

Q3 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 temporarily suspended 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	Q3 2025	met/ not met
	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 Q3 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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/ not met	Threshold: 20%
Blue Cross Community Health Plan	21.70%	20.62%	20.96%	21.20%	21.30%	21.53%	met	
CountyCare Health Plan	27.20%	26.56%	26.69%	26.73%	27.17%	27.04%	met	
Aetna (IliniCare Health)	27.86%	28.15%	29.44%	30.39%	31.09%	30.91%	met	
Meridian Health Plan	20.01%	20.00%	20.04%	20.10%	20.03%	21.91%	met	
Molina Healthcare	26.22%	25.14%	24.83%	25.14%	26.14%	26.49%	met	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/ not met	Threshold: 5%
Blue Cross Community Health Plan	5.02%	5.06%	5.04%	5.24%	5.25%	4.99%	not met	
CountyCare Health Plan	13.14%	12.63%	12.58%	12.49%	12.32%	12.38%	met	
Aetna (IliniCare Health)	6.59%	6.45%	6.49%	6.73%	7.00%	7.69%	met	
Meridian Health Plan	5.01%	5.00%	5.02%	5.08%	5.03%	5.20%	met	
Molina Healthcare	7.88%	7.84%	7.42%	7.81%	8.20%	8.16%	met	

Aetna Better Health of Illinois: Aetna uses a comprehensive, clinically grounded strategy for risk stratification that brings together predictive analytics, health risk assessments, referrals, and the expertise of clinical staff. This multifaceted approach enables early recognition of members who may benefit from additional support, while also incorporating social determinants of health that can influence engagement and outcomes. Across all product lines, Aetna reliably fulfills or surpasses the risk stratification expectations outlined by the Illinois Department of Healthcare and Family Services (HFS). Strong governance, continuous performance review, and the integration of advanced data insights contribute to this consistent achievement. By aligning each member’s unique needs with the most appropriate level of care, Aetna ensures timely, individualized interventions. Examples include pairing a pregnant member with substance use disorder needs with a behavioral health clinician trained in maternity care—supported by nursing consultation when clinically indicated—or assigning a nurse directly to members with significant physical health complexity. This flexible, needs driven assignment model enhances coordination across the care continuum and supports improved outcomes for diverse member populations.

Blue Cross Blue Shield of Illinois: BCBSIL's performance has remained stable over the past year, with a minor decline observed in the third quarter, narrowly missing the performance threshold by 0.01%. The organization is currently examining membership details and processes related to daily and monthly risk stratification data to ensure that minimum requirements continue to be met. BCBSIL leverages real-time member data and insights to ensure appropriate level of engagement, interventions and care needs are being addressed. Highly skilled clinicians may adjust risk stratification based on clinical indicators. Aligning real-time risk changes while ensuring population risk stratification levels at or above threshold continues to be a part of our oversight and monitoring practices.

Meridian: For Q3 2025, Meridian continues to meet and exceed expectations regarding High and Medium Risk Stratification for Persons with Disabilities. Modeling tool improvements went live as planned, resulting in a higher rate of identification for this population with a 1.88% increase in Moderate and High stratifications combined and a 0.17% increase for High stratification. Meridian will continue to monitor and implement improvements to continue to identify the members at most need of Care Management.

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.

% of Enrollees (Dual Eligible Adults) identified as Moderate (level 2) or High Risk (level 3)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/ not met	Threshold: 90%
Blue Cross Community Health Plan	89.79%	90.26%	90.32%	90.32%	90.48%	90.29%	met	
CountyCare Health Plan	96.35%	96.38%	96.54%	96.21%	96.36%	100.00%	met	
Aetna (IliniCare Health)	99.10%	98.95%	99.24%	98.83%	99.07%	99.23%	met	
Meridian Health Plan	90.04%	90.03%	90.11%	90.02%	90.03%	90.70%	met	
Molina Healthcare	94.35%	94.33%	94.46%	93.45%	93.88%	93.93%	met	
% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/ not met	Threshold: 20%
Blue Cross Community Health Plan	19.99%	20.14%	20.22%	20.18%	20.11%	20.19%	met	
CountyCare Health Plan	23.90%	23.95%	23.95%	23.19%	22.51%	21.84%	met	
Aetna (IliniCare Health)	21.45%	22.73%	23.84%	24.23%	24.89%	26.06%	met	
Meridian Health Plan	20.02%	20.02%	20.03%	20.00%	20.01%	20.06%	met	
Molina Healthcare	17.47%	22.40%	21.13%	19.43%	19.65%	20.43%	met	

Meridian: For Q3 2025, Meridian continues to meet the required threshold for dual eligible adults with high or medium risk stratification. We are continuously evaluating our risk stratification to ensure risk stratification is an accurate representation of the individual members and all needs are addressed in a timely manner.

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.

% of Enrollees (Families and Children) identified as High Risk (level 3)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/ not met	Threshold: 2%
Blue Cross Community Health Plan	1.99%	2.08%	2.04%	2.05%	2.00%	2.01%	met	
CountyCare Health Plan	2.14%	1.80%	1.73%	1.72%	1.80%	1.77%	not met	
Aetna (IliniCare Health)	2.08%	2.39%	2.10%	2.27%	2.85%	2.73%	met	
Meridian Health Plan	2.05%	2.04%	2.06%	2.33%	2.25%	2.23%	met	
Molina Healthcare	3.86%	3.24%	3.39%	3.33%	3.48%	3.41%	met	

CountyCare: CountyCare continues remediation for the risk stratification of members in the Families and Children population metric by identifying additional member cohorts, including high-utilizer members, and high-cost members within this line of business. Monthly working sessions and ongoing oversight provide guidance to staff and support targeted improvements, contributing to our most recent month performance of 2% of members identified as high risk within this line of business.

Meridian: For Q3 2025, Meridian continues to meet threshold expectations regarding high-risk stratification for members in the Families and Children populations. For Q3 Meridian saw a very slight decrease in members identified as High Stratification of .02%. This was attributable to minor edits in internal reporting. Meridian will continue assessing improvement opportunities to ensure members with Care Management need are identified, assigned, assessed and coordinated.

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.

% of Enrollees (ACA Adult) identified as High Risk (level 3)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: 2%
Blue Cross Community Health Plan	2.15%	2.13%	2.09%	2.10%	2.17%	2.10%	met	
CountyCare Health Plan	3.96%	3.67%	3.52%	3.57%	3.53%	3.53%	met	
Aetna (IlniCare Health)	2.16%	2.16%	2.44%	2.50%	2.48%	2.87%	met	
Meridian Health Plan	2.00%	2.00%	2.00%	2.30%	2.26%	2.62%	met	
Molina Healthcare	4.01%	3.61%	3.67%	3.58%	3.79%	3.68%	met	

Meridian: For Q3 2025, Meridian continues to meet threshold expectations regarding high-risk stratification for members in the ACA populations. The enhancements to Meridian predictive modeling tool resulted in better identification of ACA members appropriate for High-Risk stratification. For Q3 Meridian saw an increase of 0.36%. Meridian will continue improvement efforts to ensure members needing Care Management are identified, assigned, assessed and 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	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: Effective 01/01/22 60%
Blue Cross Community Health Plan	*	*	*	*	*	*	*	
CountyCare Health Plan	*	*	*	*	*	*	*	
Aetna (IlniCare Health)	*	*	*	*	*	*	*	
Meridian Health Plan	*	*	*	*	*	*	*	
Molina Healthcare	*	*	*	*	*	*	*	

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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	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: Effective 01/01/22 60%
Blue Cross Community Health Plan	42.01%	50.77%	52.97%	51.47%	52.97%	50.50%	not met	
CountyCare Health Plan	56.74%	59.33%	59.39%	57.69%	57.82%	59.44%	not met	
Aetna (IliniCare Health)	56.56%	53.26%	48.03%	49.52%	78.47%	81.59%	met	
Meridian Health Plan	83.79%	81.57%	88.02%	93.31%	76.08%	90.31%	met	
Molina Healthcare	70.59%	70.03%	73.14%	71.59%	69.81%	71.98%	met	

Aetna Better Health of Illinois: In Q3 2025, Aetna achieved a significant advancement in care planning performance, completing 81.59% of Individual Plans of Care (IPoCs) for moderate risk members within 90 days, well above the statewide industry average of 61%. This improvement reflects stronger alignment between outreach strategies, clinical operations, and member needs. Several operational enhancements contributed to this gain. Aetna refined its engagement model, emphasizing timely follow up and consistent outreach methods tailored to moderate risk populations. Collaboration with community partners and value based providers continued to expand, enabling earlier identification of members who would benefit from structured care plans. In parallel, the organization strengthened its use of real time data—such as ADT alerts and pharmacy insights—to better target members for outreach and ensure that clinicians had actionable information at the outset of the care planning process. As a result, Aetna is better positioned to support moderate risk members through proactive, coordinated care planning that reinforces their goals and promotes effective partnership between members, providers, and the health plan.

Blue Cross Blue Shield of Illinois: BCBSIL noted an above average number of newly stratified moderate risk members from Q2 to Q3 which impacted overall performance. While IPOC completions for moderate risk members has remained steady, BCBSIL has implemented additional forecasting protocols to further support proactive outreach responsiveness when changes in members needs are indicated. In addition, as part of the continuous improvement approach to IPOC completions BCBSIL has implemented the following: Care Coordination teams have been restructured to maximize engagement with specific member populations, further Care Coordination training on member engagement strategies have been employed and offering flexible work hours outside of standard business hours to support engagement. Our oversight and monitoring workgroups provide further insight to action steps and opportunities to support performance improvements.

CountyCare: CountyCare Health Plan improved and nearly met the metric of 60% of moderate risk members with an Individualized Plan of Care (IPoC) in the third quarter of 2025. The Health Plan continues its focus on IPoC development for the moderate risk population to support metric attainment. The plan is currently developing a long-term engagement strategy by analyzing and determining the root causes of limited member participation. As part of this effort, CountyCare is creating an enhanced care plan approach to improve member engagement. CountyCare’s strategy is to realign moderate risk member assignment with care managers that have extensive experience in navigating the social safety-net. As moderate risk members have higher health-related social needs, this will increase engagement and movement to meet the 60% target.

Meridian: For Q3 2025 Meridian continues to meet threshold expectations in completing Individualized Care Plans for Moderate Risk members. As a result of continuous QI on work process tools, for Q3 2025 Meridian saw an increase of 14.23% in the completion of IPoCs for Moderate Risk members within 90 days. Meridian will continue to assess for improvements to ensure timely IPoC creation for our members to foster impactable goals and interventions, leading to better health.

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	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: Effective 01/01/22 90%
Blue Cross Community Health Plan	82.28%	82.41%	78.82%	77.94%	81.40%	79.22%	not met	
CountyCare Health Plan	86.04%	84.02%	86.89%	87.13%	89.61%	90.59%	met	
Aetna (IliniCare Health)	82.17%	78.93%	82.73%	84.78%	83.93%	73.97%	not met	
Meridian Health Plan	87.75%	90.23%	92.25%	94.22%	94.04%	92.39%	met	
Molina Healthcare	61.89%	60.80%	61.20%	58.62%	57.03%	57.64%	not met	

Aetna Better Health of Illinois: Aetna recognizes that newly eligible 15 day waiver members frequently begin without established services, so we continue to emphasize strong onboarding practices to ensure timely engagement. To further reinforce these efforts, we’ve added an extra layer of administrative support dedicated specifically to provide oversight. Although we have made meaningful progress, delays related to member readiness remain the main obstacle to timely onboarding. In response, we have strengthened our monitoring tools through improved dashboards and an upgraded reporting framework. Our lag reporting tool continues to be a key resource, providing retrospective insights that highlight patterns and support ongoing improvements. Additionally, Aetna reviews every missed onboarding opportunity to better understand root causes and refine our overall approach.

Blue Cross Blue Shield of Illinois: BCBSIL maintains robust programmatic oversight mechanisms to ensure timely service plan development and service delivery for newly eligible waiver members. With a dedicated support team and report monitoring, members are identified, assigned, and outreached within 48 hours. Under person-centered planning principles, the care coordinator educates members to support timely service planning development to support assistance with activities of daily living and instrumental activities of daily living. Moreover, in a deep dive review of Q3 performance, overall outcomes improved 16% to over 95% when consideration/valid justification was made for member scheduling preferences, member declination of services or member being unavailable until a later date. BCBSIL maintains ongoing oversight to each member who becomes eligible for waiver services to ensure all appropriate follow ups and actions are completed.

Meridian: For Q3 2025 Meridian continues to meet the 90% threshold for newly HCBS eligible waiver members with a service plan creation within 15 days. Meridian has ongoing monitoring to evaluate any new trends or opportunities even when exceeding the 90% completion rate.

Molina: We are working to improve this score through two avenues: we no longer allow members to request a later visit date and we are working with the team on accurate documentation to ensure we are capturing all visits. HFS should see improvement in Q4 and Q1 2026.

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 <u>resolved</u> in less than or equal to 90 days	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Threshold:
Blue Cross Community Health Plan	99.98%	100.00%	100.00%	100.00%	99.86%	99.82%	TBD
CountyCare Health Plan	100.00%	100.00%	100.00%	100.00%	100.00%	99.39%	
Aetna (IliniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Meridian Health Plan	99.50%	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 achieve full compliance with required Grievance Turn Around Times (TATs) through a robust end-to-end intake, review, and resolution process. Aetna tracks and trends all grievance data to identify global issues and drive remediation

Blue Cross Blue Shield of Illinois: During the reporting period, grievance resolution timeliness demonstrated a slight variation compared to the prior quarter; however, performance remained within required contractual and regulatory standards. Overall results continue to reflect stable and consistent processes. BCBSIL will continue routine monitoring to ensure ongoing compliance with timeliness requirements.

Meridian: Meridian continues to maintain exemplary performance regarding timely resolution of grievances. 100% of grievances for Q3 2025 were resolved within 90 days. The average turnaround time was 37 days in Q3, 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 Q3, Molina averaged 23 days for the 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 non-Expedited resolved in less than or equal to 15 business days	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Threshold:
Blue Cross Community Health Plan	97.82%	98.90%	98.41%	99.49%	99.38%	97.14%	TBD
CountyCare Health Plan	99.57%	100.00%	99.81%	96.43%	100.00%	99.85%	
Aetna (lIniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	
Meridian Health Plan	100.00%	100.00%	99.93%	99.89%	99.81%	99.91%	
Molina Healthcare	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	

Aetna Better Health of Illinois: Aetna is fully compliant with required Appeals Turn Around Times (TATs). The Aetna Grievances & Appeals team leverages detailed and real time tracking processes to ensure timely intake, processing, and responses for all appeals within or favorable to contractual requirements.

Blue Cross Blue Shield of Illinois: Appeal resolution timeliness reflected a minor quarter-over-quarter fluctuation, while remaining compliant with applicable regulatory and contractual timeframes. Performance remains aligned with established expectations, and no impact to overall compliance was identified. Standard monitoring practices will continue to support sustained performance.

Meridian: Meridian continued to resolve non-expedited appeals with 99.91% timeliness in Q3. This sustained performance was achieved through ongoing refresher training and continued close oversight of inventory and quality data. Meridian expects this level of performance to continue into Q4 and future quarters.

Molina: Molina continues to resolve standard grievances in less than the contractual turnaround time of 15 business days. In Q3, Molina averaged 9 calendar days for the 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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Threshold:
Blue Cross Community Health Plan	83.55%	83.94%	83.42%	84.24%	84.74%	92.02%	TBD
CountyCare Health Plan	95.22%	93.90%	94.03%	92.80%	79.10%	78.43%	
Aetna (IliniCare Health)	88.46%	89.69%	90.24%	88.61%	81.99%	83.29%	
Meridian Health Plan	78.13%	77.52%	78.92%	78.22%	86.60%	86.15%	
Molina Healthcare	92.35%	92.48%	92.70%	93.33%	93.26%	89.66%	

Aetna Better Health of Illinois: Aetna continually reviews Prior Authorization activity to support efficiency and industry best practices. In Q2 2025, lower imaging approval rates reduced the overall approval percentage, a pattern our delegated vendor EviCore expected to continue. That same trend carried forward into Q3 2025, with imaging services again driving the shift in total approvals.

CountyCare: As part of our utilization management strategy, CountyCare implemented a new vendor responsible for managing prior authorizations for durable medical equipment (DME), imaging, pain management, and therapy services. Since this transition, we have identified several factors influencing the change in approval rates including changes in clinical criteria and review standards and an expansion of services requiring prior authorization. We are actively collaborating with the vendor and our provider network to address these challenges. Current efforts include enhanced provider education, clarification of criteria, and process refinement to help improve approval rates and ensure a more predictable experience for providers and members.

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 compared to 2024 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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Threshold:
Blue Cross Community Health Plan	99.38%	99.61%	99.73%	99.77%	99.78%	99.85%	TBD
CountyCare Health Plan	98.64%	99.04%	98.43%	96.53%	99.43%	99.08%	
Aetna (IliniCare Health)	96.03%	94.91%	95.36%	94.47%	94.55%	92.03%	
Meridian Health Plan	94.44%	91.67%	90.63%	90.16%	96.40%	91.32%	
Molina Healthcare	92.83%	97.20%	95.48%	93.15%	94.12%	94.44%	

Aetna Better Health of Illinois: Aetna consistently monitors trends in Behavioral Health approval rates to ensure that our determinations are in line with industry standards. For Q3 2025, we noted a small decline in approval rates and performed a deep dive analysis into the denial reasons. The prominent denial reasons in order of quantity: (1) Medical necessity criteria were not met; (2) Providers did not respond to requests for additional clinical information; (3) Authorizations submitted were for duplicate services. Aetna remains committed to effective management in rendering clinical decisions in alignment with evidence based standards of practice and operational integrity.

Meridian: Meridian monitors Behavioral Health (BH) member utilization data and looks for opportunities to improve member outcomes. Prior authorization (PA) is one intervention that Meridian employs for select BH outpatient services, to ensure requested services are medically necessary before the start of treatment. 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 in Q3 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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	Threshold:
Blue Cross Community Health Plan	0.03	0.04	0.04	0.03	0.04	0.03	TBD
CountyCare Health Plan	0.06	0.05	0.06	0.05	0.04	0.03	
Aetna (IlliCare Health)	0.16	0.14	0.12	0.12	0.09	0.13	
Meridian Health Plan	0.07	0.08	0.09	0.06	0.05	0.05	
Molina Healthcare	0.12	0.11	0.1	0.08	0.05	0.04	

Aetna Better Health of Illinois: Aetna’s HealthChoice Illinois disputes per thousand member months increased slightly from Q2 2025 to Q3 2025 from .05 to .06 driven primarily by ORP related denials. Overall dispute numbers have continued to decrease month over month with a 35% overall decrease from Q1-Q3 2024 to Q1-Q3 2025 due to 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 en masse.

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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: 80% in 30 seconds or less
Blue Cross Community Health Plan	96.92%	92.42%	96.77%	95.97%	97.48%	97.15%	met	
CountyCare Health Plan	74.34%	69.55%	91.50%	93.88%	92.82%	93.72%	met	
Aetna (IliniCare Health)	89.26%	85.65%	89.41%	90.80%	92.39%	94.04%	met	
Meridian Health Plan	95.92%	85.78%	88.74%	92.21%	95.27%	91.45%	met	
Molina Healthcare	94.81%	90.60%	88.90%	85.58%	94.33%	88.84%	met	

Aetna Better Health of Illinois: Aetna continues to exceed service level thresholds. 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 has improved quarter over quarter in 2025 with a 10% improvement in performance compared to Q3 2024.

Meridian: Meridian continues with strong performance Q1 through Q3 2025. Meridian expects this level of performance to continue into Q4 and future quarters. This year's priority is recruiting bilingual agents to meet the needs of bilingual members.

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)	Q2 2024	Q3 2024	Q4 2024	Q1 2025	Q2 2025	Q3 2025	met/not met	Threshold: 5% or less
Blue Cross Community Health Plan	0.62%	0.91%	0.36%	0.57%	0.53%	3.66%	met	
CountyCare Health Plan	3.50%	2.89%	0.87%	0.35%	0.57%	0.56%	met	
Aetna (IliniCare Health)	1.37%	1.55%	1.10%	0.90%	0.95%	0.73%	met	
Meridian Health Plan	1.28%	2.44%	2.01%	1.72%	1.17%	1.63%	met	
Molina Healthcare	0.52%	1.22%	1.27%	1.39%	0.50%	0.89%	met	

Aetna Better Health of Illinois: Aetna has maintained abandonment rates in full compliance with contractual requirements. 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. Q3 2025 performance highlights the impact of those interventions with a 53% improvement compared to the Q3 2024 metric.

Meridian: Meridian’s Contact Center continues to meet all required metrics through Q3 of 2025. Meridian partners with our Workforce Management team to assess appropriate staffing on a weekly cadence.

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.