MCO Performance Metric Dashboard Summary
Quarterly Business Review – Q3 2020

Care Coordination:

New Enrollee Screening & Assessments:

HFS has a target threshold of 70% for new enrollees to 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 39% 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 16%. 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	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	27.24%	26.75%	25.21%	24.39%	31.72%	41.97%	36.28%	not met	33%	70%
CountyCare Health Plan	28.72%	37.68%	40.54%	41.46%	41.92%	44.05%	39.90%	not met	39%	
IlliniCare Health	36.80%	44.54%	46.01%	46.87%	50.84%	55.02%	47.70%	not met	30%	
Meridian Health Plan	44.25%	17.37%	18.08%	23.63%	35.69%	46.74%	29.27%	not met	-34%	
Molina Healthcare	20.20%	27.77%	36.56%	40.15%	47.19%	49.69%	41.52%	not met	105%	

BCBSIL: BCBSIL continues to implement strategies to strengthen our data mining processes to increase timely HRS completions. In Q12021 BCBSIL will be implementing 'skip trace' technology 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.

County Care: Due to the increased Medicaid population resulting from COVID-19, CountyCare had their highest monthly influx of new membership in July 2020. Though the overall HRS completion percentage decreased in Q32020, CountyCare completed a record number of screens and actively welcomed a record number of new members. Utilizing a variety of advanced strategies with partners and technology, CountyCare's monthly completion percentage increased to 58% by September 2020.

IlliniCare Health: The health plan continues to utilize innovative member outreach strategies to increase HRS and HRA completions. These strategies include text messaging campaigns, proactive outreach calls, embedded IlliniCare staff at provider offices, and partnering with providers to complete health risk screenings using EMR systems. IlliniCare also utilizes high performing BEP vendors who are driving pioneering approaches to improve health outcomes by connecting provider partners to the HRS results and scheduling appointments in alignment with the members' risk profiles. IlliniCare's focus on these strategies has resulted in the continuous improvement of the collection of members' health risk screening data as demonstrated in the quarterly results. For Q3 2020, the decrease from Q2 2020 was driven by 22% of the membership file not having phone numbers. This was acknowledged as a technical issue by HFS and was fixed with the October membership panel.

Meridian: Meridian has made significant improvement with screening and assessing new members within 60 days of enrollment quarter over quarter. Collaborations with industry leading external Business Enterprise Program (BEP) certified engagement vendors, development of internal dedicated teams and weekend outreach campaigns have been key. Meridian's Q3 2020 performance decreased due to increased Medicaid eligibility attributable to COVID-19 and other membership growth, with minimal lead time to prepare for the increased membership in July 2020. Meridian expects the implications of the

disruption towards improvement to be fully mitigated by Q1 2021 as demonstrated by month-over-month achievement of 40% and better August through November 2020. Although the target is to screen new enrollees within 60 days, Meridian continues its efforts to outreach and engage members it did not reach beyond the initial 60 day period.

Molina Healthcare: Molina has more than doubled its number of successes in reaching newly onboarded members and conducting a health risk screener with them. 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.

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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	24.30%	37.12%	39.07%	36.91%	36.04%	34.30%	21.30%	met	-12%	20%
CountyCare Health Plan	27.78%	26.96%	31.25%	32.13%	32.33%	31.71%	31.14%	met	12%	
IlliniCare Health	23.93%	24.34%	24.86%	26.51%	27.14%	30.70%	24.52%	met	2%	
Meridian Health Plan	20.48%	20.45%	20.30%	20.50%	24.65%	26.74%	26.18%	met	28%	
Molina Healthcare	24.02%	26.56%	27.86%	28.65%	24.05%	18.33%	21.86%	met	-9%	

% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	11.92%	12.97%	13.70%	11.91%	10.63%	10.77%	6.07%	met	-49%	5%
CountyCare Health Plan	14.70%	15.47%	15.48%	15.26%	15.11%	14.68%	14.61%	met	-1%	
IlliniCare Health	8.93%	8.53%	8.22%	9.45%	10.83%	14.04%	7.51%	met	-16%	
Meridian Health Plan	4.95%	4.92%	5.00%	5.00%	5.49%	6.13%	5.82%	met	18%	
Molina Healthcare	7.77%	8.82%	8.76%	8.48%	7.40%	9.23%	10.36%	met	33%	

Meridian: For all membership populations, Meridian continues to use a proprietary risk stratification system to identify appropriate members with the most need, care gaps and probability of engagement to enroll into Care Coordination and Clinical Programs. In Q3 2020 Meridian conducted proactive outreach to vulnerable and most at risk populations for COVID-19 education, support and available resources on local, state and federal levels.

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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	87.14%	96.10%	85.31%	88.62%	95.30%	93.82%	87.28%	not met	0%	90%
CountyCare Health Plan	80.68%	65.79%	89.75%	92.32%	91.71%	95.73%	96.28%	met	19%	
IlliniCare Health	85.01%	90.26%	90.65%	90.63%	90.59%	91.38%	90.56%	met	7%	
Meridian Health Plan	100.00%	100.00%	100.00%	100.00%	98.42%	95.23%	90.02%	met	-10%	
Molina Healthcare	93.23%	96.52%	76.28%	97.70%	81.29%	90.03%	86.17%	not met	-8%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	9.41%	13.03%	12.75%	12.14%	21.07%	20.21%	21.30%	met	126%	20%
CountyCare Health Plan	21.99%	19.48%	20.78%	18.65%	17.82%	16.71%	31.14%	met	42%	
IlliniCare Health	16.56%	19.96%	21.36%	20.43%	20.01%	21.31%	24.52%	met	48%	
Meridian Health Plan	19.97%	20.00%	20.00%	20.00%	21.88%	21.71%	26.18%	met	31%	
Molina Healthcare	20.84%	24.72%	13.75%	27.58%	25.76%	29.69%	21.86%	met	5%	

BCBSIL: The decrease in Dual Eligible Adults identified as Moderate and High risk is reflective of new membership gains. BCBSIL continues to refine our risk stratification algorithms to improve models' ability to rebalance upon new member influx.

County Care: In Q3 2020, CountyCare implemented new methods to increase the risk stratification, as well as provided additional training and resources to care coordinators to assist them in identifying the needs of the dual-eligible population. CountyCare met the 20% high risk stratification target for this population in Q4 2020.

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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	4.58%	4.72%	4.43%	2.43%	2.65%	3.25%	2.05%	met	-55.24%	2%
CountyCare Health Plan	2.22%	2.10%	2.06%	2.07%	1.83%	1.65%	1.52%	not met	-32%	
IlliniCare Health	2.25%	2.31%	2.03%	2.00%	2.27%	3.28%	2.32%	met	3.11%	
Meridian Health Plan	2.00%	2.00%	2.00%	2.00%	2.97%	3.01%	2.05%	met	2.50%	
Molina Healthcare	2.64%	2.87%	3.01%	3.09%	2.14%	1.82%	1.92%	not met	-27.27%	

County Care: As of Q1 2021, additional clinical triggers are being implemented to identify families and children with high risks as well as enhanced staff training in motivational interviewing to achieve meaningful member engagement.

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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	4.29%	4.66%	5.08%	4.58%	4.05%	4.87%	2.81%	met	-34%	2%
CountyCare Health Plan	5.38%	5.47%	5.70%	5.84%	5.88%	5.46%	4.77%	met	-11%	
IlliniCare Health	3.14%	3.09%	3.06%	2.69%	2.14%	2.44%	3.09%	met	-2%	
Meridian Health Plan	2.00%	2.00%	2.00%	2.00%	3.13%	3.33%	1.95%	not met	-3%	
Molina Healthcare	2.30%	2.41%	2.25%	2.17%	1.81%	2.42%	2.65%	met	15%	

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 50% completion within 90 days, and this represents an industry average improvement of 63% compared to the first 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	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	19.48%	24.18%	28.00%	20.75%	13.79%	21.30%	22.36%	Increasing	15%	**Monitor**
CountyCare Health Plan	33.46%	51.07%	55.83%	54.61%	53.60%	57.28%	61.71%	Increasing	84%	
IlliniCare Health	22.65%	37.63%	30.55%	30.72%	37.44%	60.79%	66.57%	Increasing	194%	
Meridian Health Plan	45.22%	45.93%	37.02%	35.27%	23.10%	32.50%	38.32%	Decreasing	-15%	
Molina Healthcare	43.92%	58.65%	58.86%	49.10%	42.86%	57.31%	59.20%	Increasing	35%	

BCBSIL: BCBSIL continues to see a positive trend in 2020 in completing IPoCs within 90 days. BCBSIL Care Coordination team is working on process and reporting enhancements to ensure that our IPoC completions are being accurately reflected

Meridian: Meridian strives to complete an Individualized Plan of Care (IPoC) for all members stratified as high risk within 90 days of being identified. Additional mitigations to build on the current gains are improvements in monitoring and tracking tools and process adjustments. Improvement has been achieved quarter over quarter in 2020.

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 55% completion within 90 days, and this represents an industry average improvement of 89% in relation to the first quarter of 2019.

% **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	30.58%	28.80%	46.78%	51.27%	14.79%	37.48%	40.18%	Increasing	31%	**Monitor**
CountyCare Health Plan	40.32%	46.84%	53.85%	56.11%	55.11%	59.55%	65.43%	Increasing	62%	
IliniCare Health	48.19%	55.17%	55.41%	60.89%	63.31%	71.58%	71.54%	Increasing	48%	
Meridian Health Plan	11.85%	7.30%	14.42%	15.07%	34.51%	48.34%	46.41%	Increasing	292%	
Molina Healthcare	46.27%	60.05%	55.06%	72.88%	83.21%	79.53%	51.64%	Increasing	12%	

Meridian: Meridian strives to complete an Individualized Plan of Care (IPoC) for all members stratified as high risk within 90 days of being identified. Additional mitigations to build on the current gains are improvements in monitoring and tracking tools and process adjustments. Improvement has been achieved quarter over quarter in 2020.

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 78% completion within 15 days, and this represents an industry average improvement of 37% as measured against the first 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	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	57.71%	73.10%	69.99%	65.77%	71.98%	72.30%	73.22%	Increasing	27%	**Monitor**
CountyCare Health Plan	45.93%	38.57%	52.41%	57.88%	73.82%	77.19%	78.47%	Increasing	71%	
IliniCare Health	60.87%	70.25%	76.06%	77.46%	72.55%	73.12%	75.79%	Increasing	25%	
Meridian Health Plan	58.13%	61.66%	68.89%	73.33%	78.99%	80.77%	79.00%	Increasing	36%	
Molina Healthcare	64.37%	68.18%	70.53%	67.62%	62.16%	73.42%	83.16%	Increasing	29%	

County Care: CountyCare continues to demonstrate improvement in performance of timely service plans due to prioritizing this important metric, improved assignment of cases, efficiency of workflows, and close oversight.

IlliniCare Health: IlliniCare completes documented outreach for 100 percent of all enrollees deemed newly eligible for the HCBS Waiver within 15 days after the health plan is notified of the eligibility. 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, IlliniCare's results for Q3 2020 would improve from 75.79% to 89.60%.

Meridian: Meridian has consistently been a leader in completing service plans for newly eligible Home and Community Based Services (HCBS) Waiver enrollees. Despite the challenges of COVID-19 and the inability to be in enrollees' homes, Meridian has continued through solid program and process to have a high level of success. Meridian will continue to make improvements through and post the pandemic to achieve 100% compliance in this metric

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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	98.86%	100.00%	100.00%	99.98%	99.98%	100.00%	100.00%	Increasing	1%	**Monitor**
CountyCare Health Plan	100.00%	99.78%	99.68%	99.72%	99.76%	99.60%	100.00%	No Change	0%	
IliniCare Health	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.83%	No Change	0%	
Meridian Health Plan	100.00%	51.37%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Molina Healthcare	91.57%	87.85%	89.42%	99.96%	100.00%	100.00%	100.00%	Increasing	9%	

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 resolved in less than or equal to 15 business days	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	99.16%	99.81%	99.32%	98.27%	99.64%	99.42%	99.08%	No Change	0%	**Monitor**
CountyCare Health Plan	6.02%	95.28%	99.59%	98.16%	99.43%	100.00%	98.24%	Increasing	1531%	
IliniCare Health	86.40%	96.64%	97.67%	94.44%	99.02%	100.00%	100.00%	Increasing	16%	
Meridian Health Plan	84.48%	99.69%	100.00%	100.00%	99.47%	100.00%	98.85%	Increasing	17%	
Molina Healthcare	100.00%	100.00%	100.00%	99.55%	99.27%	100.00%	100.00%	No Change	0%	

CountyCare: A decrease in appeals resolved within 15 days in Q3 2020 is related to two causes: providers offices have used different hours related to pandemic staffing and appeal volume doubled from Q2 2020 to Q3 2020. Appeals staff working diligently with providers to ensure appeal resolution within 15 days.

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 82%. 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 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	81.16%	79.27%	80.85%	82.25%	81.63%	84.38%	82.76%	Increasing	2%	**Monitor**
CountyCare Health Plan	95.39%	95.23%	95.39%	92.45%	93.38%	93.18%	93.57%	Decreasing	-2%	
IliniCare Health	79.83%	72.52%	71.39%	70.92%	95.80%	75.46%	67.71%	Decreasing	-15%	
Meridian Health Plan	96.13%	87.72%	86.53%	86.63%	88.71%	87.24%	84.90%	Decreasing	-12%	
Molina Healthcare	76.44%	80.65%	80.50%	77.29%	85.77%	86.30%	80.78%	Increasing	6%	

IlliniCare Health: The health plan's overall goal with respect to approval of prior authorizations is to ensure the appropriate level of care while reducing administrative burden for provider partners. IlliniCare's clinical leaders conduct thorough quarterly reviews of all prior authorization requirements and results to identify any opportunities to make adjustments. Nearly all imaging denials were due to lack of medical necessity. For each imaging denial, due to lack of medical necessity, evidenced-based alternative imaging is always recommended. If imaging denials were excluded for Q3 2020, IlliniCare's percentage of total approval increases from 67.71% to 94.57%.

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 pandemic and in accordance with HFS guidance for waiving certain prior authorizations, the total number of authorization requests received during the Q3 2020 is down approximately 40% from 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 Healthcare: As a result of the COVID-19 pandemic, the volume of prior authorization requests continued to be quite low in this quarter. On top of this, state-mandated prior authorizations and Molina-mandated extensions of previously approved prior authorizations were implemented, further reducing the volume of prior authorization requests. The impact of these events resulted in a higher proportion of cases in areas traditionally having a higher denial rate, leading to a slightly lower non-behavioral health approval rate. The major reason for denials today remains a lack of clinical information sent.

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)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	99.50%	99.67%	99.50%	99.23%	99.41%	99.71%	99.55%	No Change	0%	**Monitor**
CountyCare Health Plan	86.93%	84.78%	87.69%	90.16%	93.03%	67.76%	95.33%	Increasing	10%	
IlliniCare Health	89.09%	88.68%	90.16%	92.31%	91.84%	94.44%	94.12%	Increasing	6%	
Meridian Health Plan	100.00%	99.67%	100.00%	99.08%	100.00%	97.53%	99.67%	No Change	0%	
Molina Healthcare	95.08%	96.04%	93.35%	95.98%	96.47%	98.54%	97.14%	Increasing	2%	

IlliniCare Health: Behavioral Health consistently has a low number of pre-service authorization requests based on the nature of treatment and services. IlliniCare's member-centric approach encourages providers to be proactive in beginning treatment so that members get timely access to care. As a result, in Q3 2020, 80 out of 85 total prior authorizations account for 94.12% of the plan's BH PA approvals.

Molina Healthcare: 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 11 denials. Most 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 a few 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 .09. The number of provider disputes has decreased by an industry average of 85% in relation to the first quarter of 2019. 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 of receipt.

Provider Disputes/Complaints Portal Summary (Data Source - HFS Provider Resolution Portal)										
# of disputes (per 1,000 Member Months)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Trend	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	0.21	0.14	0.14	0.12	0.06	0.03	0.01	Decreasing	-95%	Monitor
CountyCare Health Plan	0.05	0.05	0.09	0.04	0.04	0.03	0.02	Decreasing	-67%	
IlliniCare Health	0.13	0.12	0.22	0.19	0.15	0.04	0.01	Decreasing	-90%	
Meridian Health Plan	0.09	0.06	0.09	0.08	0.10	0.06	0.01	Decreasing	-89%	
Molina Healthcare	0.12	0.07	0.09	0.06	0.11	0.04	0.02	Decreasing	-84%	

Meridian: Meridian has focused on improving this metric through increased provider training, enhanced provider access to Meridian's electronic dispute form, 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. Every Health Plan met the 80% threshold and the industry average percentage 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)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	97.54%	96.94%	93.52%	92.94%	93.35%	96.83%	90.15%	met	-8%	80% in 30 seconds or less
CountyCare Health Plan	67.86%	75.48%	48.91%	66.38%	87.91%	93.62%	91.13%	met	34%	
IlliniCare Health	80.13%	81.61%	89.09%	92.08%	91.93%	83.45%	72.14%	not met	-10%	
Meridian Health Plan	73.45%	78.59%	73.72%	85.75%	89.37%	90.97%	83.04%	met	13%	
Molina Healthcare	94.66%	91.20%	81.67%	78.61%	80.41%	96.53%	82.34%	met	-13%	

IlliniCare: The health plan has brought on additional staff to support the increase in call volume due to new Medicaid membership driven by COVID-19. We have also safely brought staff back into the office who were experiencing system challenges while working remotely from home.

Calls Abandoned:

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

% of calls abandoned (combined Provider and Enrollee calls)	Q1 2019	Q2 2019	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	met/ not met	% change from Q1 2019	Threshold:
Blue Cross Community Health Plan	14.47%	2.04%	2.41%	3.90%	3.45%	1.68%	4.17%	met	-71%	5% or less
CountyCare Health Plan	8.62%	4.64%	15.96%	7.23%	2.10%	1.62%	1.71%	met	-80%	
IliniCare Health	1.95%	2.33%	1.27%	1.05%	2.62%	3.94%	5.00%	met	156%	
Meridian Health Plan	3.51%	2.85%	2.41%	0.79%	0.78%	0.82%	1.72%	met	-51%	
Molina Healthcare	0.86%	0.91%	2.33%	3.26%	3.06%	0.60%	2.69%	met	211%	

Summary Data Source:

This quarterly Performance Metric Dashboard Summary was prepared by the HCI MCOs and IAMHP. The level of data provided is based on the information each MCO has identified to share for their plan, by metric category.