Q2 2022 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. All thresholds and requirements reflected here were developed based on best practices nationally as well as 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. The target for plans to meet most of the thresholds is January 1, 2023.

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

Care Coordination:

New Enrollee Screening & Assessments:

Health Plans contact 100% of members to complete a Health Risk Screenings and Health Risk Assessment. 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. To vigorously promote care coordination, this threshold was set higher than the industry average, which is a 56% completion rate within 60 days. Also, it should be noted that HRSs and HRAs are not completed for members in the fee for service program. This is a service available only through managed care.

Care Coordination: New Enrollee Screening and Assessments										
% of new Enrollees with a health risk assessment or a health risk screening within 60 days of enrollment ***Changed as of 12/2021-The metric now only looks at screening status as of 2 months after enrollment.**	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	38.12%	42.73%	47.69%	48.11%	47.71%	64.71%	63.90%	not met	68%	**70%**
CountyCare Health Plan	51.71%	42.71%	35.50%	32.49%	31.04%	27.29%	37.54%	not met	-27%	
Aetna (IlliniCare Health)	47.36%	42.54%	37.78%	41.92%	43.92%	45.35%	36.04%	not met	-24%	
Meridian Health Plan	52.30%	52.58%	50.73%	44.69%	37.60%	49.55%	67.29%	not met	29%	
Molina Healthcare	43.64%	35.88%	45.00%	52.53%	66.32%	39.07%	42.84%	not met	-2%	
YouthCare (Meridian Health Plan)		53.15%	38.08%	39.33%	22.42%	58.63%	86.53%	met	N/A	

Aetna Better Health of Illinois: HRS completion rates deteriorated in Q2 2022 primarily due to vendor restructuring; the Aetna team rebounded in August 2022 and continues to meet/surpass our previous level of performance. Additionally, Aetna is performing a deep dive analysis of reporting of all our HRS contributing workstreams.

BCBSIL: BCBSIL is trending towards the performance target of 70% of new enrollees to have a health risk assessment or a health risk screening completed within 60 days of enrollment. Our significant improvement in 2022 is a result of bringing on dedicated staff, extending work hours to conduct outreach at more convenient time for members, and quarterly refresher training for staff on contract requirements. BCBSIL is currently evaluating the addition of social risks scores within the overall risk model to better address social determinants of health.

CountyCare: CountyCare has implemented a multi-channel approach to improve member engagement resulting in a noted increase of health risk screening (HRS) rate month over month May, June, and July ending with 39%, 40%, and 45% rates, respectively. Though there has been an incremental trend upward between Q1 and Q2 2022, CountyCare recognizes the need for ongoing improvement to the number of

members receiving their HRS. As part of its multi-channel strategy, CountyCare has invested in an increase in staff to support HRS completion, increased the number of members that receive the health risk screening by text message, begun HRS completion during the welcome call, and mailed paper health risk screenings to new members.

Meridian: Meridian continues to increase the number of members who complete a Health Risk Screening (HRS) within 60 days of new member enrollment. The plan has implemented improvements and innovations to existing processes in efforts to meet and exceed HFS' target. Strong relationships with Business Enterprise Program (BEP) certified vendors, exploration of provider partnerships, improved tracking tools, and maintained level of urgency will improve Meridian's HRS completion rates. Our efforts have greatly impacted our Q2 2022 HRS/HRA completion rate.

Molina: Molina was the performance leader in Q4 2021 for New Enrollee Health Risk Screening and Assessments completed within 60 days of enrollment, but changes in outreach staffing and systems had a temporary, predicted impact in early 2022. As new systems were emplaced, Molina enhanced its outreach efforts and modalities and began to see an increase in performance in 2022 that it expects to continue for the remainder of the year. Initial screening is only one way that Molina identifies the needs of incoming members. For all members, Molina applies predictive modeling tools based on historical medical claims and other factors to identify its most at-risk members, and it focuses outreach and interventions on those members. Molina also outreaches to members who have been hospitalized, and it works closely with providers who send referrals for case management.

YouthCare: YouthCare has made significant improvements in conducting health risk screenings of new enrollees within 60 days of enrollment in 2022. The YouthCare team has put leadership and processes in place that result in connecting quicker and more regularly with each young person and family to complete the HRS. By Q2 2022, YouthCare is far exceeding the 70% goal.

Risk Stratification: Overview

HFS requires risk stratification to help ensure that care strategies take into account differing needs. HFS requires that 20% of a plan's senior members and members with disabilities be identified as moderate or high risk. Further, HFS requires that 5% of seniors and people with disabilities be categorized as high risk. When a customer is stratified 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 need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. It is worth noting that there may be fluctuation of members stratified as high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

Enrollee Engagement: Risk Stratification										
% of Enrollees (Seniors or Person with Disabilities) identified as Moderate (level 2) or High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	21.08%	20.36%	20.42%	20.47%	20.38%	20.51%	20.83%	met	-1%	**20%**
CountyCare Health Plan	31.29%	32.51%	30.96%	30.96%	26.59%	25.59%	24.99%	met	-20%	
Aetna (IlliniCare Health)	22.64%	25.21%	26.91%	27.85%	27.83%	27.82%	28.54%	met	26%	
Meridian Health Plan	25.91%	26.40%	22.83%	20.85%	20.00%	19.98%	20.02%	met	-23%	
Molina Healthcare	22.02%	22.57%	21.69%	24.75%	24.82%	29.90%	28.00%	met	27%	
% of Enrollees (Seniors or Person with Disabilities) identified as High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	5.72%	5.29%	5.29%	5.09%	5.12%	5.30%	5.61%	met	-2%	**5%**
CountyCare Health Plan	15.04%	16.76%	15.51%	15.51%	12.55%	11.94%	12.92%	met	-14%	
Aetna (IlliniCare Health)	5.22%	5.03%	5.15%	5.37%	5.21%	5.04%	5.45%	met	4%	
Meridian Health Plan	5.63%	6.13%	5.55%	5.21%	5.00%	5.00%	5.00%	met	-11%	
Molina Healthcare	11.08%	10.83%	12.30%	10.41%	10.20%	16.32%	7.03%	met	-37%	

Aetna Better Health of Illinois: Aetna continues to meet/exceed the risk stratification targets as established by HFS, leveraging multiple referral streams in the identification of our highest need members.

CountyCare: CountyCare continues to monitor the risk stratification algorithm and meet/exceed targets as established by HFS.

Meridian: Meridian understands that timely and accurate identification of at-risk populations is paramount to assure members with the highest needs are prioritized appropriately for outreach, assessment, and care planning. We continue to review our processes for risk stratification and have met the goal of 20% for Seniors or Person with Disabilities identified as Moderate or High for Q2 2022.

Risk Stratification Dual Eligible:

HFS requires that 90% of dual eligible adults be identified as moderate or high risk. Further, HFS requires that 20% of dual eligible members be categorized as high risk. Risk stratification is based on predictive modeling algorithms and manual clinical review that consult medical history as well as other data, to assess member need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high or moderate risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (Dual Eligible Adults) identified as Moderate (level 2) or High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	91.01%	89.01%	91.85%	90.23%	90.54%	89.62%	90.31%	met	-1%	**90%**
CountyCare Health Plan	96.14%	95.18%	93.74%	93.74%	90.72%	88.38%	89.78%	not met	-7%	
Aetna (IlliniCare Health)	93.02%	98.60%	99.30%	99.47%	99.33%	99.28%	96.13%	met	3%	
Meridian Health Plan	90.00%	90.33%	90.07%	90.08%	90.01%	90.01%	90.02%	met	0%	
Molina Healthcare	86.28%	91.31%	92.54%	94.61%	95.37%	93.13%	92.06%	met	7%	

% of Enrollees (Dual Eligible Adults) identified as High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	20.58%	19.64%	20.47%	20.04%	20.00%	19.87%	20.06%	met	-3%	**20%**
CountyCare Health Plan	21.50%	21.60%	20.24%	20.24%	20.61%	19.80%	21.16%	met	-2%	
Aetna (IlliniCare Health)	18.51%	16.18%	21.81%	21.84%	21.22%	21.12%	20.09%	met	9%	
Meridian Health Plan	20.00%	20.00%	20.00%	20.08%	20.00%	20.00%	20.01%	met	0%	
Molina Healthcare	38.08%	37.61%	30.08%	30.15%	24.87%	24.88%	46.89%	met	23%	

CountyCare: CountyCare successfully adjusted risk scoring to reach the required thresholds for Q3 2022. These new practices have supported this effort and will be integrated in standard practice in response to fluctuations in risk levels.

Risk Stratification Families & Children:

HFS requires that 2% of enrollees within the family and children eligibility category be identified as high risk. Risk stratification is based on predictive modeling algorithms and manual clinical review that consult medical history as well as other data, to assess member need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (Families and Children) identified as High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	2.07%	2.06%	2.11%	2.06%	2.05%	2.04%	2.03%	met	-2%	**2%**
CountyCare Health Plan	1.49%	1.41%	1.25%	1.25%	1.12%	1.03%	1.60%	not met	7%	
Aetna (IlliniCare Health)	2.02%	0.97%	1.17%	2.05%	2.18%	2.00%	1.99%	not met	-1%	
Meridian Health Plan	2.01%	2.02%	1.94%	2.00%	2.00%	2.03%	2.14%	met	6%	
Molina Healthcare	2.12%	2.14%	1.91%	2.56%	2.71%	3.08%	2.87%	met	35%	

Aetna Better Health of Illinois: Aetna has examined and expanded its member identification acuity workflows to ensure attainment of performance on this metric.

CountyCare: CountyCare successfully adjusted risk scoring to reach the required thresholds for Q3 2022. These new practices have supported this effort and will be integrated in standard practice in response to fluctuations in risk levels.

Risk Stratification ACA adults:

HFS requires that 2% of ACA eligible adults be identified as high risk. Risk stratification is based on predictive modeling algorithms and manual clinical review that consult medical history as well as other data, to assess member need across several domains, including clinical acuity, social determinants of health need, and personal health engagement. When a member is stratified as high risk, they are enrolled in specific care coordination programs. It is worth noting that there may be fluctuation of members stratified as high or moderate risk due to membership changes and not necessarily changes to a health plan's policy.

% of Enrollees (ACA Adult) identified as High Risk (level 3)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	2.18%	2.18%	2.24%	2.22%	2.16%	2.14%	2.15%	met	-1%	**2%**
CountyCare Health Plan	4.83%	5.63%	4.85%	4.85%	3.71%	3.40%	3.28%	met	-32%	
Aetna (IlliniCare Health)	2.02%	1.47%	1.77%	2.07%	2.25%	2.21%	2.12%	met	5%	
Meridian Health Plan	2.08%	2.04%	2.00%	2.00%	2.00%	2.00%	2.03%	met	-2%	
Molina Healthcare	2.72%	2.90%	2.73%	2.97%	2.99%	3.17%	2.96%	met	9%	

Meridian: Meridian continues to meet HFS' expectations for identifying, categorizing and care managing ACA Adult populations. Meridian recognizes timely and accurate identification of at-risk populations is the first important step towards outreach, assessment, and care planning. The integration of Centene systems and platforms includes a robust stratification process which pulls data from over 200 sources including but not limited to: Demographics, Race, Claims, SDOH indicators, assessments, to identify risk on an ongoing basis and allows for more effective identification of members in need of Care Management/Coordination.

Care Plan Assessment & Individual Plan of Care High Risk:

HFS requires that high risk enrollees have an individual plan of care completed. Health plans report on the percentage of individual care plans completed within 90 days. Care plans are created with the member to identify the member's medical and other goals and identify ways the member and the health plan can work together to help the member achieve them. The industry average is approximately 47% completion within 90 days.

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 ***New threshold as of 1/1/2022**	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	26.67%	22.86%	25.57%	27.92%	38.95%	35.99%	28.73%	not met	8%	**60%**
CountyCare Health Plan	64.15%	51.86%	42.24%	41.46%	53.24%	50.41%	58.75%	not met	-8%	
Aetna (IlliniCare Health)	80.76%	72.91%	55.07%	73.16%	66.57%	72.18%	78.02%	met	-3%	
Meridian Health Plan	48.26%	51.59%	48.13%	11.69%	32.03%	34.96%	34.81%	not met	-28%	
Molina Healthcare	50.65%	61.45%	44.36%	46.96%	31.77%	35.22%	30.47%	not met	-40%	
YouthCare (Meridian Health Plan)		43.96%	59.64%	53.54%	66.67%	40.72%	51.35%	not met	N/A	

BCBSIL: BCBSIL is continuing to implement strategies to increase the number of individual care plans completed. BCBSIL has seen improvements in member engagement with the utilization of text messaging and gift card incentives. Refresher trainings are occurring quarterly with staff focusing on best practices for outreach and engagement with members.

Meridian: Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

YouthCare: YouthCare continues to make improvements completing Individualized Plans of Care for the Care Management of members identified as High or Complex Risk. Our documented metrics are

measured within 60 days of eligibility rather than at 90 days. YouthCare continues to work with caseworkers and foster families to make the IPOC a priority within all the other priorities in the first 60 days.

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 50% completion within 90 days, and this represents an industry average improvement of 10% in relation to the fourth quarter of 2020.

% **moderate risk** Enrollees with an IPoC completed **within 90 days** after being identified as moderate risk ***New threshold as of 1/1/2022**	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	32.05%	32.87%	49.96%	55.37%	63.46%	61.89%	65.78%	met	105%	**60%**
CountyCare Health Plan	47.55%	41.18%	41.52%	40.86%	43.65%	43.42%	41.10%	not met	-14%	
Aetna (IlliniCare Health)	73.31%	55.47%	63.24%	72.04%	71.54%	66.37%	63.10%	met	-14%	
Meridian Health Plan	47.01%	67.26%	75.42%	58.31%	70.41%	41.65%	40.30%	not met	-14%	
Molina Healthcare	66.98%	76.29%	44.00%	54.49%	45.03%	57.52%	59.57%	not met	-11%	
YouthCare (Meridian Health Plan)		23.94%	25.19%	36.99%	19.57%	29.60%	31.39%	not met	N/A	

CountyCare: Though CountyCare has remained in the same steady range of completing the 60% target, additional remediation plans have been implemented in Quarter 2 2022. Expectation is to see tracking upward in the quarter summary forthcoming.

Meridian: Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

YouthCare: YouthCare revised its internal processes and oversight to ensure completion of the Individual Plans of Care for moderate risk members. This has resulted in steady increases during 2022. Our documented metrics are measured within 60 days of eligibility rather than at 90 days. DCFS caseworkers have many obligations when youth first come into care. YouthCare continues to make the IPOC a priority within all the other priorities of YouthCare and DCFS caseworkers in the first 60 days of Meridian eligibility.

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 76% 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 ***New threshold as of 1/1/2022**	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	81.25%	82.39%	83.88%	86.17%	80.52%	79.58%	81.44%	not met	0%	**90%**
CountyCare Health Plan	82.24%	81.18%	82.84%	80.11%	73.02%	69.61%	73.24%	not met	-11%	
Aetna (IlliniCare Health)	68.85%	55.04%	53.30%	53.10%	53.53%	58.12%	67.96%	not met	-1%	
Meridian Health Plan	77.67%	81.71%	78.51%	67.81%	71.89%	85.61%	86.36%	not met	11%	
Molina Healthcare	66.67%	61.90%	67.43%	60.37%	70.92%	71.92%	71.33%	not met	7%	

Aetna Better Health of Illinois: Aetna has increased its capacity for outreach and engagement via staffing, restructuring and end-to-end operational improvements to ensure compliance with this metric, and all Waiver metrics.

BCBSIL: BCBSIL is continuing to implement strategies to increase the number of service plans in place within 15 days of HCBS waiver eligibility. Refresher trainings are occurring quarterly with staff focusing on best practices for outreach and engagement with members. BCBSIL is also evaluating reporting and tool mechanisms for scheduling and contact outcomes.

CountyCare: CountyCare recognizes the importance of service planning within 15 days for members with new waiver eligibility. April closed at 81%, May at 95% and June at 78%. We continue to work to improve and remain consistent with this measure.

Meridian: Meridian strives to ensure that members have service plans in place within 15 days of eligibility notification. Meridian Care Management has returned to the field effective April 2022, and we expect this metric to increase as we increase our opportunities for member touchpoints.

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	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Trend	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	99.94%	100.00%	100.00%	99.87%	100.00%	100.00%	99.95%	Increasing	0%	**Monitor**
CountyCare Health Plan	99.83%	99.87%	99.13%	99.86%	100.00%	99.55%	99.70%	Decreasing	0%	
Aetna (IlliniCare Health)	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	No Change	0%	
Meridian Health Plan	97.84%	100.00%	100.00%	98.77%	93.41%	100.00%	99.42%	Increasing	2%	
Molina Healthcare	99.96%	99.93%	100.00%	100.00%	99.89%	99.85%	100.00%	Increasing	0%	
YouthCare (Meridian Health Plan)		100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	

Meridian: Meridian implemented improvements to reduce grievance resolution turnaround time. Additionally, Meridian is reviewing root causes for grievances in order to reduce the overall volume and has successfully reduced. The normalized volume of enrollee grievances per 1,000 members remains very low, indicative of a positive enrollee experience with Meridian.

Molina: Molina continues to place a priority on the timely resolution of member grievances, specifically related to pharmacy and access to care related grievances. Molina has established an internal goal of resolving such grievances within one week of receipt. Molina identified these areas as leading indicators to ensure member satisfaction. Molina continually reviews grievances received to identify root causes and trending concerns. This information is shared across departments so that continual improvements can be made, and receipts can be reduced.

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	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Trend	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	98.01%	100.00%	99.30%	96.23%	99.36%	99.39%	99.12%	Increasing	1%	**Monitor**
CountyCare Health Plan	100.00%	99.39%	99.67%	99.16%	90.51%	98.43%	100.00%	No Change	0%	
Aetna (IlliniCare Health)	100.00%	100.00%	99.43%	98.37%	97.22%	100.00%	99.79%	Decreasing	0%	
Meridian Health Plan	99.62%	99.14%	98.93%	90.82%	98.52%	99.84%	100.00%	Increasing	0%	
Molina Healthcare	100.00%	100.00%	100.00%	99.80%	100.00%	100.00%	100.00%	No Change	0%	
YouthCare (Meridian Health Plan)		N/A	100.00%	100.00%	100.00%	100.00%	100.00%	N/A	N/A	

Aetna Better Health of Illinois: The Aetna Appeals team is continuing to identify opportunities to address all appeals timely. Improvement efforts include facilitating more streamlined processes in collaboration with Medical Affairs and Care Management to optimize Turn Around Times (TATs) for appeals requiring additional clinical review. Additionally, the Appeals team is conducting analytics to identify key trends to enable proactive resolution of appeal drivers. Aetna is continuously monitoring the appeals review and resolution process for opportunities to ensure compliance.

Meridian: Meridian identified and implemented opportunities to ensure its appeals are all processed within the allotted time.

Molina: Molina continues to review and resolve standard pre-service appeals in a timely manner. Molina recently implemented an efficiency within our documentation system. This has reduced the amount of manual intake work by having faxed appeals requests move automatically into the system. This allows the team to devote more energy to working with the member and provider to gain the needed clinical information to support the appeal review.

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 86%. Health plans utilize established criteria and medical necessity guidelines when determining clinical appropriateness. Prior authorizations may be denied because the request is missing clinical information and incomplete or the service requested does not meet clinical criteria.

Prior Authorization requests for Medical (non Behavioral Health), Nursing Facility, Rehab, DME, Home Health, Imaging & Pain Management										
% of total **Approved** (all services requested were approved)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Trend	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	82.95%	82.22%	82.60%	83.19%	84.10%	84.46%	83.71%	Increasing	1%	**Monitor**
CountyCare Health Plan	93.19%	92.63%	94.31%	94.79%	94.49%	93.48%	93.88%	Increasing	1%	
Aetna (IlliniCare Health)	83.34%	84.70%	84.64%	84.21%	83.52%	83.31%	78.93%	Decreasing	-5%	
Meridian Health Plan	84.66%	86.06%	82.90%	77.46%	75.57%	84.41%	83.42%	Decreasing	-1%	
Molina Healthcare	82.62%	83.99%	84.71%	84.05%	83.56%	84.17%	88.49%	Increasing	7%	

Aetna Better Health of Illinois: Aetna conducted a deep dive into the Prior Authorization category areas which revealed the greatest increase in denials in the Medical and Imaging categories. It is important to

note that Aetna continues its strong attention to appropriateness of care, as evidenced by the top two denial reasons being: (1) 'Does Not Meet Medical Necessity' at ~88%; (2) 'Not a covered benefit/benefit exhausted' at ~8%.

Meridian: Through its Utilization Management program, Meridian continually strives to ensure that its members are getting the right care, at the right level and at the right time. Meridian is continuing to evaluate and implement strategies and tactics to increase the number of individual care plans completed.

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 96%. 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)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Trend	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	99.57%	99.69%	99.63%	99.79%	99.73%	99.72%	99.66%	Increasing	0%	**Monitor**
CountyCare Health Plan	88.61%	87.80%	89.97%	86.72%	90.76%	89.32%	91.69%	Increasing	3%	
Aetna (IlliniCare Health)	99.66%	98.86%	97.76%	91.13%	95.01%	94.37%	93.20%	Decreasing	-6%	
Meridian Health Plan	100.00%	99.85%	99.68%	100.00%	N/A	98.59%	100.00%	No Change	0%	
Molina Healthcare	95.56%	97.38%	97.27%	98.46%	98.25%	98.30%	95.63%	Increasing	0%	

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. The new HFS provider complaint portal was put in place at the end of Q1 2020, since its implementation all provider complaints have been resolved by the plans within 30 days or receipt.

Provider Disputes/Complaints Portal Summary (Data Source - HFS Provider Resolution Portal)										
# of disputes **(per 1,000 Member Months)**	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	Trend	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	0.01	0.01	0.05	0.10	0.11	0.13	0.09	Increasing	760%	**Monitor**
CountyCare Health Plan	0.02	0.02	0.01	0.02	0.03	0.06	0.04	Increasing	122%	
Aetna (IlliniCare Health)	0.01	0.01	0.08	0.10	0.12	0.15	0.14	Increasing	914%	
Meridian Health Plan	0.01	0.01	0.13	0.16	0.17	0.21	0.16	Increasing	2987%	
Molina Healthcare	0.02	0.01	0.04	0.06	0.05	0.08	0.06	Increasing	169%	

Aetna Better Health of Illinois: The Aetna Claims team has continued to enhance processes to mitigate volume and recurrence of HFS portal escalations throughout 2022. Best practices include proactive provider notices posted upon identification of global issues and sharing information with Provider Experience representatives to transmit directly to providers. Additionally, HFS portal complaints are reviewed by provider and root cause on a recurring basis to identify opportunities for Provider outreach and education, and internal process remediation. Aetna will continue to work towards increasing levels of proactive mitigation to minimize volume of complaints driven to the HFS portal.

Meridian: After migrating claims processing platforms in July 2021, Meridian has worked diligently with providers and internally to reduce the volume of disputes back to pre-migration levels. While Meridian is glad to report the improvement in trend, its goal is to provide an even better and more seamless experience. Meridian meets with providers and trade associations on an ongoing basis to work through specific issues and reviews internal reports to both close disputes and resolve potential issues before they rise to the level of a dispute.

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 91% 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)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	94.08%	95.95%	95.72%	95.91%	97.69%	96.44%	96.46%	met	3%	80% in 30 seconds or less
CountyCare Health Plan	89.61%	86.21%	84.74%	70.13%	85.56%	85.80%	84.75%	met	-5%	
Aetna (IlliniCare Health)	60.72%	90.04%	83.45%	69.03%	92.91%	96.08%	96.85%	met	59%	
Meridian Health Plan	79.55%	92.87%	87.69%	86.46%	88.88%	88.48%	91.73%	met	15%	
Molina Healthcare	83.78%	73.19%	68.28%	79.38%	89.41%	72.90%	84.38%	met	1%	

Molina: Molina is working to leverage provider portal enhancements and self-service features in IVR to give providers enhanced options. To improve future performance, Molina has implemented some programs to improve employee retention and utilized some temporary staff to support through this period. We started to see overall improvement in the 4th Quarter as a result of these efforts.

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. Nearly every Health Plan met the fewer than 5% threshold and the industry average percentage is less than 2% for calls being abandoned.

% of calls abandoned (combined Provider and Enrollee calls)	Q4 2020	Q1 2021	Q2 2021	Q3 2021	Q4 2021	Q1 2022	Q2 2022	met/not met	% change from Q4 2020	Threshold:
Blue Cross Community Health Plan	4.06%	3.57%	1.63%	1.18%	1.00%	1.04%	1.07%	met	-74%	5% or less
CountyCare Health Plan	1.81%	2.24%	2.45%	4.83%	1.90%	2.20%	2.00%	met	10%	
Aetna (IlliniCare Health)	10.92%	1.22%	1.46%	3.33%	0.68%	0.68%	0.60%	met	-95%	
Meridian Health Plan	2.54%	0.71%	1.56%	1.78%	2.04%	3.31%	2.16%	met	-15%	
Molina Healthcare	2.32%	5.75%	7.13%	5.45%	1.08%	12.41%	1.97%	met	-15%	

Molina: Significant improvement in lowering the call abandonment rate in the 4th Quarter as a result of enhanced employee hiring and retention efforts.