.56%	2.71%	3.08%	met	60%	

CountyCare: CountyCare has enhanced the predictive modeling logic for our FHP membership as well as the continued front-line effort which has resulted in movement toward goal. For our current reporting we see MLTSS high risk is above 20% at 21.16%; FHP is at 1.6%, increase from 1.03 % and finally SNC has increase to 30. 6%. The new algorithm has not yet impacted numbers thus anticipate meeting target next quarter report.

Meridian: Meridian continues to meet or exceed the HFS requirement that 2% of enrollees within the family and children eligibility category are identified as high risk. 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.

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)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	2.81%	2.18%	2.18%	2.24%	2.22%	2.16%	2.14%	met	-24%	2%
CountyCare Health Plan	4.77%	4.83%	5.63%	4.85%	4.85%	3.71%	3.40%	met	-29%	
Aetna (IlliniCare Health)	3.09%	2.02%	1.47%	1.77%	2.07%	2.25%	2.21%	met	-28%	
Meridian Health Plan	2.17%	2.08%	2.04%	2.00%	2.00%	2.00%	2.00%	met	-8%	
Molina Healthcare	2.65%	2.72%	2.90%	2.73%	2.97%	2.99%	3.17%	met	20%	

Meridian: Meridian continues to meet HFS' 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. The integration of Centene systems and platforms includes a robust stratification process which pulls data from over 200 sources including but not limited to: Demographics, Race, Claims, SDOH indicators, assessments, to identify risk on an ongoing basis and allows 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 46% completion within 90 days.

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**	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	22.36%	26.67%	22.86%	25.57%	27.92%	38.95%	35.99%	Increasing	61%	**60%**
CountyCare Health Plan	61.71%	64.15%	51.86%	42.24%	41.46%	53.24%	50.41%	Decreasing	-18%	
Aetna (IlliniCare Health)	66.57%	80.76%	72.91%	55.07%	73.16%	66.57%	72.18%	Increasing	8%	
Meridian Health Plan	38.32%	48.26%	51.59%	48.13%	11.69%	32.03%	34.96%	Decreasing	-9%	
Molina Healthcare	59.20%	50.65%	61.45%	44.36%	46.96%	31.77%	35.22%	Decreasing	-41%	

Aetna Better Health of Illinois: Aetna has established processes to promote compliance to this measure by leveraging data from our engagement dashboards and promoting adherence to onboarding protocols. Staff are alerted daily of impending timelines for engagement in accordance with members' level of acuity and eligibility date. This staff specific tracking tool has optimized our engagement enabling Aetna to exceed the threshold established by HFS.

BCBSIL: BCBSIL is continuing to implement strategies to increase the number of individual care plans completed. BCBSIL has seen improvements in member engagement with the utilization of text messaging and is exploring the use of email with HFS. BCBSIL is also doing an analysis on barriers to contacts for high risk non waiver members.

Meridian: Our system migration in July 2021 impacted our internal Care Management processes. Now that we have been on the Centene platform for a year, we have found opportunities to identify a larger number of members whom we are actively outreaching and engaging in CM. Our percentage decrease in Q1 is reflective of the larger membership. We have more than doubled the count of members in this category and continue to increase the number of members with a Care Plan.

YouthCare: YouthCare continues to make improvements completing Individualized Plans of Care for the Care Management of members identified as High or Complex Risk within 90 Days of eligibility as evidenced by increases made. YouthCare implemented new processes for monitoring IPOC completion and overall staff productivity.

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 54% completion within 90 days, and this represents an industry average improvement of 3% in relation to the third 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**	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	40.18%	32.05%	32.87%	49.96%	55.37%	63.46%	61.89%	Increasing	54%	**60%**
CountyCare Health Plan	65.43%	47.55%	41.18%	41.52%	40.86%	43.65%	43.42%	Decreasing	-34%	
Aetna (IlliniCare Health)	71.54%	73.31%	55.47%	63.24%	72.04%	71.54%	66.37%	Decreasing	-7%	
Meridian Health Plan	46.41%	47.01%	67.26%	75.42%	58.31%	70.41%	41.65%	Decreasing	-10%	
Molina Healthcare	51.64%	66.98%	76.29%	44.00%	54.49%	45.03%	57.52%	Increasing	11%	

Aetna Better Health of Illinois: Aetna has established practices to promote compliance to this measure by leveraging data from our engagement dashboards and promoting adherence to onboarding protocols. Staff are alerted daily of impending timelines for engagement in accordance with members' level of acuity and eligibility date. This staff specific tracking tool has optimized our engagement enabling Aetna to exceed the threshold established by HFS.

Meridian: Our system migration in July 2021 impacted our internal Care Management processes. Now that we have been on the Centene platform for a year, we have found opportunities to identify a larger number of members whom we are actively outreaching and engaging in CM. Our percentage decrease in Q1 is reflective of the larger membership. We have more than doubled the count of members in this category and continue to increase the number of members with a Care Plan.

YouthCare: YouthCare revised its internal processes and oversight to ensure completion of the Individuated Plans of Care for moderate risk members.

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 73% 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**	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	73.22%	81.25%	82.39%	83.88%	86.17%	80.52%	79.58%	Increasing	9%	**90%**
CountyCare Health Plan	78.47%	82.24%	81.18%	82.84%	80.11%	73.02%	69.61%	Decreasing	-11%	
Aetna (IlliniCare Health)	75.79%	68.85%	55.04%	53.30%	53.10%	53.53%	58.12%	Decreasing	-23%	
Meridian Health Plan	79.00%	77.67%	81.71%	78.51%	67.81%	71.89%	85.61%	Increasing	8%	
Molina Healthcare	83.16%	66.67%	61.90%	67.43%	60.37%	70.92%	71.92%	Decreasing	-14%	

Aetna Better Health of Illinois: The Aetna 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. Aetna requests consideration from HFS for these reasonable exclusions.

CountyCare: CountyCare recognizes the importance of service planning within 15days for members with new waiver eligibility. In Q1, we worked through some challenges associated with moving into a new care management software system. CountyCare is now confidently capturing our activity with these members with April and May 2022 performance reaching 81% and 95% respectively.

Meridian: Meridian strives to ensure that members have service plans in place within 15 days of eligibility notification. Meridian Care Management has returned to the field effective April 2022, and we expect this metric to increase as we increase our opportunities for member touchpoints.

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 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	100.00%	99.94%	100.00%	100.00%	99.87%	100.00%	100.00%	No Change	0%	**Monitor**
CountyCare Health Plan	100.00%	99.83%	99.87%	99.13%	99.86%	100.00%	99.55%	No Change	0%	
Aetna (IlliniCare Health)	99.83%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	97.84%	100.00%	100.00%	98.77%	93.41%	100.00%	No Change	0%	
Molina Healthcare	100.00%	99.96%	99.93%	100.00%	100.00%	99.89%	99.85%	No Change	0%	

Meridian: Meridian identified opportunities to improve grievance resolution timeliness, including improving internal communication to prevent delays. Additionally, Meridian is reviewing root causes for grievances in order to reduce the overall volume.

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 has established an internal goal of resolving such grievances within one week of receipt. Molina identified these areas as leading indicators to ensure member satisfaction. Molina continually reviews grievances received to identify root causes and trending concerns. This information is shared across departments so that continual improvements can be made, and receipts can be reduced.

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 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	99.08%	98.01%	100.00%	99.30%	96.23%	99.36%	99.39%	No Change	0%	**Monitor**
CountyCare Health Plan	98.24%	100.00%	99.39%	99.67%	99.16%	90.51%	98.43%	No Change	0%	
Aetna (IlliniCare Health)	100.00%	100.00%	100.00%	99.43%	98.37%	97.22%	100.00%	No Change	0%	
Meridian Health Plan	98.86%	99.62%	99.14%	98.93%	90.82%	98.52%	99.84%	Increasing	1%	
Molina Healthcare	100.00%	100.00%	100.00%	100.00%	99.80%	100.00%	100.00%	No Change	0%	

Aetna Better Health of Illinois: Improvements implemented in the latter half of 2021 including optimized intake workflows, consolidated reporting, staff cross-training and enhanced monitoring of cases have led to visible performance improvement in Q1 2022. Aetna is continuously monitoring the appeals review and resolution process for optimization opportunities to ensure compliance.

Meridian: Meridian identified opportunities to ensure its appeals are all processed within the allotted time.

Molina: Molina continues to review and resolve standard pre-service appeals in a timely manner. Molina recently implemented an efficiency within our documentation system. This has reduced the amount of manual intake work by having faxed appeals requests move automatically into the system. This allows the team to devote more energy to working with the member and provider to gain the needed clinical information to support the appeal review.

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 86%. 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)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	82.76%	82.95%	82.22%	82.60%	83.19%	84.10%	84.46%	Increasing	2%	**Monitor**
CountyCare Health Plan	93.57%	93.19%	92.63%	94.31%	94.79%	94.49%	93.48%	No Change	0%	
Aetna (IlliniCare Health)	67.71%	83.34%	84.70%	84.64%	84.21%	83.52%	83.31%	Increasing	23%	
Meridian Health Plan	84.90%	84.66%	86.06%	82.90%	77.46%	75.57%	84.41%	Decreasing	-1%	
Molina Healthcare	80.78%	82.62%	83.99%	84.71%	84.05%	83.56%	84.17%	Increasing	4%	

CountyCare: CountyCare continuously reviews trends related to the Utilization Management program. We are currently evaluating high volume and low-cost services where we can implement auto-authorizations. We can achieve multiple goals with this change: alleviate some of the provider burden around the PA process and free up staff to do other tasks to improve the UM program.

Meridian: Through its Utilization Management program, Meridian continually strives to ensure that its members are getting the right care, at the right level and at the right time. Our system migration in July 2021 impacted our internal UM processes. Now that we have been on the Centene platform for a year, we have identified opportunities with how we gather data and use the data to create improvements. We are also developing relationships with providers to gather feedback on their experience to identify ways we can be better partners.

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 96%. 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 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	99.55%	99.57%	99.69%	99.63%	99.79%	99.73%	99.72%	No Change	0%	**Monitor**
CountyCare Health Plan	95.33%	88.61%	87.80%	89.97%	86.72%	90.76%	89.32%	Decreasing	-6%	
Aetna (IlliniCare Health)	94.12%	99.66%	98.86%	97.76%	91.13%	95.01%	94.37%	No Change	0%	
Meridian Health Plan	99.67%	100.00%	99.85%	99.68%	100.00%	N/A	98.59%	Decreasing	-1%	
Molina Healthcare	97.14%	95.56%	97.38%	97.27%	98.46%	98.25%	98.30%	Increasing	1%	

CountyCare: Upon review of trends and denial rates, CountyCare has identified multiple opportunities that may help improve the BH denial rates. We are evaluating prospects for value-based provider contracts with providers which would include services requiring prior authorization. Additionally, June 2, 2022, we executed new logic around authorization for 2 of the community-based services. We will plan to re-evaluate to determine if there any changes in provider practices; then we will determine if prior authorization can be removed totally.

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 .12. 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)**	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Trend	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	0.01	0.01	0.01	0.05	0.10	0.11	0.13	Increasing	1157%	**Monitor**
CountyCare Health Plan	0.02	0.02	0.02	0.01	0.02	0.03	0.06	Increasing	229%	
Aetna (IlliniCare Health)	0.01	0.01	0.01	0.08	0.10	0.12	0.15	Increasing	1063%	
Meridian Health Plan	0.01	0.01	0.01	0.13	0.16	0.17	0.21	Increasing	2078%	
Molina Healthcare	0.02	0.02	0.01	0.04	0.06	0.05	0.08	Increasing	326%	

Aetna Better Health of Illinois: ABHIL continues to see a trend of increasing utilization of the complaints portal with submission volume concentrated amongst similar providers and complaint reasons. Independent of volume, ABHIL compliance to required response TATs continues to be 100% since portal inception. ABHIL is working directly with Providers to work through escalated issues and understand how to best address ongoing challenges to mitigate portal complaint volume. Interventions continue to include Provider Summits throughout 2022 to further boost visibility into open global concerns and provider educational opportunities, root cause analysis and issue prioritization, and consistent notification of Providers and Provider Associations via notices and emails regarding latest plan updates, global projects, etc.

Meridian: Meridian migrated claims processing platforms in July 2021. While most open issues have been resolved, disputes peaked in Q1. When global issues are identified and remediated, whenever possible, Meridian will reprocess all impacted claims without any action needed by providers. Meridian is meeting with providers and trade associations on an ongoing basis to work through specific issues. Through detailed review of claims metrics, Meridian will identify and resolve issues with goal of resolution prior to rising to level of a HFS portal dispute.

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 88% of calls being answered within 30 seconds.

Provider and Enrollee Service Call Center										
% of calls answered in 30 seconds or less (combined Provider and Enrollee calls)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	90.15%	94.08%	95.95%	95.72%	95.91%	97.69%	96.44%	met	7%	80% in 30 seconds or less
CountyCare Health Plan	91.13%	89.61%	86.21%	84.74%	70.13%	85.56%	85.80%	met	-6%	
Aetna (IlliniCare Health)	72.14%	60.72%	90.04%	83.45%	69.03%	92.91%	96.08%	met	33%	
Meridian Health Plan	83.04%	79.55%	92.87%	87.69%	86.46%	88.88%	88.48%	met	7%	
Molina Healthcare	82.34%	83.78%	73.19%	68.28%	79.38%	89.41%	72.90%	not met	-11%	

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. We started to see overall improvement in the 4th Quarter as a result of these efforts.

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 4% for calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	met/not met	% change from Q3 2020	Threshold:
Blue Cross Community Health Plan	4.17%	4.06%	3.57%	1.63%	1.18%	1.00%	1.04%	met	-75%	5% or less
CountyCare Health Plan	1.71%	1.81%	2.24%	2.45%	4.83%	1.90%	2.20%	met	29%	
Aetna (IlliniCare Health)	5.00%	10.92%	1.22%	1.46%	3.33%	0.68%	0.68%	met	-86%	
Meridian Health Plan	1.72%	2.54%	0.71%	1.56%	1.78%	2.04%	3.31%	met	92%	
Molina Healthcare	2.69%	2.32%	5.75%	7.13%	5.45%	1.08%	12.41%	not met	361%	

Molina: Significant improvement in lowering the call abandonment rate in the 4th Quarter as a result of enhanced employee hiring and retention efforts.