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 2019, with the average improvement rate being 54%. 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	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	25.21%	24.39%	31.72%	41.97%	36.28%	34.99%	39.79%	44.02%	not met	75%	70%
CountyCare Health Plan	40.54%	41.46%	41.92%	44.05%	39.90%	43.01%	48.40%	40.89%	not met	1%	
Aetna (IliniCare Health)	46.01%	46.87%	50.84%	55.02%	47.70%	46.68%	46.17%	42.70%	not met	-7%	
Meridian Health Plan	18.08%	23.63%	35.69%	46.74%	39.82%	39.35%	51.29%	53.10%	not met	194%	
Molina Healthcare	36.56%	40.15%	47.19%	49.69%	41.52%	42.52%	40.80%	39.12%	not met	7%	
	33.28%	35.30%	41.47%	47.49%	41.04%	41.31%	45.29%	43.97%		53.80%	

Aetna Better Health of Illinois (ABHIL): ABHIL has constructed a systematic approach to meeting/exceeding HFS' 70% threshold. The ABHIL team has refined two of our previous best practices – the HRS Mini Screener and our Provider partnerships. Specifically for Provider partnerships, this includes the development of an HRS Playbook. Our Value-Based Providers are excited about partnering with ABHIL to enhance our HRS completion rates.

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 Q2 we achieved our highest quarterly performance (44.02%) and anticipate ongoing improvement from the implementation of this technology throughout 2021.

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. As the community has reopened, engagement has become challenging again, reflecting the many competing priorities our members have for their time and attention. 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.

Meridian: Meridian is proud to be the performance leader in Q2 2021 for New Enrollee Health Risk Screening and Assessments completed within 60 days of enrollment. Meridian's third party BEP certified vendors continue to provide positive results in contacting difficult to reach members. Meridian added another performance proven BEP certified partner in Q2 2021 to further enhance Meridian's efforts of outreach and engagement. Meridian expects that the re-introduction of face-to-face care coordinator contact in Q3 will add to our current success as we continue to progress toward the 70% threshold.

Molina: Molina has more than doubled its success rate in reaching newly onboarded members and conducting a health risk screener with them; it now reaches over 40% of new members. 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 significant improvement in engaging new enrollees within 60 days of enrollment from Q4 2020 to Q2 2021. 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)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	39.07%	36.91%	36.04%	34.30%	21.30%	21.08%	20.36%	20.42%	met	-48%	20%
CountyCare Health Plan	31.25%	32.13%	32.33%	31.71%	31.14%	31.29%	32.51%	30.96%	met	-1%	
Aetna (IliniCare Health)	24.86%	26.51%	27.14%	30.70%	24.52%	22.64%	25.21%	26.91%	met	8%	
Meridian Health Plan	20.30%	20.50%	24.65%	26.74%	26.18%	25.91%	26.40%	22.83%	met	12%	
Molina Healthcare	27.86%	28.65%	24.05%	18.33%	21.86%	22.02%	22.57%	21.69%	met	-22%	
	28.67%	28.94%	28.84%	28.36%	25.00%	24.59%	25.41%	24.56%		-10.02%	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	13.70%	11.91%	10.63%	10.77%	6.07%	5.72%	5.29%	5.29%	met	-61%	5%
CountyCare Health Plan	15.48%	15.26%	15.11%	14.68%	14.61%	15.04%	16.76%	15.51%	met	0.2%	
Aetna (IliniCare Health)	8.22%	9.45%	10.83%	14.04%	7.51%	5.22%	5.03%	5.15%	met	-37%	
Meridian Health Plan	5.00%	5.00%	5.49%	6.13%	5.82%	5.63%	6.13%	5.55%	met	11%	
Molina Healthcare	8.76%	8.48%	7.40%	9.23%	10.36%	11.08%	10.83%	12.30%	met	40%	
	10.23%	10.02%	9.89%	10.97%	8.87%	8.54%	8.81%	8.76%		-9.44%	

Meridian: Meridian continues to meet and exceed HFS' expectations for identifying, categorizing, and care managing appropriate Seniors and People with Disabilities. For Q2 2021 Meridian continued to use its proprietary predictive modeling tool to identify members with the highest needs and potential for positive impact. During Q2 2021, Meridian conducted outreach to this vulnerable population offering education on, and appointment assistance with COVID-19 vaccinations. In Q2 Meridian also added a BEP vendor to help outreach and remote monitor high risk maternity members and members with hypertension. As of 10/25/2021 more than 1,000 Meridian members have enrolled. This outreach and engagement further enhance our identification of high-risk members in this population and helps bridge the health inequity barrier.

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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	85.31%	88.62%	95.30%	93.82%	87.28%	91.01%	89.01%	91.85%	met	8%	90%
CountyCare Health Plan	89.75%	92.32%	91.71%	95.73%	96.28%	96.14%	95.18%	93.74%	met	4%	
Aetna (IliniCare Health)	90.65%	90.63%	90.59%	91.38%	90.56%	93.02%	98.60%	99.30%	met	10%	
Meridian Health Plan	100.00%	100.00%	98.42%	95.23%	90.02%	90.00%	90.33%	90.07%	met	-10%	
Molina Healthcare	76.28%	97.70%	81.29%	90.03%	86.17%	86.28%	91.31%	92.54%	met	21%	
	88.40%	93.86%	91.46%	93.24%	90.06%	91.29%	92.89%	93.50%		6.61%	
% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3	Threshold:
Blue Cross Community Health Plan	12.75%	12.14%	21.07%	20.21%	18.92%	20.58%	19.64%	20.47%	met	61%	20%
CountyCare Health Plan	20.78%	18.65%	17.82%	16.71%	16.13%	21.50%	21.60%	20.24%	met	-3%	
Aetna (IliniCare Health)	21.36%	20.43%	20.01%	21.31%	20.11%	18.51%	16.18%	21.81%	met	2%	
Meridian Health Plan	20.00%	20.00%	21.88%	21.71%	20.01%	20.00%	20.00%	20.00%	met	0.003%	
Molina Healthcare	13.75%	27.58%	25.76%	29.69%	45.75%	38.08%	37.61%	30.08%	met	119%	
	17.73%	19.76%	21.31%	21.93%	24.18%	23.73%	23.01%	22.52%		35.76%	

Meridian: Meridian continues to meet HFS' expectations for identifying, categorizing, and care managing appropriate Dual Eligible members. Ongoing through 2021, Meridian conducted outreach to over our members with documented history of more than 8 medication prescriptions. Members were referred to Meridian's Pharmacy Program, which is aimed at assessing member safety, understanding, and potential voluntary enrollment into a dose pack prescription fill program to enhance compliance, to increase medication adherence and to improve health outcomes.

Molina: Molina's risk stratification levels for dual-eligible enrollees fell slightly below 90% for the most recent two quarters. All dual-eligible enrollees are enrolled in case management regardless of risk stratification level. Molina reviewed its methods for risks stratification of dual members and has seen an increase in stratification levels in early 2021.

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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/not met	from Q3 2019	Threshold:
Blue Cross Community Health Plan	4.43%	2.43%	2.65%	3.25%	2.05%	2.07%	2.06%	2.11%	met	-52%	2%
CountyCare Health Plan	2.06%	2.07%	1.83%	1.65%	1.52%	1.49%	1.41%	1.25%	not met	-39%	
Aetna (IliniCare Health)	2.03%	2.00%	2.27%	3.28%	2.32%	2.02%	0.97%	1.17%	not met	-42%	
Meridian Health Plan	2.00%	2.00%	2.97%	3.01%	2.05%	2.01%	2.02%	1.94%	not met	-3%	
Molina Healthcare	3.01%	3.09%	2.14%	1.82%	1.92%	2.12%	2.14%	1.91%	not met	-37%	
	2.71%	2.32%	2.37%	2.60%	1.97%	1.94%	1.72%	1.68%		-34.73%	

Aetna Better Health of Illinois (ABHIL): ABHIL demonstrated modest improvement in Q2 from Q1 as we developed (post migration from Centene to Aetna) sustainable solutions to achieving this metric. Process and program enhancements are now incorporated into standard operating practices to meet/exceed this measure in the future.

CountyCare: Stratification for high acuity is dependent on a successful contact with a member who willing to complete and HRS. All members receive multiple outreaches from welcome calls to letters to care

coordination efforts which result in a range of responses and engagement. This initial engagement precedes claims data and other source data information, which are used for predicative modeling, which provides an alternative for stratification. Remediation has been in-progress using these two latter strategies and we expect improvement in the coming quarters.

Meridian: Meridian was slightly under the Q2 2021 threshold for identifying, categorizing and care managing the Families and Children populations. Meridian will continuous quality improvement of Meridian's predictive modeling allows for identification of members with the highest need and probability of engagement and impact to assure compliance with HFS expectations for future quarters.

Molina: Molina experienced a slight dip in acuity for Families and Children in the second quarter of 2021 but is generally at or near the 2% threshold. The Families and Children population traditionally has lower acuity compared to other population groups.

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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	5.08%	4.58%	4.05%	4.87%	2.81%	2.18%	2.18%	2.24%	met	-56%	2%
CountyCare Health Plan	5.70%	5.84%	5.88%	5.46%	4.77%	4.83%	5.63%	4.85%	met	-15%	
Aetna (IlliniCare Health)	3.06%	2.69%	2.14%	2.44%	3.09%	2.02%	1.47%	1.77%	not met	-42%	
Meridian Health Plan	2.00%	2.00%	3.13%	3.33%	2.17%	2.08%	2.04%	2.00%	met	0%	
Molina Healthcare	2.25%	2.17%	1.81%	2.42%	2.65%	2.72%	2.90%	2.73%	met	21%	
	3.62%	3.46%	3.40%	3.70%	3.10%	2.77%	2.84%	2.72%		-18.33%	

Aetna Better Health of Illinois (ABHIL): ABHIL demonstrated modest improvement in Q2 from Q1 as we developed sustainable solutions to achieving this metric (post migration from Centene to Aetna). Similar to the enhancements made for the Family & Children metrics, the improvements are now incorporated into the standard operating practices for ACA Adults to meet/exceed this measure in the future.

Meridian: Meridian continues to meet and exceed HFS' expectations for identifying, categorizing and care managing ACA Adult populations. During Q2 and continuing into Q3, Meridian is working to maximize data gathered by multiple BEP Vendors as well as community collaborations. The date includes additional demographics not included in the State files, health condition information, as well as social determinants of health information to help Meridian connect, assess, and care plan for members that have health and social gaps.

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 43% completion within 90 days, and this represents an industry average improvement of 11% compared to the third quarter of 2019.

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	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	28.00%	20.75%	13.79%	21.30%	22.36%	26.67%	22.86%	25.57%	Decreasing	-9%	**Monitor**
CountyCare Health Plan	55.83%	54.61%	53.60%	57.28%	61.71%	64.15%	51.86%	42.24%	Decreasing	-24%	
Aetna (IlliniCare Health)	30.55%	30.72%	37.44%	60.79%	66.57%	80.76%	72.91%	55.07%	Increasing	80%	
Meridian Health Plan	37.02%	35.27%	23.10%	32.50%	38.32%	48.26%	51.59%	48.13%	Increasing	30%	
Molina Healthcare	58.86%	49.10%	42.86%	57.31%	59.20%	50.65%	61.45%	44.36%	Decreasing	-25%	
	42.05%	38.09%	34.16%	45.84%	49.63%	54.10%	52.13%	43.07%		10.52%	

Aetna Better Health of Illinois (ABHIL): Our compliance driven approach leverages engagement dashboards, which are fully operational. Staff are now informed daily when a due date is approaching so that the necessary action (outreach or closure) can be taken.

BCBSIL: BCBSIL Care Coordination team has resumed in-person engagement at facilities as of Q3 2021 to better assess member and complete IPoCs. In addition, contract frequency for high-risk enrollees has increased by 7.1% from Q1 to Q2 2021 and evening and weekend outreach will continue. BCBSIL Care Coordination team continues working on process and reporting enhancements to ensure that our IPoC completions are being accurately reflected.

CountyCare: A large proportion of CountyCare's population had risk level updates in Q1 2021, which created a bulk of members needing to be reengaged with care management. Truly high-risk members often take more than 90 days to engage in care planning. Also, it can take a several quarters to catch-up following a mass initiative, but the end result is to ensure ongoing engagement with the highest priority members.

Meridian: Meridian continues to strive for improvement completing Individualized Plans of Care for Care Management High Risk identified members within 90 Days of eligibility. For Q2, Meridian Care Management went through a transition of Medical Management systems. Subsequent training and resource allotment did not lend to improvement. As of 7/1, Meridian was fully integrated, and we expect to make improvement.

YouthCare: YouthCare continues to make significant improvement completing Individualized Plans of Care for Care Management High Risk identified members within 90 Days of eligibility as evidenced by increases made from Q4 2020 to Q2 2021. 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 54.8% completion within 90 days, and this represents an industry average improvement of 80% in relation to the third quarter of 2019.

% **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	46.78%	51.27%	14.79%	37.48%	40.18%	32.05%	32.87%	49.96%	Increasing	7%	**Monitor**
CountyCare Health Plan	53.85%	56.11%	55.11%	59.55%	65.43%	47.55%	41.18%	41.52%	Decreasing	-23%	
Aetna (IlliniCare Health)	55.41%	60.89%	63.31%	71.58%	71.54%	73.31%	55.47%	63.24%	Increasing	14%	
Meridian Health Plan	14.42%	15.07%	34.51%	48.34%	46.41%	47.01%	67.26%	75.42%	Increasing	423%	
Molina Healthcare	55.06%	72.88%	83.21%	79.53%	51.64%	66.98%	76.29%	44.00%	Decreasing	-20%	
	45.10%	51.24%	50.19%	59.30%	55.04%	53.38%	54.61%	54.83%		80.19%	

BCBSIL: BCBSIL Care Coordination team continues working on process and reporting enhancements to ensure that our IPoC completions are being accurately captured and reported.

CountyCare: A large proportion of CountyCare's population had risk level updates in Q1 2021, which created a bulk of members needing to be reengaged with care management. Truly high-risk members often take more than 90 days to engage in care planning. Also, it can take a several quarters to catch-up following a mass initiative, but the end result is to ensure ongoing engagement with the highest priority members.

Meridian: In Q2, Meridian had the highest percentage of all MCOs for the number of moderate risk enrollees with completed IPoCs. Continuous quality improvements on existing tracking and accountability are expected to have a positive impact in meeting and exceeding Meridian member experience, impact and expectations.

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 73% completion within 15 days, and this represents an industry average improvement of 12% as measured against the third quarter of 2019.

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	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	69.99%	65.77%	71.98%	72.30%	73.22%	81.25%	82.39%	83.88%	Increasing	20%	**Monitor**
CountyCare Health Plan	52.41%	57.88%	73.82%	77.19%	78.47%	82.24%	81.18%	82.84%	Increasing	58%	
Aetna (IliniCare Health)	76.06%	77.46%	72.55%	73.12%	75.79%	68.85%	55.04%	53.30%	Decreasing	-30%	
Meridian Health Plan	68.89%	73.33%	78.99%	80.77%	79.00%	77.67%	81.71%	78.51%	Increasing	14%	
Molina Healthcare	70.53%	67.62%	62.16%	73.42%	83.16%	66.67%	61.90%	67.43%	Decreasing	-4%	
	67.58%	68.41%	71.90%	75.36%	77.93%	75.34%	72.44%	73.19%		11.51%	

Aetna Better Health of Illinois (ABHIL): ABHIL strives for reporting precision for the metric for enrollees deemed eligible for HCBS Waiver who had a Service Plan within 15 days. ABHIL's results for Q1 and Q2 2021 materially improve if the reporting metric for service plan completion excluded instances of member out-of-state relocation, member expiration, lack of member eligibility, member hospitalization, and member's refusal of the waiver.

Meridian: Meridian has consistently exceeded the industry average of 72% completion within 15 days. Meridian strives to ensure that members have service plans in place within 15 days of eligibility notification. Meridian expects that we will see an increase in this measure and other associated metrics as our Care Managers have started to return to face to face visits with members.

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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	100.00%	99.98%	99.98%	100.00%	100.00%	99.94%	100.00%	100.00%	No Change	0%	Monitor
CountyCare Health Plan	99.68%	99.72%	99.76%	99.60%	100.00%	99.83%	99.87%	99.13%	Decreasing	-1%	
Aetna (IliniCare Health)	100.00%	100.00%	100.00%	100.00%	99.83%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	100.00%	100.00%	100.00%	100.00%	97.72%	100.00%	100.00%	No Change	0%	
Molina Healthcare	89.42%	99.96%	100.00%	100.00%	100.00%	97.84%	100.00%	100.00%	Increasing	12%	
	97.82%	99.93%	99.95%	99.92%	99.97%	99.06%	99.97%	99.83%		2.26%	

Molina: Molina continues to review and resolve member grievances in a timely manner. Molina continues to prioritize the resolution of pharmacy and access to care related grievances. This focus was put into place to ensure member satisfaction. Molina continues to work to identify trends and form interdepartmental workgroups to address. Key examples include work done with our dental and transportation vendors.

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 Grievances resolved in less than or equal to 90 days	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	100.00%	99.98%	99.98%	100.00%	100.00%	99.94%	100.00%	100.00%	No Change	0%	Monitor
CountyCare Health Plan	99.68%	99.72%	99.76%	99.60%	100.00%	99.83%	99.87%	99.13%	Decreasing	-1%	
Aetna (IliniCare Health)	100.00%	100.00%	100.00%	100.00%	99.83%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	100.00%	100.00%	100.00%	100.00%	97.72%	100.00%	100.00%	No Change	0%	
Molina Healthcare	89.42%	99.96%	100.00%	100.00%	100.00%	97.84%	100.00%	100.00%	Increasing	12%	
	97.82%	99.93%	99.95%	99.92%	99.97%	99.06%	99.97%	99.83%		2.26%	

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)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	80.85%	82.25%	81.63%	84.38%	82.76%	82.95%	82.22%	82.60%	Increasing	2%	**Monitor**
CountyCare Health Plan	95.39%	92.45%	93.38%	93.18%	93.57%	93.19%	92.63%	94.31%	Decreasing	-1%	
Aetna (IliniCare Health)	71.39%	70.92%	78.12%	75.46%	67.71%	83.34%	84.70%	84.64%	Increasing	19%	
Meridian Health Plan	86.53%	86.63%	88.71%	87.24%	84.90%	84.66%	86.06%	82.90%	Decreasing	-4%	
Molina Healthcare	80.50%	77.29%	85.77%	86.30%	80.78%	82.62%	83.99%	84.71%	Increasing	5%	
	82.93%	81.91%	85.52%	85.31%	81.94%	85.35%	85.92%	85.83%		4.13%	

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 Q2 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.

Molina: Reduced prior authorization volume resulting from COVID-19 pandemic led to a higher proportion of cases in areas traditionally having a higher denial rate, leading to a slightly lower non-behavioral health approval rate. Few providers are submitting information through the Molina Provider Portal or a connected EMR; the vast majority of providers still use faxing to submit a request. The major reason for denials today remains a lack of clinical information sent. Clinical coverage policies are readily available on the Molina Provider Portal. Molina medical directors and utilization management staff continue to be proactive by calling providers and educating them on what is needed in order to get an approval.

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 97%. 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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	99.50%	99.23%	99.41%	99.71%	99.55%	99.57%	99.69%	99.63%	No Change	0%	**Monitor**
CountyCare Health Plan	87.69%	90.16%	93.03%	67.76%	95.33%	88.61%	87.80%	89.97%	Increasing	3%	
Aetna (IliniCare Health)	90.16%	92.31%	91.84%	94.44%	94.12%	99.66%	98.86%	97.76%	Increasing	8%	
Meridian Health Plan	100.00%	99.08%	100.00%	97.53%	99.67%	100.00%	99.85%	99.68%	No Change	0%	
Molina Healthcare	93.35%	95.98%	96.47%	98.54%	97.14%	95.56%	97.38%	97.27%	Increasing	4%	
	94.14%	95.35%	96.15%	91.60%	97.16%	96.68%	96.72%	96.86%		3.01%	

Molina: The pandemic has substantially impacted mental health. More people are being hospitalized who were never hospitalized before. Substance use and overdoses are unfortunately on the increase as well. Behavioral health prior authorization requests continue to be low. Molina has a very high approval rate with only 18 denials. Almost all the denials were for psychological testing that was not appropriate for the requested indication or did not have documentation of how the testing would be used. There were also several denials for non-covered benefits. Overall, Molina continues to have a strong approval rate for behavioral health prior authorization requests.

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 .06. 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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	0.14	0.12	0.06	0.03	0.01	0.01	0.01	0.05	Decreasing	-62%	Monitor
CountyCare Health Plan	0.09	0.04	0.04	0.03	0.02	0.02	0.02	0.01	Decreasing	-90%	
Aetna (IlliniCare Health)	0.22	0.19	0.15	0.04	0.01	0.01	0.01	0.08	Decreasing	-66%	
Meridian Health Plan	0.09	0.08	0.10	0.06	0.01	0.01	0.01	0.13	Decreasing	50%	
Molina Healthcare	0.09	0.06	0.11	0.04	0.02	0.02	0.01	0.04	Decreasing	-50%	
	0.13	0.10	0.09	0.04	0.01	0.01	0.01	0.06		-43.74%	

Meridian: Meridian has focused 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 84% 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 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	93.52%	92.94%	93.35%	96.83%	90.15%	94.08%	95.95%	95.72%	met	2%	80% in 30 seconds or less
CountyCare Health Plan	48.91%	66.38%	87.91%	93.62%	91.13%	89.61%	86.21%	84.74%	met	73%	
Aetna (IlliniCare Health)	89.09%	92.08%	91.93%	83.45%	72.14%	60.72%	90.04%	83.45%	met	-6%	
Meridian Health Plan	73.72%	85.75%	89.37%	90.97%	83.04%	79.55%	92.87%	87.69%	met	19%	
Molina Healthcare	81.67%	78.61%	80.41%	96.53%	82.34%	83.78%	73.19%	68.28%	not met	-16%	
	77.38%	83.15%	88.59%	92.28%	83.76%	81.55%	87.65%	83.98%		14.37%	

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 less than 3% of calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Q1 2021	Q2 2021	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	2.41%	3.90%	3.45%	1.68%	4.17%	4.06%	3.57%	1.63%	met	-32%	5% or less
CountyCare Health Plan	15.96%	7.23%	2.10%	1.62%	1.71%	1.81%	2.24%	2.45%	met	-85%	
Aetna (IliniCare Health)	1.27%	1.05%	2.62%	3.94%	5.00%	10.92%	1.22%	1.46%	met	15%	
Meridian Health Plan	2.41%	0.79%	0.78%	0.82%	1.72%	2.54%	0.71%	1.56%	met	-35%	
Molina Healthcare	2.33%	3.26%	3.06%	0.60%	2.69%	2.32%	5.75%	7.13%	not met	206%	
	4.87%	3.25%	2.40%	1.73%	3.06%	4.33%	2.70%	2.85%		13.82%	

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.