MCO PERFORMANCE METRIC DASHBOARD SUMMARY
QUARTERLY BUSINESS REVIEW – Q4 2020

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 41% 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 36%. 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	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%	not met	39%	70%
CountyCare Health Plan	40.54%	41.46%	41.92%	44.05%	39.90%	43.01%	not met	6%	
Aetna (IlliniCare Health)	46.01%	46.87%	50.84%	55.02%	47.70%	46.68%	not met	1%	
Meridian Health Plan	18.08%	23.63%	35.69%	46.74%	39.82%	39.35%	not met	118%	
Molina Healthcare	36.56%	40.15%	47.19%	49.69%	41.52%	42.52%	not met	16%	

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. We anticipate seeing ongoing improvement from the implementation of this technology throughout 2021.

CountyCare: CountyCare's HRS rates increased in Q4, however the team continued to balance HRS outreach calls with an increased need for COVID outreach due to the peak of infections through the second wave of the pandemic during October through December 2020.

Aetna Better Health of Illinois (ABHIL): The health plan continues to utilize innovative member outreach strategies to increase HRS and HRA completions and 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.

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 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.

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	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%	met	-46%	20%
CountyCare Health Plan	31.25%	32.13%	32.33%	31.71%	31.14%	31.29%	met	0%	
Aetna (IliniCare Health)	24.86%	26.51%	27.14%	30.70%	24.52%	22.64%	met	-9%	
Meridian Health Plan	20.30%	20.50%	24.65%	26.74%	26.18%	25.91%	met	28%	
Molina Healthcare	27.86%	28.65%	24.05%	18.33%	21.86%	22.02%	met	-21%	

% 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	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%	met	-58%	5%
CountyCare Health Plan	15.48%	15.26%	15.11%	14.68%	14.61%	15.04%	met	-3%	
Aetna (IliniCare Health)	8.22%	9.45%	10.83%	14.04%	7.51%	5.22%	met	-37%	
Meridian Health Plan	5.00%	5.00%	5.49%	6.13%	5.82%	5.63%	met	13%	
Molina Healthcare	8.76%	8.48%	7.40%	9.23%	10.36%	11.08%	met	26%	

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)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	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%	met	7%	90%
CountyCare Health Plan	89.75%	92.32%	91.71%	95.73%	96.28%	96.14%	met	7%	
Aetna (IliniCare Health)	90.65%	90.63%	90.59%	91.38%	90.56%	93.02%	met	3%	
Meridian Health Plan	100.00%	100.00%	98.42%	95.23%	90.02%	90.00%	met	-10%	
Molina Healthcare	76.28%	97.70%	81.29%	90.03%	86.17%	86.28%	not met	13%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	12.75%	12.14%	21.07%	20.21%	18.92%	20.58%	met	61%	20%
CountyCare Health Plan	20.78%	18.65%	17.82%	16.71%	16.13%	21.50%	met	3%	
Aetna (IliniCare Health)	21.36%	20.43%	20.01%	21.31%	20.11%	18.51%	not met	-13%	
Meridian Health Plan	20.00%	20.00%	21.88%	21.71%	20.01%	20.00%	met	0%	
Molina Healthcare	13.75%	27.58%	25.76%	29.69%	45.75%	38.08%	met	177%	

Aetna Better Health of Illinois (ABHIL): Due to system changes, there were identified data integrity issues that required clean-up. As a result, the Dual Eligible population fell slightly below the 20% high risk stratification threshold for Q4 2020. On-going

assessment of caseloads and re-stratification is driving improvement to meet and exceed the threshold for this metric.

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	met/ not met	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	4.43%	2.43%	2.65%	3.25%	2.05%	2.07%	met	-53.25%	2%
CountyCare Health Plan	2.06%	2.07%	1.83%	1.65%	1.52%	1.49%	not met	-28%	
Aetna (IliniCare Health)	2.03%	2.00%	2.27%	3.28%	2.32%	2.02%	met	0.00%	
Meridian Health Plan	2.00%	2.00%	2.97%	3.01%	2.05%	1.35%	not met	-32.50%	
Molina Healthcare	3.01%	3.09%	2.14%	1.82%	1.92%	2.12%	met	-29.66%	

CountyCare: 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)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	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%	met	-57%	2%
CountyCare Health Plan	5.70%	5.84%	5.88%	5.46%	4.77%	4.83%	met	-15%	
Aetna (IliniCare Health)	3.06%	2.69%	2.14%	2.44%	3.09%	2.02%	met	-34%	
Meridian Health Plan	2.00%	2.00%	3.13%	3.33%	2.17%	2.08%	met	4%	
Molina Healthcare	2.25%	2.17%	1.81%	2.42%	2.65%	2.72%	met	21%	

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 54% completion within 90 days, and this represents an industry average improvement of 38% 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	28.00%	20.75%	13.79%	21.30%	22.36%	26.67%	Decreasing	-5%	**Monitor**
CountyCare Health Plan	55.83%	54.61%	53.60%	57.28%	61.71%	64.15%	Increasing	15%	
Aetna (IliniCare Health)	30.55%	30.72%	37.44%	60.79%	66.57%	80.76%	Increasing	164%	
Meridian Health Plan	37.02%	35.27%	23.10%	32.50%	38.32%	48.26%	Increasing	30%	
Molina Healthcare	58.86%	49.10%	42.86%	57.31%	59.20%	50.65%	Decreasing	-14%	

BCBSIL: BCBSIL Care Coordination team continues 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 53% completion within 90 days, and this represents an industry average improvement of 47% 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	46.78%	51.27%	14.79%	37.48%	40.18%	32.05%	Decreasing	-31%	**Monitor**
CountyCare Health Plan	53.85%	56.11%	55.11%	59.55%	65.43%	47.55%	Decreasing	-12%	
Aetna (IlliniCare Health)	55.41%	60.89%	63.31%	71.58%	71.54%	73.31%	Increasing	32%	
Meridian Health Plan	14.42%	15.07%	34.51%	48.34%	46.41%	47.01%	Increasing	226%	
Molina Healthcare	55.06%	72.88%	83.21%	79.53%	51.64%	66.98%	Increasing	22%	

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:
Throughout Q4, the second wave and peak in COVID infections, CountyCare prioritized contact and care plan updates with high risk members, which increased as seen in the table above.

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 75% completion within 15 days, and this represents an industry average improvement of 14% 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	69.99%	65.77%	71.98%	72.30%	73.22%	81.25%	Increasing	16%	**Monitor**
CountyCare Health Plan	52.41%	57.88%	73.82%	77.19%	78.47%	82.24%	Increasing	57%	
Aetna (IlliniCare Health)	76.06%	77.46%	72.55%	73.12%	75.79%	68.85%	Decreasing	-9%	
Meridian Health Plan	68.89%	73.33%	78.99%	80.77%	79.00%	77.67%	Increasing	13%	
Molina Healthcare	70.53%	67.62%	62.16%	73.42%	83.16%	66.67%	Decreasing	-5%	

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.

Aetna Better Health of Illinois (ABHIL): The Aetna Care Management team 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, ABHIL's results for Q4 2020 would improve from 68.85% to 88%.

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	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	100.00%	99.98%	99.98%	100.00%	100.00%	99.94%	No Change	0%	**Monitor**
CountyCare Health Plan	99.68%	99.72%	99.76%	99.60%	100.00%	99.83%	No Change	0%	
Aetna (IliniCare Health)	100.00%	100.00%	100.00%	100.00%	99.83%	100.00%	No Change	0%	
Meridian Health Plan	100.00%	100.00%	100.00%	100.00%	100.00%	97.72%	Decreasing	-2%	
Molina Healthcare	89.42%	99.96%	100.00%	100.00%	100.00%	99.96%	Increasing	12%	

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	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	99.32%	98.27%	99.64%	99.42%	99.08%	98.01%	No Change	-1%	**Monitor**
CountyCare Health Plan	99.59%	98.16%	99.43%	100.00%	98.24%	100.00%	No Change	0%	
Aetna (IliniCare Health)	97.67%	94.44%	99.02%	100.00%	100.00%	100.00%	Increasing	2%	
Meridian Health Plan	100.00%	100.00%	99.47%	100.00%	98.85%	99.62%	No Change	0%	
Molina Healthcare	100.00%	99.55%	99.27%	100.00%	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 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	80.85%	82.25%	81.63%	84.38%	82.76%	82.95%	Increasing	3%	**Monitor**
CountyCare Health Plan	95.39%	92.45%	93.38%	93.18%	93.57%	93.19%	Decreasing	-2%	
Aetna (IlliniCare Health)	71.39%	70.92%	78.12%	75.46%	67.71%	83.34%	Increasing	17%	
Meridian Health Plan	86.53%	86.63%	88.71%	87.24%	84.90%	85.00%	Decreasing	-2%	
Molina Healthcare	80.50%	77.29%	85.77%	86.30%	80.78%	82.62%	Increasing	3%	

Aetna Better Health of Illinois (ABHIL): 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. ABHIL'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.

CountyCare: Throughout Q4, CountyCare continued to adjust prior authorization requirements in response to changes in the public health emergency. The approval rate continues to be in and acceptable range for industry standards and for strong alignment with providers overall.

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: 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	99.50%	99.23%	99.41%	99.71%	99.55%	99.57%	No Change	0%	**Monitor**
CountyCare Health Plan	87.69%	90.16%	93.03%	67.76%	95.33%	88.61%	Increasing	1%	
Aetna (IliniCare Health)	90.16%	92.31%	91.84%	94.44%	94.12%	99.66%	Increasing	11%	
Meridian Health Plan	100.00%	99.08%	100.00%	97.53%	99.67%	101.72%	No Change	2%	
Molina Healthcare	93.35%	95.98%	96.47%	98.54%	97.14%	95.56%	Increasing	2%	

CountyCare: 12% of Behavioral Health Prior Authorizations were denied in Q42020. Of those denials, 48% were secondary to multiple Community Bases Service (CBS) providers reporting that they did not fully maintain documentation during the PA relaxation period preventing submission of the required documentation for medical necessity review. Providers are offered Peer to Peer consultations on denials and requests were made for additional submission of clinical data. Provider Relations and Behavioral Health staff are providing continuing education with providers who have higher denial rates due to not sending the required documentation.

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 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 .01. The number of provider disputes has decreased by an industry average of 88% in relation to the third 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 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	Trend	% change from Q3 2019	Threshold:
Blue Cross Community Health Plan	0.14	0.12	0.06	0.03	0.01	0.01	Decreasing	-93%	**Monitor**
CountyCare Health Plan	0.09	0.04	0.04	0.03	0.02	0.02	Decreasing	-82%	
Aetna (IliniCare Health)	0.22	0.19	0.15	0.04	0.01	0.01	Decreasing	-94%	
Meridian Health Plan	0.09	0.08	0.10	0.06	0.01	0.01	Decreasing	-94%	
Molina Healthcare	0.09	0.06	0.11	0.04	0.02	0.02	Decreasing	-76%	

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.

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	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%	met	1%	80% in 30 seconds or less
CountyCare Health Plan	48.91%	66.38%	87.91%	93.62%	91.13%	89.61%	met	83%	
Aetna (IliniCare Health)	89.09%	92.08%	91.93%	83.45%	72.14%	60.72%	not met	-32%	
Meridian Health Plan	73.72%	85.75%	89.37%	90.97%	83.04%	79.55%	not met	8%	
Molina Healthcare	81.67%	78.61%	80.41%	96.53%	82.34%	83.78%	met	3%	

Aetna Better Health of Illinois (ABHIL): Related to both Calls Answered and Calls Abandoned metrics, 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.

Molina: Molina saw consistent performance in our member queues as call volumes stabilized from earlier in the year. We are working to leverage provider portal enhancements and self-service features in our IVR to give options to our provider groups. We have worked to provide support to members throughout the pandemic by assisting with inquiries regarding testing, access to community resources and vaccine availability.

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)	Q3 2019	Q4 2019	Q1 2020	Q2 2020	Q3 2020	Q4 2020	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%	met	68%	5% or less
CountyCare Health Plan	15.96%	7.23%	2.10%	1.62%	1.71%	1.81%	met	-89%	
Aetna (IliniCare Health)	1.27%	1.05%	2.62%	3.94%	5.00%	10.92%	not met	759%	
Meridian Health Plan	2.41%	0.79%	0.78%	0.82%	1.72%	2.54%	met	6%	
Molina Healthcare	2.33%	3.26%	3.06%	0.60%	2.69%	2.32%	met	0%	

Summary Data Source:
This quarterly performance metric dashboard 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.