# Q1 & Q2 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** | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 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 2024 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/ not met | % change from Q1 2024 | Threshold: **20**% |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 20.70% | 21.70% | 20.62% | 20.96% | 21.20% | 21.30% | **met** | 0.03% | |
| CountyCare Health Plan | 27.22% | 27.20% | 26.56% | 26.69% | 26.73% | 27.17% | **met** | 0.00% | |
| Aetna (IliniCare Health) | 27.75% | 27.86% | 28.15% | 29.44% | 30.39% | 31.09% | **met** | 0.12% | |
| Meridian Health Plan | 20.15% | 20.01% | 20.00% | 20.04% | 20.10% | 20.03% | **met** | -0.01% | |
| Molina Healthcare | 25.58% | 26.22% | 25.14% | 24.83% | 25.14% | 26.14% | **met** | 0.02% | |

| % of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/ not met | % change from Q1 2024 | Threshold: **5%** |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 4.96% | 5.02% | 5.06% | 5.04% | 5.24% | 5.25% | **met** | 0.06% | |
| CountyCare Health Plan | 12.94% | 13.14% | 12.63% | 12.58% | 12.49% | 12.32% | **met** | -0.05% | |
| Aetna (IliniCare Health) | 6.39% | 6.59% | 6.45% | 6.49% | 6.73% | 7.00% | **met** | 0.10% | |
| Meridian Health Plan | 5.10% | 5.01% | 5.00% | 5.02% | 5.08% | 5.03% | **met** | -0.01% | |
| Molina Healthcare | 8.24% | 7.88% | 7.84% | 7.42% | 7.81% | 8.20% | **met** | 0.00% | |

**Aetna Better Health of Illinois:** Aetna employs a comprehensive, clinically informed approach to risk stratification, leveraging multiple modalities including predictive modeling, health risk assessments, referrals, and clinical judgment. This framework allows for early identification and targeted support of high-risk members, with particular attention to social determinants of health that may impact engagement and outcomes. Aetna consistently meets or exceeds the risk stratification targets set by the Illinois Department of Healthcare and Family Services (HFS) across all product lines. This success is driven by rigorous oversight, continuous performance monitoring, and the integration of advanced data analytics. By aligning member needs with the appropriate level of care, Aetna ensures timely, person-centered interventions—for example, assigning a maternity-trained behavioral health clinician to a pregnant member with substance use disorder needs, with nursing consultation available as needed, or assigning a nurse directly to cases with high physical health complexity. This dynamic, needs-based assignment model enhances care coordination and improves health outcomes across diverse populations.

**Meridian:** For Q1 and Q2 2025, Meridian has consistently met expectations regarding High and Moderate Risk Stratification for Seniors and Persons with Disabilities. Recent enhancements to our predictive modeling tool are anticipated to expand the identification of at-risk populations, enabling us to extend care management services to more members

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/ not met | % change from Q1 2024 | Threshold: **90%** |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 90.81% | 89.79% | 90.26% | 90.32% | 90.32% | 90.48% | **met** | 0.00% | |
| CountyCare Health Plan | 96.63% | 96.35% | 96.38% | 96.54% | 96.21% | 96.36% | **met** | 0.00% | |
| Aetna (IliniCare Health) | 98.38% | 99.10% | 98.95% | 99.24% | 98.83% | 99.07% | **met** | 0.01% | |
| Meridian Health Plan | 90.04% | 90.04% | 90.03% | 90.11% | 90.02% | 90.03% | **met** | 0.00% | |
| Molina Healthcare | 94.81% | 94.35% | 94.33% | 94.46% | 93.45% | 93.88% | **met** | -0.01% | |
| % of Enrollees (Dual Eligible Adults) identified as High Risk (level 3) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | Threshold: **20%** |
| Blue Cross Community Health Plan | 20.63% | 19.99% | 20.14% | 20.22% | 20.18% | 20.11% | **met** | -0.03% | |
| CountyCare Health Plan | 24.06% | 23.90% | 23.95% | 23.95% | 23.19% | 22.51% | **met** | -0.06% | |
| Aetna (IliniCare Health) | 20.88% | 21.45% | 22.73% | 23.84% | 24.23% | 24.89% | **met** | 0.19% | |
| Meridian Health Plan | 20.02% | 20.02% | 20.02% | 20.03% | 20.00% | 20.01% | **met** | 0.00% | |
| Molina Healthcare | 20.13% | 17.47% | 22.40% | 21.13% | 19.43% | 19.65% | **not met** | -0.02% | |

**Meridian:** For Q1 and Q2 2025, Meridian continues to meet expectations regarding High and Moderate Risk Stratification for Dual Eligible Adults. Meridian will continue to conduct QI regularly on all systems, processes and care management workforce to ensure this metric continues to meet and exceed expectations.

**Molina:** This is completed manually through review with each member. This was missed slightly for Q1 and Q2. We will work with the care coordinators to ensure ongoing appropriate risk stratification of their members.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/ not met | % change from Q1 2024 | Threshold: **2%** |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 2.04% | 1.99% | 2.08% | 2.04% | 2.05% | 2.00% | **met** | -0.02% | |
| CountyCare Health Plan | 2.14% | 2.14% | 1.80% | 1.73% | 1.72% | 1.80% | **not met** | -0.16% | |
| Aetna (IliniCare Health) | 2.01% | 2.08% | 2.39% | 2.10% | 2.27% | 2.85% | **met** | 0.42% | |
| Meridian Health Plan | 2.37% | 2.05% | 2.04% | 2.06% | 2.33% | 2.25% | **met** | -0.05% | |
| Molina Healthcare | 3.89% | 3.86% | 3.24% | 3.39% | 3.33% | 3.48% | **met** | -0.11% | |

**CountyCare:** The decrease in Q3 2024 is attributed to an influx of immigrant children that increased the denominator. CountyCare's strategy for correction is to continue to utilize our multilingual staff for assignment of these cases. CountyCare's internal metrics show this percentage is trending upwards, currently averaging 1.9% and we anticipate meeting the target within the next quarter.

**Meridian:** For Q1 and Q2 2025**,** Meridian continues to meet expectations regarding High and Moderate Risk Stratification for Families and Children. Enhancements to predictive modeling algorithms have successfully identified additional members eligible for care management services. Meridian remains committed to ongoing improvements throughout the remainder of 2025, with continued focus on accurately identifying all members within this population who would benefit from care management support.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/ not met | % change from Q1 2024 | Threshold: **2%** |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 2.11% | 2.15% | 2.13% | 2.09% | 2.10% | 2.17% | **met** | 0.03% | |
| CountyCare Health Plan | 3.93% | 3.96% | 3.67% | 3.52% | 3.57% | 3.53% | **met** | -0.10% | |
| Aetna (IliniCare Health) | 2.09% | 2.16% | 2.16% | 2.44% | 2.50% | 2.48% | **met** | 0.19% | |
| Meridian Health Plan | 2.26% | 2.00% | 2.00% | 2.00% | 2.30% | 2.26% | **met** | 0.00% | |
| Molina Healthcare | 3.63% | 4.01% | 3.61% | 3.67% | 3.58% | 3.79% | **met** | 0.04% | |

**Meridian:** For Q1 and Q2 2025, Meridian continues to meet expectations regarding High and Moderate Risk Stratification for members in the ACA population. Enhancements to predictive modeling algorithms have successfully identified additional members eligible for care management services. Meridian remains committed to ongoing improvements throughout the remainder of 2025, with continued focus on accurately identifying all members within this population who would benefit from care management support.

## 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 | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | Threshold: **Effective 01/01/22** 60% |
| 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 2024 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.

| % **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | Threshold: |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 40.03% | 42.01% | 50.77% | 52.97% | 51.47% | 52.97% | not met | 0.32% | **Effective 01/01/22** |
| CountyCare Health Plan | 56.06% | 56.74% | 59.33% | 59.39% | 57.69% | 57.82% | not met | 0.03% | |
| Aetna (IliniCare Health) | 57.19% | 56.56% | 53.26% | 48.03% | 49.52% | 78.47% | met | 0.37% | 60% |
| Meridian Health Plan | 80.35% | 83.79% | 81.57% | 88.02% | 93.31% | 76.08% | met | -0.05% | |
| Molina Healthcare | 71.80% | 70.59% | 70.03% | 73.14% | 71.59% | 69.81% | met | -0.03% | |

**Aetna Better Health of Illinois:** ABHIL has made significant strides in enhancing member engagement, reflected in our marked increase in IPOC completion rates—from **49.52% to 78.47%**. This progress is driven by a multi-pronged strategy that deepens our community footprint and strengthens provider collaboration. Accelerators to improve IPOC completion rates include: reinforcing training for teams to enhance their skills and productivity; engagement with our Healthcare Transformation Collaborative (HTCs) partners; embedding our clinical workforce in our value-based provider offices; and deploying ADT and pharmacy data to bolster our member demographic data.

**Blue Cross Blue Shield of Illinois:** Performance has increased quarter over quarter since Q1 2024. Ongoing improvement of member engagement demonstrated by timely IPOC completions for newly moderate risk membership is a key focus area in order to facilitate improved health outcomes as changes in condition occur. BCBSIL is enhancing program oversight through individual staff and programmatic dashboards demonstrating more real-time status of IPOC completions.

**CountyCare:** CountyCare Health Plan has deployed multiple strategies for outreach in the 2nd quarter of 2025 to meet the 60% threshold. This includes implementation of a detailed system for identification of members who fall into the specification for outreach versus other types of member contacts.

**Meridian:** For Q1 and Q2 2025, Meridian continues to meet expectations in completing Individualized Care Plans for Moderate Risk members. Meridian remains committed to ongoing improvements throughout the remainder of 2025, with continued focus on increasing member engagement.

## 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 | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | Threshold: **Effective 01/01/22** |
| Blue Cross Community Health Plan | 85.17% | 82.28% | 82.41% | 78.82% | 77.94% | 81.40% | **not met** | -0.04% | |
| CountyCare Health Plan | 86.17% | 86.04% | 84.02% | 86.89% | 87.13% | 89.61% | **not met** | 0.04% | |
| Aetna (IliniCare Health) | 80.90% | 82.17% | 78.93% | 82.73% | 84.78% | 83.93% | **not met** | 0.04% | 90% |
| Meridian Health Plan | 86.01% | 87.75% | 90.23% | 92.25% | 94.22% | 94.04% | **met** | 0.09% | |
| Molina Healthcare | 62.31% | 61.89% | 60.80% | 61.20% | 58.62% | 57.03% | **not met** | -0.08% | |

**Aetna Better Health of Illinois:** Recognizing that newly eligible 15-day waiver members often enter without existing services in place, Aetna continues to prioritize robust onboarding efforts to ensure timely engagement. To strengthen these efforts, we've recently introduced an additional layer of administrative support focused on provider oversight. While progress has been made, member-related delays remain the primary barrier to timely onboarding. To address this, we've enhanced our monitoring capabilities through dashboard optimization and improved reporting infrastructure. Our lag reporting tool remains a critical asset, offering retrospective insights that help identify trends and drive continuous improvement. Additionally, Aetna conducts a thorough review of every missed onboarding opportunity to better understand root causes and refine our approach.

**Blue Cross Blue Shield of Illinois:** Supporting person-centered planning principles, care coordinators document valid justification to evidence member preferences, such as when a member requests to complete service plan after the due date. We continue to focus on initial engagement through our dedicated staff who engage newly eligible waiver membership.

**CountyCare:** CountyCare continues to demonstrate quarter-over-quarter improvement on this metric. We train our care coordinators quarterly on the newly waiver eligible member requirements and expectations and are tightly monitoring these members to meet the 90% threshold.

**Meridian:** For Q1 and Q2 2025, Meridian consistently met threshold expectations for Service Plans for HCBS members. This achievement reflects the strength of Meridian's processes, people, and systems, positioning the organization as a best-in-class performer in this measure. Meridian remains committed to continuous quality improvement and will implement enhancements as needed to maintain and exceed performance standards.

**Molina:** We are providing ongoing review and support to ensure the 15-day service plan is completed in a timely manner as members request to schedule the initial assessments outside of the 15-day service window. We will continue to work with each individual CM to provide the education needed for our members to ensure they are meeting with us within the 15-day timeframe as we work to schedule these visits in a timely manner.

## Grievance and Appeals:

### Resolution of Grievances:

Health plans are required to adjudicate grievances in a timely fashion. They report on the percentage of grievances resolved in less than or equal to 90 days. Nearly all grievances across the industry are resolved within 90 days.

| % of Grievances **resolved** in less than or equal to 90 days | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Trend | % change from Q1 2024 | Threshold: |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 99.89% | 99.98% | 100.00% | 100.00% | 100.00% | 99.86% | no change | 0.00% | **TBD** |
| CountyCare Health Plan | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.00% | |
| Aetna (IliniCare Health) | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.00% | |
| Meridian Health Plan | 99.29% | 99.50% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.01% | |
| Molina Healthcare | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.00% | |

**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:** Our plan consistently meets the required timeframe for grievance resolution, maintaining positive trends.

**Meridian:** Meridian continues to maintain exemplary performance regarding timely resolution of grievances. 100% of grievances for Q1 and Q2 2025 were resolved within 90 days. The average turnaround time was 47 days, 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:** By refining our Quality Assurance (QA) review process, we've greatly improved grievance resolution quality, boosted response accuracy, and shortened turnaround times. We have consistently resolved grievances within the 90-day benchmark, achieving a 100% performance rate. From January to June, average resolution time decreased to 14 days, with a year-to-date average of 17 days—well below our 90-day target. These results demonstrate the effectiveness of our new approach and our commitment to ongoing improvement.

## 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 non-Expedited **resolved** in less than or equal to 15 business days | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Trend | % change from Q1 2024 | Threshold: |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 97.58% | 97.82% | 98.90% | 98.41% | 99.49% | 99.38% | increasing | 0.02% | **TBD** |
| CountyCare Health Plan | 95.97% | 99.57% | 100.00% | 99.81% | 96.43% | 100.00% | increasing | 0.04% | |
| Aetna (IliniCare Health) | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.00% | |
| Meridian Health Plan | 99.71% | 100.00% | 100.00% | 99.93% | 99.89% | 99.81% | no change | 0.00% | |
| Molina Healthcare | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | 100.00% | no change | 0.00% | |

**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:** Our plan consistently meets the required timeframe for non-Expedited Appeal resolution, maintaining positive trends.

**Meridian:** Meridian continued to resolve non-expedited appeals at over 99% timely in Q1 and Q2. Our consistent performance is attributed to ongoing, frequent refresher training sessions and continued close oversight of inventory through reporting enhancements. Meridian expects to maintain performance into Q3 and beyond.

**Molina:** Molina has made enhancements to our appeals resolution process, including setting an internal goal of seven business days for standard appeals. Appeals are routed for clinical review within three business days, helping us meet deadlines efficiently. Our system sets routing due dates and notifies clinical and Appeals & Grievances staff to keep the process coordinated and timely. From January to June, average resolution time was 7 business days, with the year-to-date average at 8—well below the 15-day threshold—showing our commitment to prompt issue resolution and exceeding performance targets.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Trend | % change from Q1 2024 | Threshold: |
|---|---|---|---|---|---|---|---|---|---|
| Blue Cross Community Health Plan | 85.76% | 83.55% | 83.94% | 83.42% | 84.24% | 84.74% | decreasing | -0.01% | **TBD** |
| CountyCare Health Plan | 95.55% | 95.22% | 93.90% | 94.03% | 92.80% | 79.10% | decreasing | -0.17% | |
| Aetna (IliniCare Health) | 89.61% | 88.46% | 89.69% | 90.24% | 88.61% | 81.99% | decreasing | -0.09% | |
| Meridian Health Plan | 77.31% | 78.13% | 77.52% | 78.92% | 78.22% | 86.60% | increasing | 0.12% | |
| Molina Healthcare | 89.30% | 92.35% | 92.48% | 92.70% | 93.33% | 93.26% | increasing | 0.04% | |

**Aetna Better Health of Illinois:** Aetna continually evaluates prior authorizations (PA) to enhance efficiency and drive industry best practices across Utilization Management (UM) activities. For Q2 2025, Aetna reports a lower Imaging % Approved rate driving the overall % of total Approved rate decrease, which our delegated vendor EviCore describes as a trend that will likely remain in future periods.

**Blue Cross Blue Shield of Illinois:** Our plan consistently achieves high approval percentages for prioritization request quarter over quarter.

**CountyCare:** CountyCare partnered with **Evolent** (formerly **National Imaging Associates, Inc.**) to implement prior authorization (PA) changes effective **March 1, 2025**. The PA process now occurs in a separate system that was not included in the data transmitted to the **Illinois Department of Healthcare and Family Services (HFS)**. As a result, the **lower approval rate of 79%** reflected in the **Q2 2025** data is due to incomplete data capture rather than performance concerns. We are currently compiling the full dataset and will submit the updated information once the process is complete.

**The prior authorization changes include the following service categories:**

- Physical Therapy Services
- Occupational Therapy Services
- Speech Therapy Services
- Musculoskeletal (MSK) Surgery
- Interventional Pain Management
- CT/CTA
- MRI/MRA
- PET Scan
- MUGA Scan
- Nuclear Stress Test
- Echocardiograph

**Meridian:** Meridian continually evaluates codes and procedures to determine whether prior authorization (PA) can be retired based on approval volumes. Meridian uses PA to ensure members are receiving care consistent with clinical best practices and to identify members who may be newly in need of care coordination services. Providers are encouraged to use Availity to enhance two-way communication about their PA requests. Meridian noticed continued increases in approval rates from Q1 to Q2 2025 along with corresponding continuing decreases in denial rates during the same time period.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Trend | % change from Q1 2024 | Threshold: |
| Blue Cross Community Health Plan | 99.48% | 99.38% | 99.61% | 99.73% | 99.77% | 99.78% | no change | 0.00% | **TBD** |
| CountyCare Health Plan | 99.48% | 98.64% | 99.04% | 98.43% | 96.53% | 99.43% | no change | 0.00% | |
| Aetna (IliniCare Health) | 95.92% | 96.03% | 94.91% | 95.36% | 94.47% | 94.55% | no change | -0.01% | |
| Meridian Health Plan | 93.33% | 94.44% | 91.67% | 90.63% | 90.16% | 96.40% | increasing | 0.03% | |
| Molina Healthcare | 88.97% | 92.83% | 97.20% | 95.48% | 93.15% | 94.12% | increasing | 0.06% | |

**Aetna Better Health of Illinois:** Aetna meets the industry average on approvals for Behavioral Health (BH) services; Aetna does not require Pre-Service review for members seeking outpatient BH care.

**Meridian**: A select number of Behavioral Health (BH) outpatient services undergo prior authorization (PA) review to ensure there is adequate capacity for members stepping down from acute care and assurance that members are receiving services at the right place and time. These services are reviewed frequently to ensure Meridian is effectively managing the levels of care most utilized and needed for our members requiring BH. PA also serves as a conduit to care coordination for our members. Our Utilization Management (UM) team collaborates closely with Care Management (CM). It is through the PA process that members are identified and discussed in UM/CM rounds to ensure care coordination occurs. Meridian notes' trends for Q1 to Q2 show an increase in approvals and corresponding decrease in denial rates.

## 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**<br>**Data Source: HFS Provider Complaint Portal.** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| # of disputes **(per 1,000 Member Months)** | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | Trend | % change from Q1 2024 | Threshold: |
| Blue Cross Community Health Plan | 0.06 | 0.03 | 0.04 | 0.04 | 0.03 | 0.04 | decreasing | -0.33% | **TBD** |
| CountyCare Health Plan | 0.06 | 0.06 | 0.05 | 0.06 | 0.05 | 0.04 | decreasing | -0.33% | |
| Aetna (IliniCare Health) | 0.15 | 0.16 | 0.14 | 0.12 | 0.12 | 0.09 | decreasing | -0.40% | |
| Meridian Health Plan | 0.10 | 0.07 | 0.08 | 0.09 | 0.06 | 0.05 | decreasing | -0.50% | |
| Molina Healthcare | 0.14 | 0.12 | 0.11 | 0.10 | 0.08 | 0.05 | decreasing | -0.64% | |

**Aetna Better Health of Illinois:** Aetna's HealthChoice Illinois disputes per thousand member months have decreased from Q1 2025 to Q2 2025 from .09 to .05. Overall dispute numbers have continued to decrease month over month with a 35% overall decrease from Q1-Q2 2024 to Q1-Q2 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. Aetna has deployed system automations to enhance payment accuracy and resolution of key volume drivers, including Share of Cost reconciliation and authorization disputes which will help reduce the number of provider disputes.

**CountyCare:** For Q1 and Q2 2025 CountyCare saw a decrease in number of provider complaints per 1,000 members in both quarters. Updates to our elective delivery policy were made with feedback from IHA and participating hospitals contributed to this decrease. Additionally, CountyCare analyzes all claim denials on a weekly basis and proactively addresses any adjudication issues identified, without action from providers. To improve communication 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 to the HFS portal level. Through proactive provider communication and addressing known issues for all impacted claims, CountyCare expects to maintain complaint numbers well below the industry average.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | |
| Blue Cross Community Health Plan | 96.68% | 96.92% | 92.42% | 96.77% | 95.97% | 97.48% | **met** | 0.01% | Threshold: **80%** in 30 seconds or less |
| CountyCare Health Plan | 86.02% | 74.34% | 69.55% | 91.50% | 93.88% | 92.82% | **met** | 0.08% | |
| Aetna (IlliniCare Health) | 89.25% | 89.26% | 85.65% | 89.41% | 90.80% | 92.39% | **met** | 0.04% | |
| Meridian Health Plan | 95.89% | 95.92% | 85.78% | 88.74% | 92.21% | 95.27% | **met** | -0.01% | |
| Molina Healthcare | 91.09% | 94.81% | 90.60% | 88.90% | 85.58% | 94.33% | **met** | 0.04% | |

**Aetna Better Health of Illinois:** Aetna continues to exceed service level thresholds. The Aetna call center 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.

**Meridian:** Meridian continues to exceed service level thresholds with strong performance in Q1 and Q2 2025. This year, a priority is recruiting bilingual agents to meet the needs of bilingual members.

**Molina:** Molina Healthcare is fully staffed and prepared to answer all incoming member and provider calls timely. We continue to see our quarterly service levels exceed the required level. We monitor our call queues in “real time” and utilize a detailed forecasting model to ensure we are prepared for any fluctuations to call volume.

## 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) | Q1 2024 | Q2 2024 | Q3 2024 | Q4 2024 | Q1 2025 | Q2 2025 | met/not met | % change from Q1 2024 | Threshold: **5%** or less |
| Blue Cross Community Health Plan | 0.69% | 0.62% | 0.91% | 0.36% | 0.57% | 0.53% | **met** | -0.23% | |
| CountyCare Health Plan | 1.60% | 3.50% | 2.89% | 0.87% | 0.35% | 0.57% | **met** | -0.64% | |
| Aetna (IliniCare Health) | 1.21% | 1.37% | 1.55% | 1.10% | 0.90% | 0.95% | **met** | -0.21% | |
| Meridian Health Plan | 1.20% | 1.28% | 2.44% | 2.01% | 1.72% | 1.17% | **met** | -0.03% | |
| Molina Healthcare | 0.50% | 0.52% | 1.22% | 1.27% | 1.39% | 0.50% | **met** | 0.00% | |

**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.

**Meridian:** Meridian's Contact Center has continued to meet all required metrics for Q1 and Q2 of 2025. Meridian partners with our Workforce Management team to assess appropriate staffing at a weekly cadence.

**Molina:** Molina monitors call abandonment rate in real time and makes adjustments to staffing (work schedules, lunches, breaks, etc.) to ensure we have adequate support in the queue to minimize any abandoned calls. We continue to see positive results in this area.

## 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 Continuingly, 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.