

Q4 2025 Quarterly Business Review (QBR) Report

Purpose of QBR Reports

The HealthChoice Illinois Quarterly Business Review is designed to provide measures and context around key subject areas and categories for the Illinois Managed Care Plans. All thresholds and requirements reflected here were developed based on best practices nationally and were shaped by the Department’s Managed Care Quality Strategy and Pillars. Among other objectives, these include improving access to care, fostering outcome-based approaches, addressing social determinants of health, and promoting equity.

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

Note: MCO data entry for Q3 and Q4 2023 metrics were suspended, temporarily, by the Department due to alignment concerns across the MCOs. The Department reinstated data entry into the MCO Performance Reporting System for most metrics for Q1 2024 and beyond.

Care Coordination:

New Enrollee Screening & Assessments:

Health Plans contact 100% of members to complete Health Risk Screenings and Health Risk Assessments. HFS has a target threshold of 70% of new enrollees to have a health risk assessment or a health risk screening completed within 60 days of enrollment. Also, it should be noted that HRSs and HRAs are not completed for members in the fee-for-service program. This service is only available through managed care.

New Enrollee Screening and Assessments								
% of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment - Changed as of 12/7/2021-The metric now only looks at screening status as of 2 months after enrollment	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q4 2025	met/ not met	Threshold: 70%
	Blue Cross Community Health Plan	*	*	*	*	*	*	
CountyCare Health Plan	*	*	*	*	*	*	*	
Aetna (IliniCare Health)	*	*	*	*	*	*	*	
Meridian Health Plan	*	*	*	*	*	*	*	
Molina Healthcare	*	*	*	*	*	*	*	

***HFS is auditing alignment of the application, of the performance metric definitions across plans to ensure future reporting outcomes are consistent and reflect the same interpretation of guidance provided. MCO metric data continues to be suspended and was not required for the Q4 2025 reporting period.**

Risk Stratification: Overview

HFS requires risk stratification to help ensure that care strategies consider differing needs. HFS requires that 20% of a plan’s seniors and members with disabilities are identified as moderate or high risk. Further, HFS requires that 5% of seniors and members with disabilities be categorized as high risk. When a customer is classified as high or moderate risk, they are enrolled in specific care coordination programs. Risk stratification is based on predictive modeling algorithms and manual clinical reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. It is important to note that there may be a fluctuation in members stratified as a 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					Q4	met/	Threshold: 20%
	2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2025	not met	
Blue Cross Community Health Plan	20.62%	20.96%	21.20%	21.30%	21.53%	21.75%	met	
CountyCare Health Plan	26.56%	26.69%	26.73%	27.17%	27.04%	27.46%	met	
Aetna (IliniCare Health)	28.15%	29.44%	30.39%	31.09%	30.91%	30.63%	met	
Meridian Health Plan	20.00%	20.04%	20.10%	20.03%	21.91%	21.64%	met	
Molina Healthcare	25.14%	24.83%	25.14%	26.14%	26.49%	26.63%	met	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q3					Q4	met/	Threshold: 5%
	2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2025	not met	
Blue Cross Community Health Plan	5.06%	5.04%	5.24%	5.25%	4.99%	4.90%	Not Met	
CountyCare Health Plan	12.63%	12.58%	12.49%	12.32%	12.38%	12.35%	met	
Aetna (IliniCare Health)	6.45%	6.49%	6.73%	7.00%	7.69%	7.45%	met	
Meridian Health Plan	5.00%	5.02%	5.08%	5.03%	5.20%	5.62%	met	
Molina Healthcare	7.84%	7.42%	7.81%	8.20%	8.16%	8.50%	met	

Aetna Better Health of Illinois: Aetna employs a structured, clinically informed risk stratification process to identify members who require care coordination or targeted interventions. The methodology integrates predictive modeling, health risk assessments, referrals, and clinical review to assess medical complexity, functional needs, engagement history, and social risk factors. Risk stratification results are routinely reviewed through established governance and quality oversight processes to ensure accuracy and consistency. As reflected in Aetna’s submitted data, the organization consistently meets and exceeds HFS contractual requirements, including identifying at least 20 percent of seniors and persons with disabilities as moderate or high risk, with a minimum of 5 percent classified as high risk. Risk stratification directly informs care coordination enrollment and assignment. Members are aligned to appropriate care management resources based on clinical acuity and identified needs, supporting timely engagement, multidisciplinary coordination, and individualized service planning while maintaining compliance with HFS expectations.

Blue Cross Blue Shield of Illinois: Care Coordination continuously reassess member risk using real-time data and clinical judgment, resulting in population stratification that shifts throughout the quarter. To ensure ongoing compliance with contractual requirements, we are adjusting the internal minimum threshold for this population.

CountyCare: CountyCare consistently exceeds the HFS requirements for identifying and managing moderate and high-risk members among seniors and individuals with disabilities. Quarter over quarter, CountyCare has sustained strong performance, significantly surpassing State benchmarks. This consistent performance reflects CountyCare’s commitment to proactive population health management and accurate risk stratification to ensure members with the greatest needs are identified early and connected to appropriate, high-quality care.

Meridian: Meridian continues to meet and exceed expectations for high and moderate risk stratification among Persons with Disabilities. The plan will continue to monitor performance and implement targeted enhancements to ensure members with the greatest care needs are identified and connected to Care Management. Notably, Meridian implemented its MomCare program in Q4 2025, which is designed to identify pregnant members earlier in their pregnancy. This initiative is expected to increase identification and Care Management enrollment for High and Moderate risk members, with preliminary impacts anticipated in Q1 2026.

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 needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high or moderate risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in 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 (Dual Eligible Adults) identified as Moderate (level 2) or High Risk (level 3)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/not met	Threshold: 90%
Blue Cross Community Health Plan	90.26%	90.32%	90.32%	90.48%	90.29%	90.38%	met	
CountyCare Health Plan	96.38%	96.54%	96.21%	96.36%	100.00%	97.14%	met	
Aetna (IliniCare Health)	98.95%	99.24%	98.83%	99.07%	99.23%	96.62%	met	
Meridian Health Plan	90.03%	90.11%	90.02%	90.03%	90.70%	90.40%	met	
Molina Healthcare	94.33%	94.46%	93.45%	93.88%	93.93%	91.10%	met	
% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/not met	Threshold: 20%
Blue Cross Community Health Plan	20.14%	20.22%	20.18%	20.11%	20.19%	20.18%	met	
CountyCare Health Plan	23.95%	23.95%	23.19%	22.51%	21.84%	21.59%	met	
Aetna (IliniCare Health)	22.73%	23.84%	24.23%	24.89%	26.06%	26.40%	met	
Meridian Health Plan	20.02%	20.03%	20.00%	20.01%	20.06%	20.05%	met	
Molina Healthcare	22.40%	21.13%	19.43%	19.65%	20.43%	14.96%	not met	

CountyCare: CountyCare continues to demonstrate strong performance in meeting and exceeding HFS standards for identifying risk levels among dual eligible adults. Quarter over quarter CountyCare consistently maintains compliance above the required thresholds.

Meridian: In Q4 2025, Meridian continued to meet required threshold expectations for high-risk and moderate-risk stratification among dual-eligible adult members. Meridian consistently evaluates its risk stratification processes to ensure they accurately reflect each member’s comprehensive needs and support timely identification, intervention, and coordination of care.

Molina: MLTSS Risk stratification is a manual process. The risk stratification is completed through meeting with, completion of HRA and care plan. Throughout Q4 our team has worked to improve this metric. Will continue to build on the opportunity for improvement.

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 reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in members stratified as a high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

Enrollee Engagement, Risk Stratification								
% of Enrollees (Families and Children) identified as High Risk (level 3)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/ not met	Threshold: 2%
Blue Cross Community Health Plan	2.08%	2.04%	2.05%	2.00%	2.01%	2.02%	met	
CountyCare Health Plan	1.80%	1.73%	1.72%	1.80%	1.77%	1.82%	not met	
Aetna (IliniCare Health)	2.39%	2.10%	2.27%	2.85%	2.73%	2.25%	met	
Meridian Health Plan	2.04%	2.06%	2.33%	2.25%	2.23%	2.23%	met	
Molina Healthcare	3.24%	3.39%	3.33%	3.48%	3.41%	3.23%	met	

CountyCare: CountyCare has historically met the 2% high-acuity stratification requirement. Following a temporary decline in Q1 2024 associated with a delegate transition to a new NCQA-aligned case management system, we implemented a performance improvement plan. This plan has resulted in measurable, incremental improvement in identification and risk stratification. Based on these positive trends and enhanced oversight, CountyCare anticipates achieving the 2% threshold in the upcoming reporting cycle.

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 reviews that consult medical history as well as other data, to assess member needs across several domains, including clinical acuity, social determinants of health, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is important to note that there may be a fluctuation in members stratified as a high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

Enrollee Engagement, Risk Stratification								
% of Enrollees (ACA Adult) identified as High Risk (level 3)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/not met	Threshold: 2%
Blue Cross Community Health Plan	2.13%	2.09%	2.10%	2.17%	2.10%	2.10%	met	
CountyCare Health Plan	3.67%	3.52%	3.57%	3.53%	3.53%	3.47%	met	
Aetna (lIniCare Health)	2.16%	2.44%	2.50%	2.48%	2.87%	3.08%	met	
Meridian Health Plan	2.00%	2.00%	2.30%	2.26%	2.62%	2.94%	met	
Molina Healthcare	3.61%	3.67%	3.58%	3.79%	3.68%	3.67%	met	

CountyCare: Over 3% of ACA enrollees are identified as high risk, exceeding the required HFS threshold. This sustained performance reflects our commitment to accurately identifying members with elevated needs and ensuring timely access to appropriate care management and support services.

Meridian: For Q4 2025, Meridian continues to meet established threshold expectations for high- risk Stratification within the ACA population. As noted in the Q3 2025 analysis, enhancements to Meridian's predictive modeling tools have continued to improve identification of ACA members appropriate for high-risk stratification. In Q4 2025, Meridian observed a 12.2% increase in high-risk identification. Meridian will continue its improvement efforts to ensure members requiring Care Management are accurately identified, assigned, assessed, and effectively coordinated.

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 members goals related to medical, health, and overall well-being. When a care plan is designed, members and their health plan collaborate to create interventions and barriers allowing the members to successfully achieve their established goals.

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 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025		Threshold: Effective 01/01/22 60%
Blue Cross Community Health Plan	*	*	*	*	*	*	*	
CountyCare Health Plan	*	*	*	*	*	*	*	
Aetna (lIniCare Health)	*	*	*	*	*	*	*	
Meridian Health Plan	*	*	*	*	*	*	*	
Molina Healthcare	*	*	*	*	*	*	*	

***HFS is auditing alignment of the application of the performance metric definitions across plans to ensure future reporting outcomes are consistent and reflect the same interpretation of guidance provided. MCO metric data continues to be suspended and was not required for the Q4 2025 reporting period.**

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 61% completion within 90 days.

Enrollee Engagement: Care Assessment and Individualized Plan of Care (IPoC)								
% moderate risk Enrollees with an IPoC completed within 90 days after being identified as moderate risk	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/ not met	Threshold: Effective 01/01/22 60%
Blue Cross Community Health Plan	50.77%	52.97%	51.47%	52.97%	50.50%	55.18%	not met	
CountyCare Health Plan	59.33%	59.39%	57.69%	57.82%	59.44%	27.16%	not met	
Aetna (IliniCare Health)	53.26%	48.03%	49.52%	78.47%	81.59%	54.06%	not met	
Meridian Health Plan	81.57%	88.02%	93.31%	76.08%	90.31%	91.27%	met	
Molina Healthcare	70.03%	73.14%	71.59%	69.81%	71.98%	76.35%	met	

Aetna Better Health of Illinois: From Q1 through Q3 2025, Aetna demonstrated strong performance on this measure, exceeding required thresholds in both Q2 and Q3. This performance reflected consistent high-risk outreach, strong care team engagement, and prioritization of member safety and clinical needs. In Q4 2025, reported performance declined to 54.06%, prompting immediate review. The analysis determined the decline was due to a temporary care management system performance slowdown, not a reduction in outreach. Required outreach activities continued to occur within appropriate timeframes; however, system latency delayed documentation entry for some users, resulting in underrepresentation in reported metrics. Importantly, this was a documentation timing issue rather than a care delivery issue. Business continuity processes ensured uninterrupted high-risk member engagement. The system issue has since been fully remediated, validation confirms no expected impact to Q1 2026 reporting, and additional monitoring safeguards have been implemented to prevent recurrence.

Blue Cross Blue Shield of Illinois: BCBSIL continues to prioritize overall member engagement, with particular focus when changes in condition increase member risk. In Q4, BCBSIL achieved an increase in performance of nearly 5%, driven in part by further structuring Care Coordination teams to align with specific cohort groups. Notably, a dedicated, high-performing team now focuses on community members within the FHP population. This approach has improved engagement among members who are traditionally less responsive to telephonic outreach.

CountyCare: The Health Plan previously utilized a tickler-based system aligned with 2022 directives for contact cadence and trigger dates; however, this approach did not fully align with member engagement preferences. The revised MPR metric incorporates member preferred contact cadence and a rolling 90 day outreach requirement, supporting a more person-centered approach and improved engagement. Updates to the case management system are underway, including development of an engagement dashboard and revision of the existing tickler system to establish a triple check process across teams to ensure timely and consistent member outreach.

Meridian: For Q4 2025, Meridian continues to exceed established threshold expectations for completion of Individualized Care Plans (IPoCs) for moderate-risk members. As noted in the Q3 2025 analysis, ongoing quality improvement efforts focused on work process tools resulted in an additional quarter-over-quarter increase of approximately 1.0% in Q4 2025. Meridian will continue to evaluate opportunities for improvement to ensure timely IPoC development, supporting meaningful, actionable goals and interventions that drive improved health outcomes for members.

Service Plan for HCBS members:

HFS requires that HCBS-eligible members have a service plan in place. Health plans report on the percentage of individual service plans in place within 15 days after the Health Plan is notified of HCBS waiver eligibility. Health Plans also provide all members a 90-day “continuity of care” period that ensures their waiver services are not changed until they have had a chance to review their plan with health plan care managers. The industry average is 80% completion within 15 days.

Enrollee Engagement: Service Plan								
% of Enrollees deemed newly eligible for HCBS Waiver who had a Service Plan within 15 days after the MCO is notified of the Enrollees HCBS Waiver eligibility	Q3					Q4	met/	Threshold: Effective 01/01/22 90%
	2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	2025	not met	
Blue Cross Community Health Plan	82.41%	78.82%	77.94%	81.40%	79.22%	79.03%	not met	
CountyCare Health Plan	84.02%	86.89%	87.13%	89.61%	90.59%	87.24%	not met	
Aetna (IliniCare Health)	78.93%	82.73%	84.78%	83.93%	73.97%	88.74%	not met	
Meridian Health Plan	90.23%	92.25%	94.22%	94.04%	92.39%	91.71%	met	
Molina Healthcare	60.80%	61.20%	58.62%	57.03%	57.64%	60.65%	not met	

Aetna Better Health of Illinois: Aetna acknowledges the importance of onboarding members newly eligible for waiver services, to promptly initiate support services. As such, Aetna continues to emphasize care manager education focused on timely scheduling practices, including early scheduling to accommodate potential member-initiated reschedules. To ensure consistent oversight, Aetna reviews all missed onboarding activities to identify root causes and implement corrective actions for any impactable factors. While member readiness remains the primary contributor to onboarding delays, enhanced dashboards and lag reporting tools are used to monitor performance trends, inform targeted interventions, and support continuous process improvement to promote timely engagement.

Blue Cross Blue Shield of Illinois: BCBSIL demonstrates consistent performance in this metric. When appropriate consideration is given to valid factors such as member scheduling preferences, member declination of services, or temporary unavailability, performance remains at or above the 90% threshold. We continue to apply best practices and maintain ongoing oversight for each member who becomes eligible for waiver services to ensure all required follow-ups and actions are completed.

CountyCare: CountyCare closely monitors the newly waiver eligible members and activities associated with this metric to support an increase in the number of service plans in place within 15 days of waiver notification. Documentation training focused on accurately capturing member outreach efforts was conducted in April 2026. In addition, quarterly training is being provided to reinforce best practices and ensure continued focus on the timely implementation of the waiver service plan.

Meridian: Meridian has consistently met and exceeded the 90% performance threshold for completing service plans for newly eligible HCBS waiver members within 15 days, beginning in Q3 2024. Meridian’s targeted focus on newly eligible HCBS waiver members reflects recognition that these individuals are at increased risk for institutionalization. Timely outreach and rapid implementation of service plans are critical to ensuring member safety and supporting community-based living. Meridian continuously monitors performance on this measure to identify trends, assess progress, and implement process improvements as needed across all service areas statewide. To support timely service plan development, Meridian maintains dedicated LTSS case managers within local geographic regions to ensure adequate staffing coverage and prompt response for newly eligible HCBS waiver members requiring accelerated turnaround.

Molina: We have made improvements in this area which include enhanced reporting and oversight and built a tracker to better see the movement from identification, assignment and outreach to the member. We will see demonstrable improvement in Q1.

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.

Enrollee Grievances and Appeals							
% of Grievances resolved in less than or equal to 90 days	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Threshold: TBD
Blue Cross Community Health Plan	100.00%	100.00%	100.00%	99.86%	99.82%	99.62%	
CountyCare Health Plan	100.00%	100.00%	100.00%	100.00%	99.39%	100.00%	
Aetna (lIniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Meridian Health Plan	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Molina Healthcare	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	

Aetna Better Health of Illinois: Aetna continues to maintain full compliance with required Grievance Turnaround Times (TATs) through a comprehensive end-to-end intake, review, and resolution process. Grievance data is consistently tracked and trended to identify systemic issues and inform targeted remediation efforts.

CountyCare: CountyCare prioritizes prompt grievance resolution, striving to resolve issues at the point of contact or as expeditiously as possible, and always within 90 days of receipt. To ensure timely resolution, CountyCare employs deadline-driven grievance queues, resolution escalation procedures, performance auditing, and continuous staff training. In response to 5 untimely grievance resolutions in Q3 2025, CountyCare implemented enhanced monitoring and escalation controls for grievance queues.

Meridian: Meridian continues to maintain exemplary performance regarding timely resolution of grievances. 100% of grievances for Q4 2025 were resolved within 90 days. The average turnaround time was 32 days in Q4, which is significantly below the expected turnaround time of 90 days. Meridian was able to achieve this through daily monitoring of inventory and timely responses from business partners. Meridian continues to work closely with the transportation vendor and the vendor managers to reduce the number of complaints received from the members. Meridian continues to have biweekly workgroups to discuss and brainstorm complicated trips and any barriers for the members.

Molina: Molina continues to review and resolve grievances ahead of the required turnaround time of 90 days. In Q4, Molina averaged 23 days for the resolution of grievances. Molina maintained 100% compliance with the timely resolution of grievances.

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.

Enrollee Grievances and Appeals							
% of Appeals <u>non-Expedited resolved</u> in less than or equal to 15 business days	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Threshold: TBD
Blue Cross Community Health Plan	98.90%	98.41%	99.49%	99.38%	97.14%	96.63%	
CountyCare Health Plan	100.00%	99.81%	96.43%	100.00%	99.85%	99.31%	
Aetna (lIniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Meridian Health Plan	100.00%	99.93%	99.89%	99.81%	99.91%	100.00%	
Molina Healthcare	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	

Aetna Better Health of Illinois: Aetna remains fully compliant with all required Appeals Turnaround Times (TATs). The Grievances & Appeals team utilizes detailed, real-time tracking processes to support timely intake, processing, and response for all appeals in accordance with, or exceeding, contractual requirements.

CountyCare: CountyCare consistently exceeds timeliness standards for processing member appeals. This reflects our commitment to responsive member service to ensure that members receive prompt resolution of their concerns and access to needed care.

Meridian: Meridian achieved 100% timeliness for non-expedited appeal resolutions in Q4. This performance reflects continued improvement driven by regular refresher training and enhanced oversight of inventory management and quality metrics. Meridian anticipates sustaining this level of performance into Q1.

Molina: Molina continues to resolve standard grievances in less than the contractual turnaround time of 15 business days. In Q4, Molina averaged 9 calendar days for the resolution of standard appeals. Molina maintained 100% compliance in Q4 with the timely resolution of standard appeals.

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 88%. 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, 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 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Threshold: TBD
Blue Cross Community Health Plan	83.94%	83.42%	84.24%	84.74%	92.02%	91.99%	
CountyCare Health Plan	93.90%	94.03%	92.80%	79.10%	78.43%	78.20%	
Aetna (IliniCare Health)	89.69%	90.24%	88.61%	81.99%	83.29%	94.20%	
Meridian Health Plan	77.52%	78.92%	78.22%	86.60%	86.15%	86.00%	
Molina Healthcare	92.48%	92.70%	93.33%	93.26%	89.66%	89.76%	

CountyCare: CountyCare monitors prior authorization rates for medical services as a key measure of access to care and alignment with industry standards. CountyCare’s approval of prior authorizations declined starting Q2 through Q4 following a period of transition associated with the implementation of a new vendor and updated clinical review criteria. CountyCare recognizes the importance of maintaining appropriate access to medically necessary services and is actively conducting a comprehensive review of service categories with lower approval rates, including therapy services, imaging, pain management, and DME. Findings from this review will inform a targeted corrective action plan to ensure alignment with industry expectations while maintaining clinical appropriateness and quality of care.

Meridian: Meridian’s Prior Authorization program continuously reviews and updates code usage to align with evolving standardized practice patterns. Approval rates reflect only full approvals and exclude partial approvals. The overall reduction in denial rates in 2025 reflects our sustained focus on provider education and partnership.

Prior Authorization Behavioral Health:

Health plans are required to report on the percentage of prior authorizations that are approved for medical services. The industry average is 95%. Health plans utilize established criteria and medical necessity guidelines when determining clinical appropriateness. Prior authorizations may be denied because the request is missing clinical information and incomplete or the service requested does not meet clinical criteria.

Prior Authorization (Behavioral Health Only)							
% of total Approved (all services requested were approved)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Threshold: TBD
Blue Cross Community Health Plan	99.61%	99.73%	99.77%	99.78%	99.85%	99.27%	
CountyCare Health Plan	99.04%	98.43%	96.53%	99.43%	99.08%	99.91%	
Aetna (IliniCare Health)	94.91%	95.36%	94.47%	94.55%	92.03%	92.77%	
Meridian Health Plan	91.67%	90.63%	90.16%	96.40%	91.32%	90.65%	
Molina Healthcare	97.20%	95.48%	93.15%	94.12%	94.44%	92.18%	

Aetna Better Health of Illinois: In Q4 2025, Aetna had an increase in authorization requests compared to Q3. The overall trend of denial reasons remained consistent with previous reports, including denials for medical necessity criteria not being met, providers not responding to requests for additional clinical information to support the need for a request, and a smaller number with a request for duplicative outpatient services. One additional outlier in Q4 was the onset of denials attributed to a specific request type from one facility, with 37 administrative denials due to lack of timely notification of requests that fell outside of the retrospective review period.

CountyCare: CountyCare demonstrates consistently strong performance in the approval of prior authorizations for behavioral health services, exceeding industry benchmarks. This sustained performance reflects a streamlined authorization process designed to support timely access to care.

Meridian: Meridian monitors Behavioral Health (BH) member utilization data and looks for opportunities to improve member outcomes. The purpose of PA is to ensure members are at the right level of care, at the right time, and at the best place to meet their behavioral health needs. While approval rates decreased lightly in Q4 2025, Meridian closely monitors approval and denial rates, conducts monthly audits to ensure accurate application of Medical Necessity Criteria (MNC), and looks for opportunities to improve Utilization Management (UM) authorization processes. Meridian also frequently collaborates with providers to solidify understanding of UM processes and encourage submission of timely and sufficient documentation to demonstrate MNC. Additionally, by reviewing these services, Meridian can identify opportunities to connect members to Care Management (CM), allowing Meridian to outreach members, offer members additional support and resources, and improve member outcomes.

Provider Complaints:

HFS Provider Complaint Portal:

HFS tracks the number of provider disputes submitted through the HFS complaint portal per 1,000 member months. The industry average is .10.

Provider Disputes/ Complaints Summary							
Data Source: HFS Provider Complaint Portal.							
# of disputes (per 1,000 Member Months)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	Threshold: TBD
Blue Cross Community Health Plan	0.04	0.04	0.03	0.04	0.03	0.12	
CountyCare Health Plan	0.05	0.06	0.05	0.04	0.03	0.05	
Aetna (lliniCare Health)	0.14	0.12	0.12	0.09	0.13	0.12	
Meridian Health Plan	0.08	0.09	0.06	0.05	0.05	0.04	
Molina Healthcare	0.11	0.1	0.08	0.05	0.04	0.07	

Aetna Better Health of Illinois: Aetna’s HealthChoice Illinois disputes per thousand member months decreased slightly from Q3 2025 to Q4 2025 from .06 to .05 reflecting the overall downward trend in portal complaint volume across the last three years. Overall dispute numbers have continued to decrease month over month with a 37% overall decrease year over year (YoY) from 2024 to 2025. These improvements were driven by a rigorous weekly monitoring, root cause, and resolution process that was instituted in early 2023. Deep dives are conducted into key drivers of portal complaints to identify global trends that can be addressed in mass.

CountyCare: For Q4 2025 CountyCare experienced a minimal increase in the number of provider complaints per 1,000 members but remains among the health plans with the lowest number of provider disputes. CountyCare conducts weekly analysis of all claim denials and proactively resolves any adjudication issues identified, without action from providers. To enhance communication and transparency and eliminate the need for providers to file a dispute, an issues tracking log is posted to the CountyCare website with the status of all known global issues. We continue to leverage our provider relations team and work directly with providers to avoid issue escalation. Through proactive provider communication and addressing known issues for all impacted claims, CountyCare expects to maintain complaint numbers well below the industry average.

Molina: Molina continues to be below the industry average of .10. Molina continues to focus on controllable errors and educational opportunities to avoid providers from submitting an HFS complaint. Continue to identify enhancement and process improvement opportunities to increase workflow efficiencies and accuracy. Conduct Appeals and Grievances Process Provider Webinars to ensure our providers are familiar with the dispute process.

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 92% 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 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/not met	Threshold: 80% in 30 seconds or less
Blue Cross Community Health Plan	92.42%	96.77%	95.97%	97.48%	97.15%	97.98%	met	
CountyCare Health Plan	69.55%	91.50%	93.88%	92.82%	93.72%	94.40%	met	
Aetna (IliniCare Health)	85.65%	89.41%	90.80%	92.39%	94.04%	93.80%	met	
Meridian Health Plan	85.78%	88.74%	92.21%	95.27%	91.45%	93.50%	met	
Molina Healthcare	90.60%	88.90%	85.58%	94.33%	88.84%	85.37%	met	

Aetna Better Health of Illinois: Aetna continues to exceed service level thresholds with the metrics for call answered exceeding 90% across CY 2025. The Aetna Member Services team tracks all metrics on an hourly basis via automated reporting and hosts multiple workforce management huddles daily to ensure staffing levels are meeting incoming call volumes. The percentage of calls answered in 30 seconds or less improved YoY in 2025 with a 5% improvement in performance compared to Q4 2024.

CountyCare: Since Q3 of 2024, CountyCare has significantly exceeded the 80% target threshold with 94.4% of calls answered within 30 seconds in Q4 of 2025. This is a result of constant monitoring of staffing levels and continuous call quality assurance.

Meridian: Meridian continues to meet and exceed established service-level metrics through Q4 2025, with 2026 also demonstrating a strong start. Workforce stability remains favorable, with increasing average tenure and annualized attrition maintained below 20%.

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 with an industry average percentage of 1.04% for calls being abandoned.

Provider and Enrollee Service Call Center								
% of calls abandoned (combined Provider and Enrollee calls)	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Q4 2025	met/not met	Threshold: 5% or less
Blue Cross Community Health Plan	0.91%	0.36%	0.57%	0.53%	3.66%	0.87%	met	
CountyCare Health Plan	2.89%	0.87%	0.35%	0.57%	0.56%	0.61%	met	
Aetna (IliniCare Health)	1.55%	1.10%	0.90%	0.95%	0.73%	0.88%	met	
Meridian Health Plan	2.44%	2.01%	1.72%	1.17%	1.63%	1.30%	met	
Molina Healthcare	1.22%	1.27%	1.39%	0.50%	0.89%	0.85%	met	

Aetna Better Health of Illinois: Aetna has maintained abandonment rates in full compliance with contractual requirements with abandonment rates below 1% across CY 2025. The Aetna Member Services team tracks all call metrics on an hourly basis via automated reporting and hosts multiple workforce management huddles daily to ensure staffing levels are meeting incoming call volumes and any negative trends are addressed in real time. Q4 2025 performance highlights the impact of those interventions with a 20% improvement compared to the Q4 2024 metric.

CountyCare: CountyCare has consistently had less than 5% of calls abandoned quarter over quarter and in Q4 of 2025 had the lowest abandonment rate across all the Managed Care Organizations with 0.61% calls abandoned. This is a result of constant monitoring of staffing levels and continuous call quality assurance.

Meridian: Meeting and exceeding call center performance metrics is a collective effort. Meridian continues to partner closely with our Forecasting, Capacity, and Real-Time Workforce Management teams to ensure appropriate coverage and the ability to respond quickly to real-time operational needs.

MCO Provider Credentialing:

Under the HealthChoice Illinois Contract,

5.9 UNIFORM PROVIDER CREDENTIALING AND RE-CREDENTIALING

5.9.1 By 42 CFR 438.214, Provider enrollment in the Illinois Medicaid Program Advanced Cloud Technology (IMPACT) system constitutes Illinois' Medicaid managed care uniform credentialing and re-credentialing process. To participate in the Contractor's Provider Network, the Contractor must verify that provider is enrolled in IMPACT.

5.9.1.1 Upon receipt of a Provider's completed and accurate Universal Roster Template, Contractor shall load the Provider information into its system within thirty (30) days.

5.9.2 Continuously, the Contractor shall monitor Enrollee Complaints and Appeals, quality-of-care and quality-of-service events, and medical record review. The contractor shall document its process for selecting and retaining Providers.

5.9.3 Contractor shall ensure that only those Providers that are approved and authorized by the Department are providing Covered Services under HCBS Waivers, and that those Providers are providing to Enrollees only Covered Services for which they are approved and authorized. The Department will provide Contractor with a weekly Department extract file containing the list of such approved and authorized Providers.

5.9.4 Contractor is prohibited from requiring providers to undergo additional credentialing processes that are not a part of this Contract.

MCOs do not credential providers per Contract requirements as outlined above. Instead, HFS considers providers credentialed once they are enrolled in IMPACT. As HFS credentials the providers in IMPACT, there is no credentialing activity that the MCOs perform or report to HFS.