Medicaid Managed Care Oversight Commission

10:30 – 12:30 PM, Wednesday Oct. 8th, 2025

Virtual WebEx Meeting

HFS
Illinois Department of
Healthcare and Family Services

I. Call To Order

HFS
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OUR VISION FOR THE FUTURE

We improve lives.

- We address social and structural determinants of health.
- We empower customers to maximize their health and well being.
- We provide consistent, responive service to our colleagues and customers.
- We make equity the foundation of everything we do.

This is possible because:

We value our staff as our greatest asset.

We do this by:

Fully staffing a diverse workforce whose skills and experiences strengthen HFS.

Ensuring all staff and systems work together.

Maintaining a positive workplace where strong teams contribute, grow and stay.

Providing exceptional training programs that develop and support all employees.

We are always improving.

We do this by:

Having specific and measurable goals and using analytics to improve outcomes.

Using technology and interagency collaboration to maximize efficiency and impact.

Learning from successes and failures.

We inspire public confidence.

We do this by:

Using research and analytics to drive policy and shape legislative initiatives.

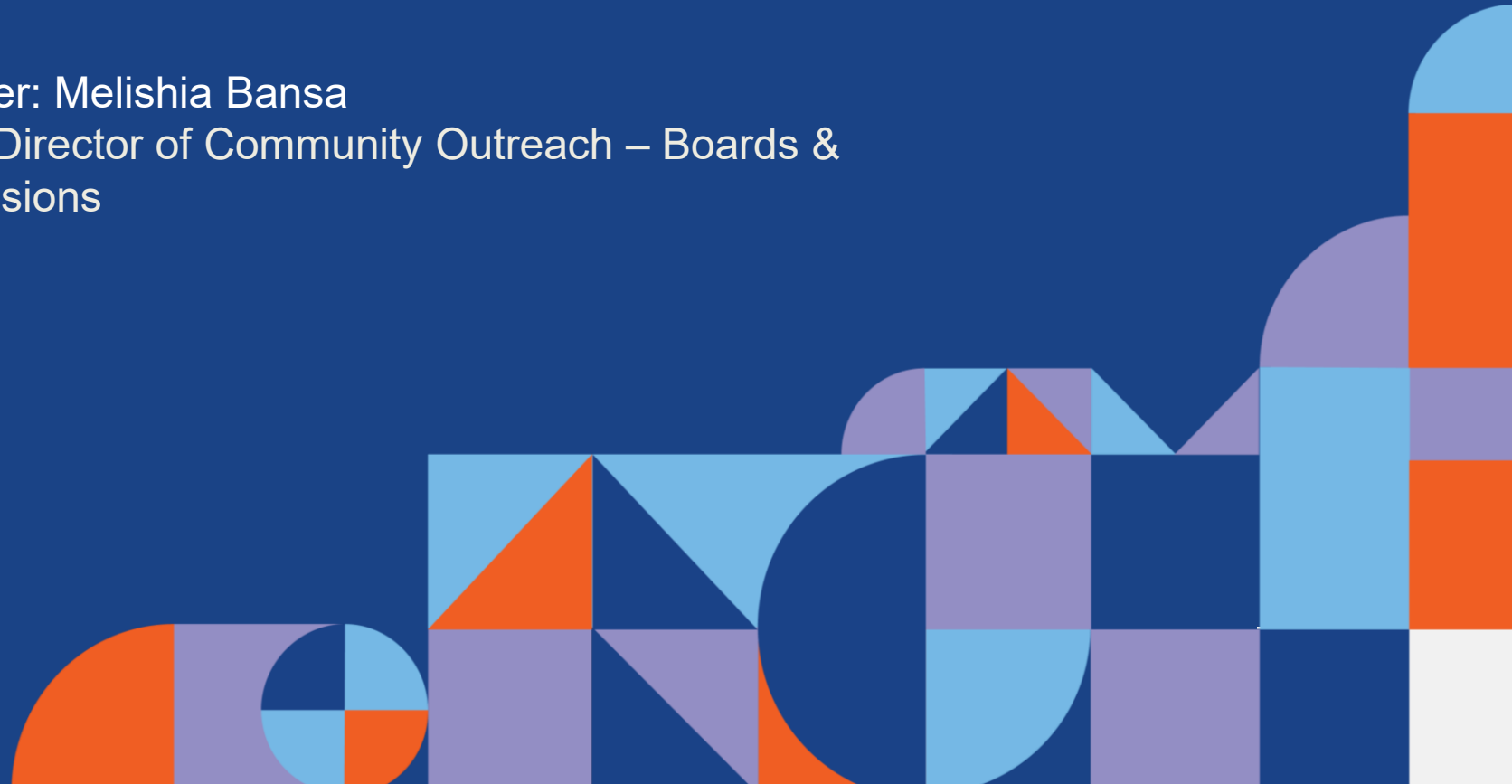
Clearly communicating the impacts of our work.

Being responsible stewards of public resources.

Staying focused on our goals.

II. Welcome by Co Chairs

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions



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General Meeting Operations and Communications

Meeting basics

- Please note, this meeting is being recorded.

  To ensure accurate records, please type your name and organization into the chat.

- If possible, members are asked to attend meetings with their camera's turned on, however, if you call in & need materials, please email HFS.Boards.and.Commissions@illinois.gov as soon as safely possible.

- Please be sure to mute your audio except when speaking.

- Please note that HFS staff may mute participants to minimize any type of disruptive noise or feedback.

General Meeting Operations and Communications

Comments or questions during the meeting

- If you are a Commission member and wish to make a comment or ask a question during the meeting, please use the WebEx feature to raise your hand, contact the host/co-host, or unmute yourself during QA sections facilitated by the Co-Chairs.
- Please state your full name when asking a question or passing a motion.
- If you are a member of the general public and wish to make a comment, please register to make a public comment prior to the meeting. Instructions to make public comments have been provided for you in the public meeting posting located on the MCO Oversight Boards and Commissions webpage.
- If you have a question during the meeting, please utilize the Webex chat feature to send your question directly to the meeting host.

General Meeting Operations and Communications

Meeting basics Cont.

- The Co-Chairs will try to address as many questions as possible during designated sections of the meeting. We recognize that due to the limited allotted time, your questions may not be answered during the meeting, therefore be sure to visit the HFS Webpage for a list of helpful resources. Your questions are important to us and will help inform the development of future presentations and informational materials.
- HFS is committed to hosting meetings that are accessible and ADA compliant. Closed captioning has been made available to you today via the WebEx Platform. Please email HFS.Boards.and.Commissions@illinois.gov in advance to report any requests or accommodations you may require or use the chat to alert me of challenges you may have encountered during the meeting. Patience, please – many meeting attendees may be new to these proceedings.
- Meeting minutes of the prior meeting have been circulated to commission members in advance of today's session. Once approved, they will be posted to the website along with today's MCO Oversight Commission presentation deck.

Summary of Agenda

I. Call to Order

II. Welcome by Co-Chairs

III. Roll Call of Members

IV. Introduction to HFS Staff

V. Review of Meeting Minutes

VI. Healthcare and Family Services Executive Presentations

VII. Discussion

VIII. Public Comments

IX. Additional Business Old & New

X. Adjournment

III. Roll Call of MCO Members

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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Roll Call of MCO Commission Members

Senator Mattie Hunter	Co-Chair
State Representative Camille Lilly	Co-Chair

Anthony (Tony) LoSasso	Joshua Gottlieb
Audrey Tanksley	**Jordan Powell***
Caprice Carthans	Mark Corey
Charles (Matt)Hartman	**Marie Rucker**
Cornetta Levi*	**Matthew Wolf**
David Sharar*	**Nadeen Israel**
Garth Reynolds	Olumide Idowu
Gerald (Jud) DeLoss*	Raul Garza
Jennie Pinkwater*	Sen. Dave Syverson*
Nina Davis*	**Keshonna Lones**
	William Simon

IV. Introduction of HFS Staff & Leadership Comments

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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Introduction of HFS Staff

A. Dana Kelly

Chief of Staff, HFS

B. Melishia Bansa

Deputy Director of Community Engagement

C. Helena Lefkow

Deputy Administrator, Managed Care Performance

D. Keshonna Lones

Bureau Chief, Bureau of Managed Care

E. Aileen Kim

Deputy Chief of Staff

V.

Review of Meeting Minutes

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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VI. Healthcare & Family Services Executive Presentations

Presenter: Keshonna Lones, Bureau of Managed Care

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Point 6

Review data on the effectiveness of claims processing to medical providers

Claims Processing Discussion

- Overview of Contractual Requirements
- Current Oversight Process
- ACE presentation

Overview of Contractual Requirements

Section 5.29 of the HealthChoice IL Medicaid Contracts.

- MCOs are required to make payments to Providers for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A) and 215 ILCS 5/368a.
- MCOs are required to pay:
  - 90% of clean claims within 30 days
  - 99% of clean claims within 90 days
- Complaints or disputes concerning payments for the provision of services shall be subject to the Provider complaint resolution system.

Note: "clean claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party

Current Oversight Process

HFS regularly reviews MCOs claims processing trends.

- Pursuant to Public Act 100-0580, HFS publishes an analysis of hospital claims processing every 6 months.
  - **In Q2 2024, 98% of claims were adjudicated/processed in 0-30 days[1].**
- HFS plans to enhance reporting and transparency on claims processing by using data collected directly through its ACE pipeline project for hospitals and other provider types.
  - Conducted working sessions to walk through logic requirements, testing and validation.

1. 2025 HFS Hospital Claims report

ACE Presentation

Marcela Reyes
IL ACE Program Manager, Optum

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Agenda

1. Introductions
2. What is the ACE Solution?
3. Stakeholders
4. ACE Member Edits Pilot Program
5. Analytics Dashboards
6. Use Cases
7. Q&A

What is ACE?

ACE stands for **Advanced Communication Engine**. It's a system created by Optum to help the State of Illinois manage healthcare claims more efficiently, especially for Medicaid services.

(Illinois Public Aid Code: (305 ILCS 5/5-30.12)

How Does ACE Work?

ACE has **three main parts** that work together:

1. **Smart Claims Gateway (iEDI):**
    - Think of this like a digital mailroom.
    - It receives and sends healthcare claim files between hospitals, doctors, insurance companies, and state systems.
    - It makes sure the right information goes to the right place quickly and securely.
2. **Claim Checking Engine (ACE Engine):**
    - This part checks claims before they are officially processed.
    - It looks for mistakes or missing information and predicts if a claim will be accepted or rejected.
    - If there's a problem, it sends a message back explaining what needs to be fixed.
3. **Reporting Tools (ACE-EDW):**
    - These tools create easy-to-understand reports.
    - They help the state and healthcare providers see how claims are being handled.
    - This helps everyone make better decisions and improve how healthcare payments are managed.

Why Is ACE Important?

- It helps reduce errors and delays in processing healthcare claims.
- It gives hospitals and insurance companies clear feedback so they can fix issues faster.
- It supports better care for patients by making sure providers get paid correctly and on time.

Illinois ACE - High Level

Who Sends the Claims?

Healthcare Providers

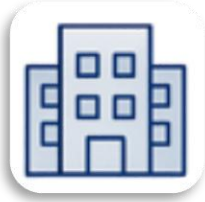
- Doctors
- Hospitals
- Billing Services

Where Do Claims Go First?

Initial Review Centers

- Clearinghouses
- Direct Connection

Who Processes the Claims?



Managed Care Organizations

- Aetna
- BCBS
- County Care
- Meridian
- Molina

What Happens Next?

State of Illinois Systems

Illinois Data Warehouse

Used for tracking and improving healthcare services

Key Stakeholders

State of Illinois, Healthcare and Family Services

- Healthcare & Family Services (HFS)
- Illinois Department of Innovation & Technology (DoIT)
- Office of the Illinois Attorney General
- Office of Medicaid Innovation (OMI)

Hospitals

- Hospitals
- Groups we may incorporate in the future

Managed Care Organizations

- Aetna
- BCBS IL
- CountyCare
- Meridian
- Molina

Clearinghouse

- Availity
- SSI
- Others

Collaborations

- Healthcare & Family Services (HFS)
- Illinois Association of Medicaid Health Plans (IAMHP)
- Illinois Health and Hospital Association (IHA)
- X12 group

Optum

EDW: Teradata Database, System/Application Admin, HelpDesk Support

Intelligent Electronic Data Interchange (iEDI)

Advanced Communication Engine (ACE)

ACE Member Edits
Pilot Program

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ACE Member edits - Pilot Program (5 Providers)

Purpose and Goal:

Purpose

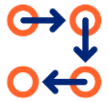
- Launch a targeted initiative to improve Medicaid claims processing, accuracy and efficiency.
- Implement customized member eligibility edits for selected providers in Illinois.

Goals

- Reduce claim rejections and denials by addressing top error categories:
  - Member not found
  - Invalid eligibility dates
  - Incorrect date of birth
- Enhance data quality and streamline provider workflows.

837 Institutional and Professional Claims

Pre-Adjudicated Claims Files



277 Claim Response from ACE Claims Manager

ACE Claims manager validate each claims against HFS Recipient data (File) and generates an informational Edits even before it goes to MCO/Plans.

ACE EDW Edit Message (STC12) that goes to the Providers
Subscriber ID does not match the State of IL - HFS Subscriber/Recipient file.
Subscriber Date of Birth does not match the State of IL - HFS Subscriber/Recipient file.
Subscriber Eligibility dates do not match the State of IL - HFS Subscriber/Recipient file.

Invalid Member

Payer ID	Patient Control Number	Recipient ID	Total Charge Amt	Claim Status Date	Source	Status	Edit Message (STC12)
CCXXX	ABC123000	123456789	$429	2/11/2025	MCO	Rejected	02 - INVALID MBR
CCXXX	ABC123000	123456789	$429	2/11/2025	ACE Edits	Informational	Subscriber ID does not match the State of IL - HFS Subscriber/Recipient file.

Member not found in recipient file.

Dates of Service Outside of Eligibility Period

Payer ID	Patient Control Nbr	Total Charge Amt	Claim StatusDt	Subscriber PrimaryId	Service FromDt	Service ToDt	Subscriber LastNm	Subscriber FirstNm	Subscriber BirthDt	Status Source	Status	Edit Message
XXXXX	ABC123000	$ 8,215.00	2/4/2025	123456789	1/1/2025	1/31/2025	XXX	XXX	01/01/1958	MCO	Rejected	09 - MBR NOT VALID AT DOS
XXXXX	ABC123000	$ 8,215.00	2/4/2025	123456789	1/1/2025	1/31/2025	XXX	XXX	01/01/1958	ACE Edits	Informational	Subscriber Eligibility dates do not match the State of IL - HFS Subscriber/Recipient file.

RIN	FIRST NAME	MIDDLE NAME	LAST NAME	DATE OF BIRTH	ELIGIBILITY BEGIN DATE	ELIGIBILITY END DATE
123456789	XXX	XXX	XXX	8/11/1958	1/4/2024	31/12/2024

Member eligibility mismatch.

ACE Analytics Dashboards

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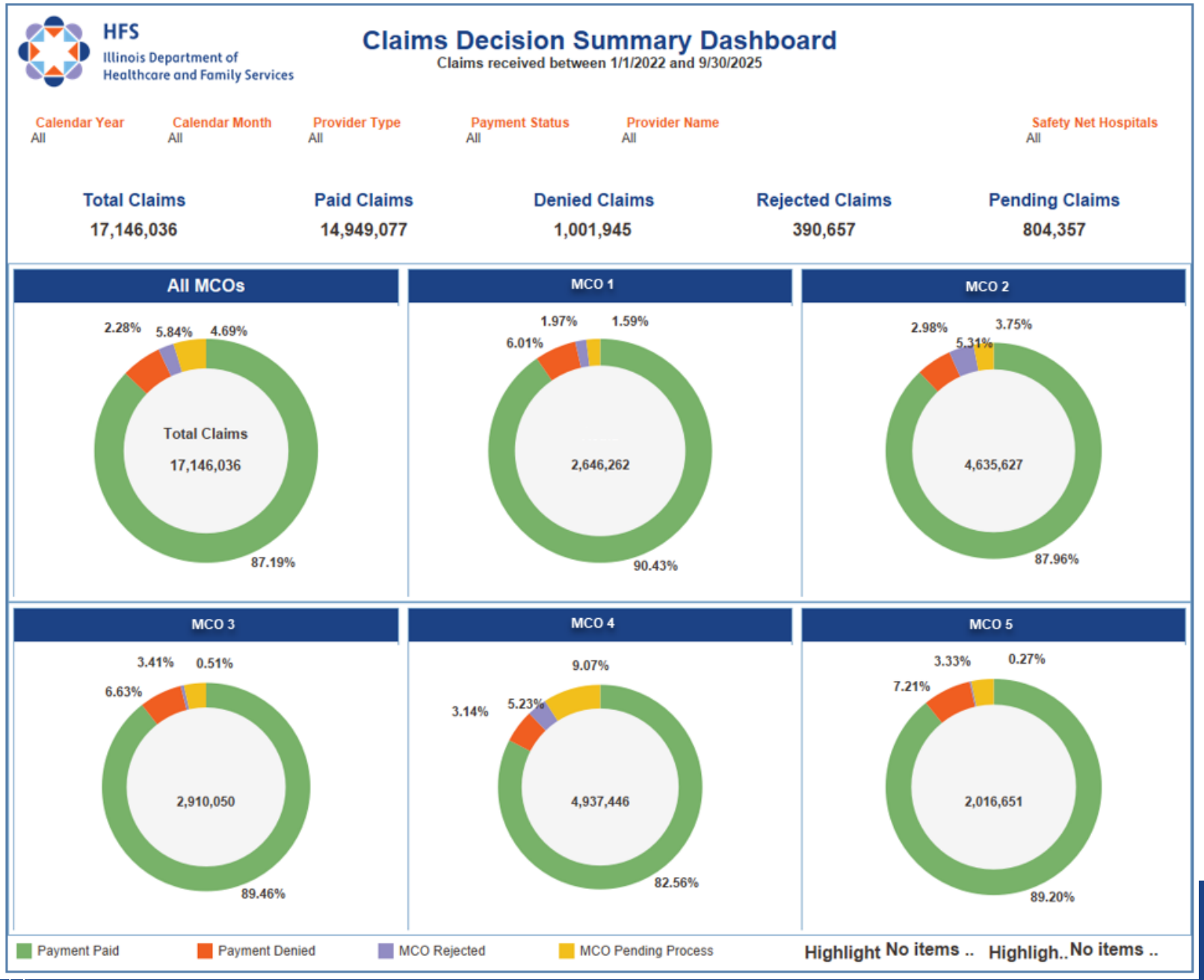
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Claims Decision Summary Dashboard
Claims received between 1/1/2022 and 9/30/2025
Calendar Year
All
Calendar Month
All
Provider Type
All
Payment Status
All
Provider Name
All
Safety Net Hospitals
All
Total Claims
17,146,036
Paid Claims
14,949,077
Denied Claims
1,001,945
Rejected Claims
390,657
Pending Claims
804,357
All MCOs
2.28%
5.84%
4.69%
Total Claims
17,146,036
87.19%
MCO 1
1.97%
1.59%
6.01%
2,646,262
90.43%
MCO 2
2.98%
3.75%
5.31%
4,635,627
87.96%
MCO 3
3.41%
0.51%
6.63%
2,910,050
89.46%
MCO 4
9.07%
3.14%
5.23%
4,937,446
82.56%
MCO 5
3.33%
0.27%
7.21%
2,016,651
89.20%
Payment Paid
Payment Denied
MCO Rejected
MCO Pending Process
Highlight No items ..
Highligh..No items ..

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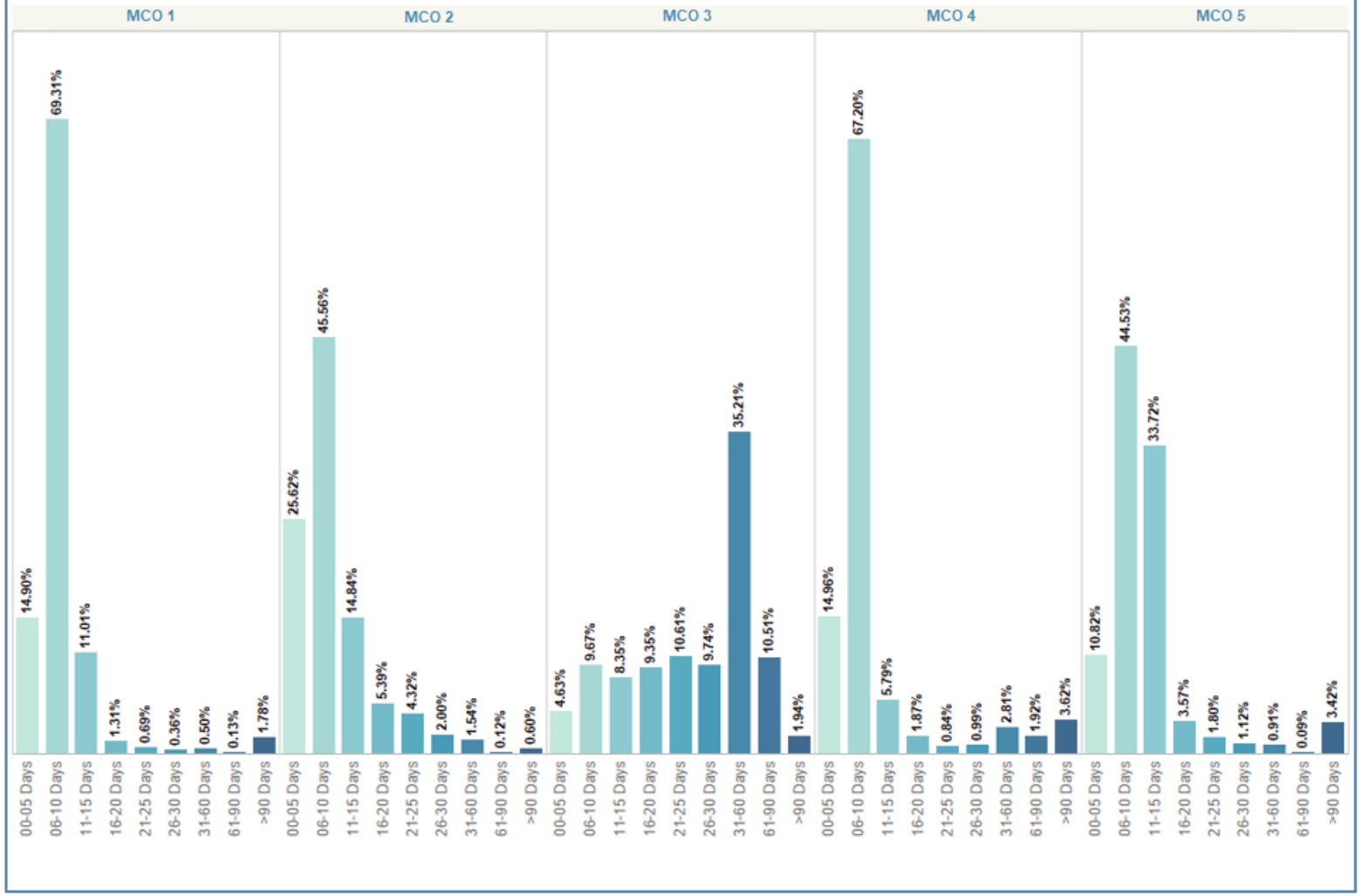
Provider and MCO Timeliness Dashboard

Claims received between 1/1/2022 and 9/30/2025

Dashboard Type	Calendar Year	Calendar Month	Provider Type	Provider Name	Safety Net Hospitals	Payment Status	Chart Type
(•) Days to Pay ( ) Days to Submit	All	All	All	All	All	All	( ) Counts (•) Percentage



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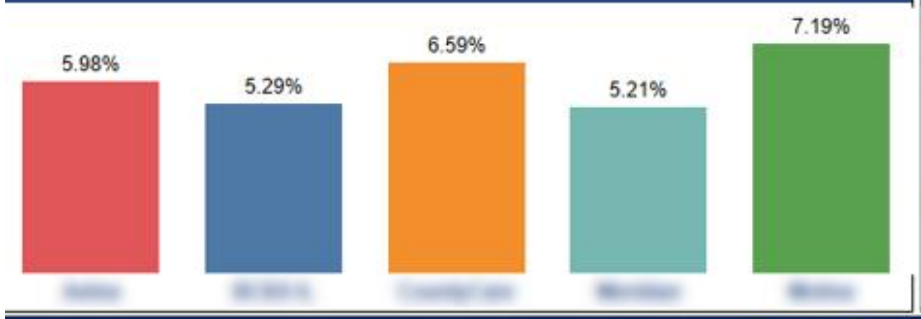
Claim Denials & Rejections Analysis Dashboard

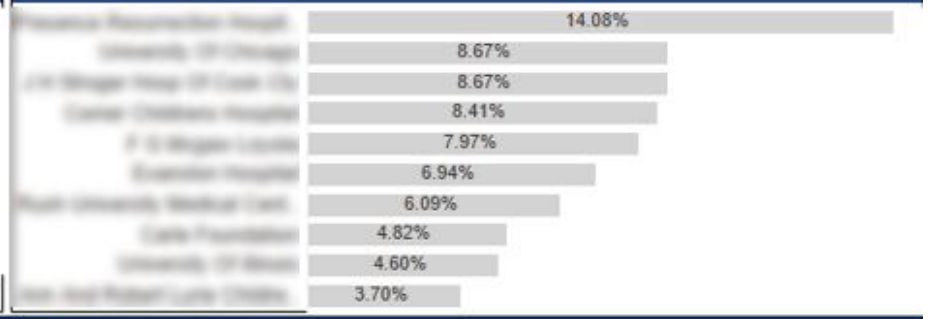
Claims received between 1/1/2022 and 9/30/2025

Dashboard Type	Calendar Year	Calendar Month	Provider Type	Provider Name	Safety Net Hospitals
(•) Denied ( ) Rejected	All	All	Hospitals	All	All

Denied Percentage By Payer

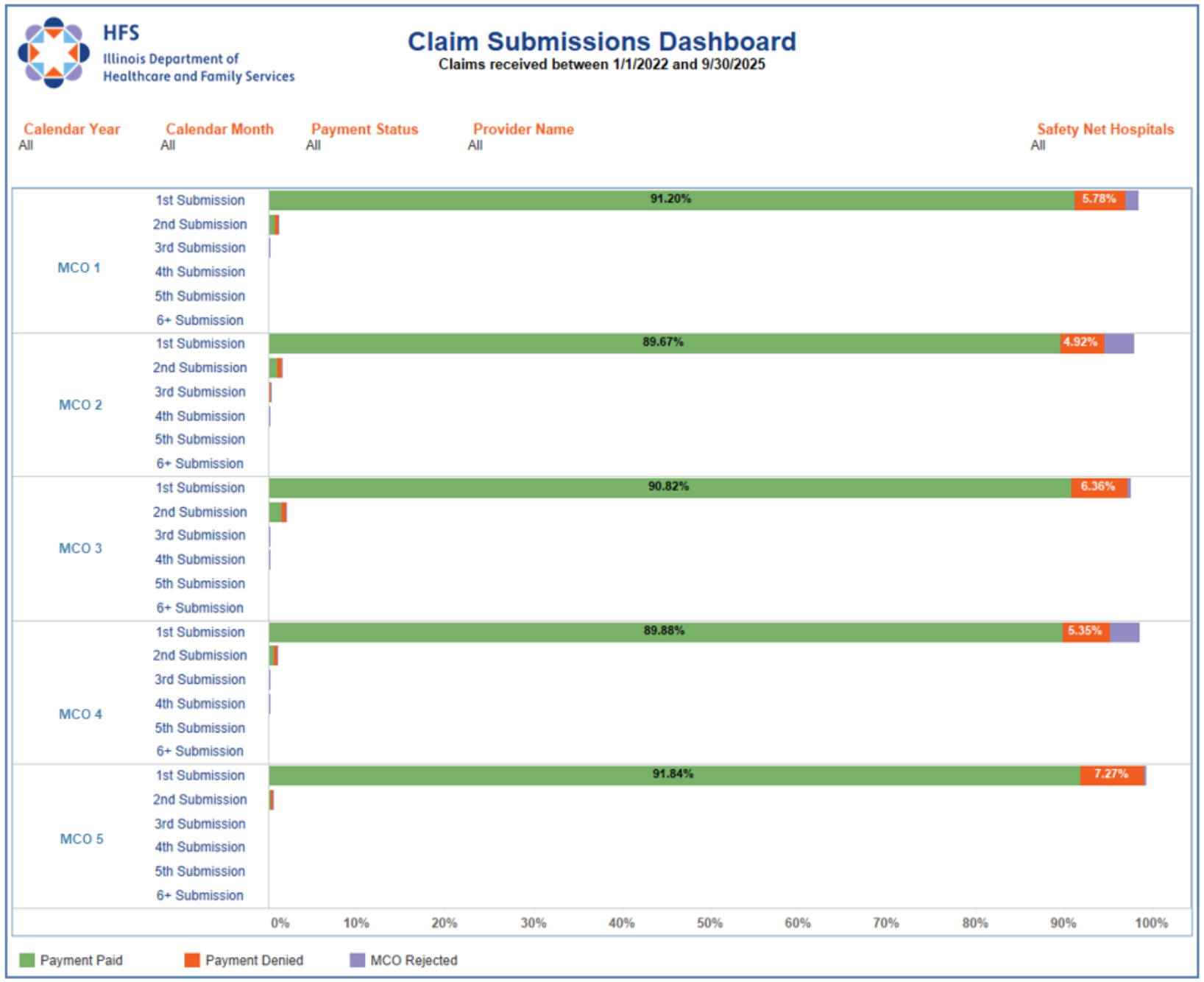


Top 10 Denied Providers



Top 10 Denied Reasons

Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Claim Counts: **151,249**	Precertification/authorization/notification/pre-treatment absent. Claim Counts: **135,702**	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Claim Counts: **97,604**	Prior processing information appears incorrect. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	An
	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) Claim Counts: **125,515**	The time limit for filing has expired. Claim Counts: **82,083**	National Provider Identifier - Not matched. Claim Counts: **28,731**	Services denied at the time Services not provided by network/primary care providers.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Claim Submissions Dashboard
Claims received between 1/1/2022 and 9/30/2025
Calendar Year
All
Calendar Month
All
Payment Status
All
Provider Name
All
Safety Net Hospitals
All
MCO 1
1st Submission
2nd Submission
3rd Submission
4th Submission
5th Submission
6+ Submission
91.20%
5.78%
MCO 2
1st Submission
2nd Submission
3rd Submission
4th Submission
5th Submission
6+ Submission
89.67%
4.92%
MCO 3
1st Submission
2nd Submission
3rd Submission
4th Submission
5th Submission
6+ Submission
90.82%
6.36%
MCO 4
1st Submission
2nd Submission
3rd Submission
4th Submission
5th Submission
6+ Submission
89.88%
5.35%
MCO 5
1st Submission
2nd Submission
3rd Submission
4th Submission
5th Submission
6+ Submission
91.84%
7.27%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%
Payment Paid
Payment Denied
MCO Rejected

ACE Analytics
Use Cases

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Hospital *A* - Q1 & Q2 2025

- **Top Rejection Reason**: Claim submitted to incorrect payer. (CARC 116)
- 1,906 claims ($16.41M)

Total Rejected Claims

- 4,847 out of 351,532 (1.38%)
- Total Charge Amount: $55.42M

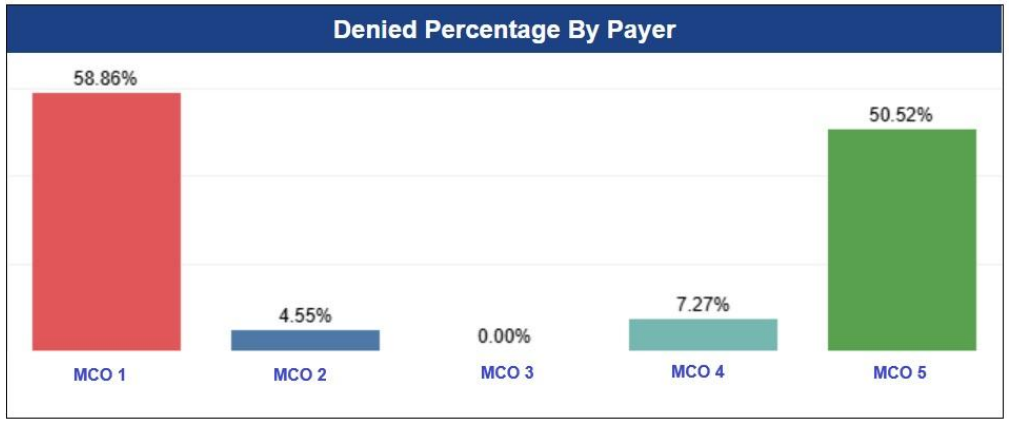
- **Top Denied Reason**: National Provider Identifier – Not matched. (CARC 208)
- 4,658 claims ($47.35M)

Total Denied Claims

- 19,708 out of 351,531 (5.61%)
- Total Charge Amount: $184.91M

April 2025 Top Denied Hospitals

- **53% of hospital claims denied**
- 799 out of 1,514 total claims – $4.38M Total Charge Amount
- Provider NPI: 123456789



Hospital A - April Top Denied Payers and Reason

MCO 1

Top Denied Reason: CARC 208 with RARC N527 for all claims

- **National Provider Identifier – Not Matched**
- Very few claim counts for other months, but CARC 208 was still present
- Denied Claim Counts: 498 out of 592
- Denied Total Charge Amount: $3.33M

MCO 5

Top Denied Reason: CARC B7

- **This provider was not certified/eligible to be paid for this procedure/service on this date of service**
- Denied Claim Counts: 179 out of 200
- Denied Total Charge Amount: $994.70K

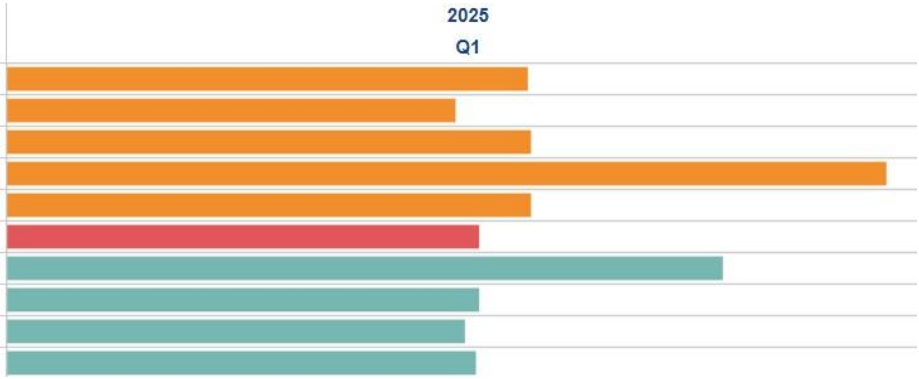
Hospital *A*
Denials January and February 2025

Top Denied Reason CARC 29: The time limit for filing has expired.

- CARC 29 Denied Claim Counts – 379 out of 776 ($593.63K)

- Total Claim Counts – 776 denied out of 6,400 ($3.03M)
- Provider NPIs: 123456789 and 987654321

Payer	Reject/Denial Code	Reject/Denial Reason
MCO 1	4	The procedure code is inconsistent with the modifier used. Usage: Refer to the 835 Healthcare Policy Identificati..
	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attach..
	29	The time limit for filing has expired.
	197	Precertification/authorization/notification/pre-treatment absent.
	252	An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must..
MCO 2	197	Precertification/authorization/notification/pre-treatment absent.
MCO 3	16	Claim/service lacks information or has submission/billing error(s). Usage: Do not use this code for claims attach..
	18	Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulati..
	197	Precertification/authorization/notification/pre-treatment absent.
	216	Based on the findings of a review organization



Q & A

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VII. Discussion

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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VIII. Public Comments

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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Public Comments

Name	Title	Org	Comment
None Reported			

IX. Additional Business: Old & New

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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Additional Business: Old & New

Items for future discussion?

HFS announcements?

For Future Meetings:	• 2025 Meetings will meet quarterly • MCO Oversight Commission Meeting Schedule (illinois.gov)
Next Meeting Date & Times	• December 10, 2025
HFS Announcements	• Please complete your mandatory training

Mandatory Ethics Trainings Reminder Email

All appointees must complete the following trainings on OneNet:

1. Security Awareness Training 2025
2. Diversity, Equity, Inclusion and Accessibility Training 2025
3. LGBTQIA+ Equity and Inclusion 2025
4. Ethics Training Program for State Employees and Appointees 2025
5. Harassment and Discrimination Prevention Training 2025
6. HIPAA & Privacy Training 2025

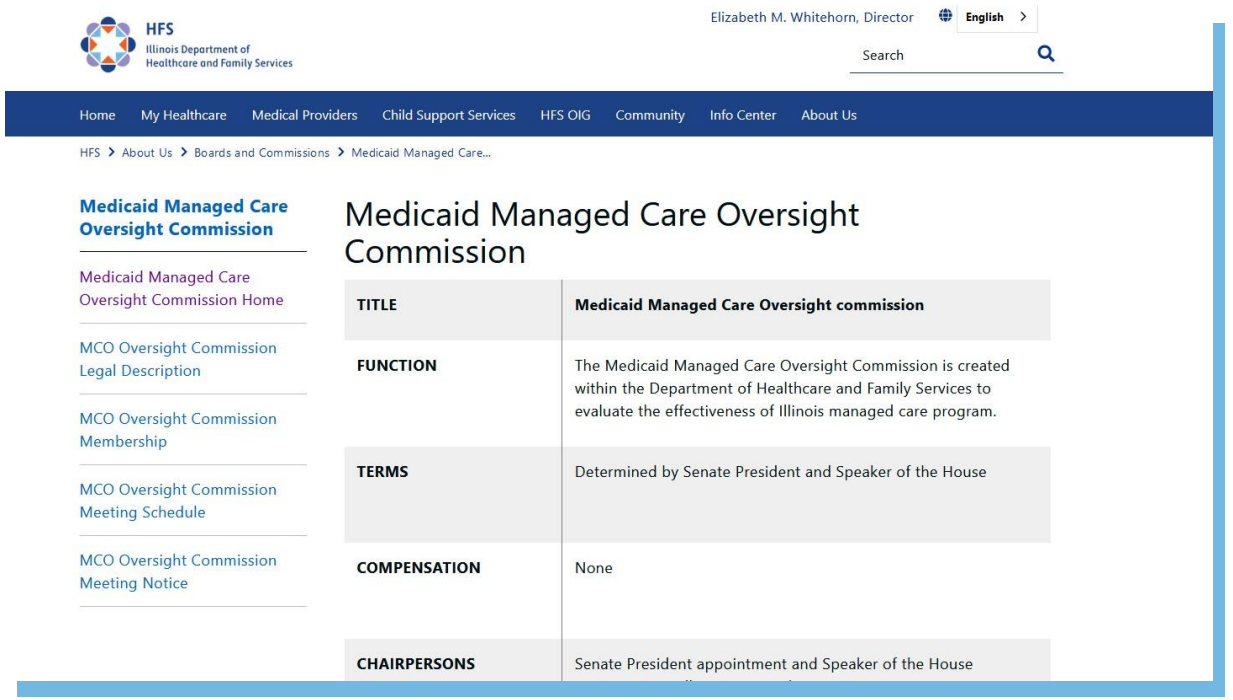
You can access the trainings at the following link: http://onenet.Illinois.gov/mytraining

Please see attached memo for additional details. Please complete the trainings through OneNet no later than December 23, 2025. If anyone has any issues logging into OneNet, please email HFS.BureauofTraining@Illinois.gov

MCO Oversight Commission Member Resources

Website and resources

- Medicaid Managed Care Oversight Commission (illinois.gov)



Commission Resources

The Illinois Department of Healthcare and Family Services (HFS) utilizes a range of social media accounts to better reach our customers and stakeholders. We encourage you to follow us on:

1. Twitter: https://twitter.com/ILDHFS
2. Facebook: https://www.facebook.com/ILDHFS
3. LinkedIn: https://www.linkedin.com/company/ildhfs/

for important news, announcements and alerts. And please spread the word to your own followers.

Together, let's keep those we serve well informed, educated and empowered!

X. Adjournment

Presenter: Melishia Bansa
Deputy Director of Community Outreach – Boards & Commissions

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