ILLINOIS DEPARTMENT OF Healthcare and Family Services

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Medicaid Advisory Committee
Quality Care Subcommittee

November 1, 2016
10 a.m. - 12 p.m.

401 S. Clinton
1st Floor Video Conference Room
Chicago, Illinois
And

201 South Grand Avenue East
1st Floor Video Conference Room
Springfield, Illinois

Conference Call-In Number: 888-494-4032
Access Code: 5589848112

Agenda

I. Call to Order

II. Introductions

III. Approval of July 2016 Meeting Minutes

IV. New Business

a. The Star Report — Catina Latham
http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0725

b. Quality Strategy Report — Catina Latham
c. Auto-Assignment Algorithm — Robert Mendonsa
d. MCO Performance Metric Report — Robert Mendonsa
e. Data Analytic Group Update — Jennifer Cartland

V. Other Business

VI. Adjournment

If you plan to participate by phone please respond in advance to Elizabeth.diaz-castillo@illinois.gov for meeting materials, and so we may record your presence at the meeting accurately.

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee July 19, 2016

Members Present
Kathy Chan, Cook County Health and Hospitals System
Kelly Carter, Illinois Primary Health Care Association
Margaret Kirkegaard, Illinois Academy of Family Physicians
Alvia Siddiqi, Advocate ACE
Jennifer Cartland, Lurie Children's Hospital
Barrett Hatches, Chicago Family Health Center

Members Absent
Candace Clevenger, Heritage Behavior Health Center
Joshua Evans, Illinois Association of Rehabilitation Facilities

HFS Staff Present
Arvind Goyal
Catina Latham
Robert Mendonsa
Sylvia Riperton-Lewis
Paula O'Brien
Elizabeth Diaz-Castillo

Interested Parties
Carol Leonard, DentaQuest
Michael K. Berkes, IDOA
David Lecik, IDOA SHIP
Paula Dillon, Illinois Health and Hospital Association
Laura Minzer, BCBS Of Illinois
Michael Gelder,
Patrick Besler, House Republican Staff
Judy King
Marcia Luckett, Genetech
Hetal Patel, Ililnicare
Alap Shah Illinois Academy of Family Physician
Amy O'Rourke, Respiratory Health Association
Tom Wilson Access Living
Daniel Frey, AIDS Foundation of Chicago
Mawasi Jayapraph, IPHCA
Sally Szumlas, FHN/CCAI
John Jansa, WKG Advisory
Sherri Arriazola, TASC
Dianna Grant, Molina Health
Kelly McKenna, EverThrive Illinois
Kathy Shanahan, CCAI
Rachel Reichlin, County Care
Luvia Quiñones, ICIRR
Patricia Reedy, IDHS/DMH
Heather Scalia/ Humana
Elizabeth Hackett/ CDC/EverThrive Illinois
Ninus David, NextLevel Health
Eric Boklage, Chicago Family Health Center
Alicai Siani, EverThrive Illinois
Jeenifer Cortland, Ana & Robert H Lurie Children's Hospital
Priti Patel, Greater Elgin Family Care Center
Dan Lewis, EverThrive Illinois
Jessica Rhodes, Legal Council for Health Justice
Amy Sagen, -UIHealth
Diane Montañez, North Shore
Katie Lustig, Harmony
Marijeet Kaur, FHN
Sandy DeLeón, Ounce of Prevention Fund
Davis Hunter, Presence Health
Alivia Siddiqi, Advocate ACE/MCCN
Gerri Clark, DSCC
Katherine Shaffer, DSCC

Illinois Department of Healthcare and Family Services
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Ralph Schubert, IPHA
Eric Foster, IABH
Judy Bowlby, Liberty Dental Plan
Jill Hayden, Meridian Health Plan
David Vinke, Molina Healthcare

Meeting Minutes

I. **Call to Order:** The regular bi-monthly meeting of the Medicaid Advisory Committee Quality Care Subcommittee was called to order at July 19, 2016 10:07 a.m. by chair Kelly Carter. A quorum was established.

II. **Introductions:** Quality Care subcommittee members, HFS staff, and interested parties were introduced in Chicago, Springfield and on the phone

III. **Approval of March 2016 and May 2016 Meeting Minutes:** A quorum was established and minutes were approved.

IV. **New Business:**

a. New Member introduced :
Barrett Hatchet – President/CEO of Chicago Family Health Centers
Dr. Verletta Saxon – also member of MAC, background is BH, downstate

b. Discussion of Proposed Initial Quality Metrics
i. Asthma
ii. Diabetes
iii. Immunizations

A suggestion was made to the Subcommittee not to pick a specific metric but to look at all the metrics and see where HFS can move forward with their choice.
Jennifer Cartland proposed creating an analytic plan that takes into account recommendations concerning access and network. Another recommendation was made by Jennifer Cartland that a small group get together to draft the analytic plan. The small group will circulate their results prior to the next Subcommittee meeting in September.

Amy O'Rourke of the Respiratory Health Association presented updates on the Coordinated Healthcare Interventions for Childhood Asthma Gaps in Outcomes Collaboration (CHICAGO II). Further updates will be provided at future subcommittee meetings.

V. **Old Business:** Robert Mendonsa reported: MCO and MLTSS roll out began 7/1/16. SmartPlan Choice ACE will merge with FHN effective Sept 1.

Illinois Department of Healthcare and Family Services
Quality Care Subcommittee July 19, 2016

HFS has been working with MCOs and providers to get payment issues behind them, making incremental progress. They had a meeting yesterday between MCOs and home care/hospice providers.

Only quality results from CY2014 are available on ICP plans; HFS is in process of developing five star rating report that will be launched in the next few weeks (will be shared at the next quality care meeting); went from many quality measures to about 22 measures for FHP/ACA and ICP – reason HFS reduced the number of metrics was to make process more "consumer friendly"

HFS will have CY2015 results for FHP/ ACA, and ICP in the next few weeks – will develop a five-star rating system ready in the fall; and this will be the basis for auto-assignment algorithm; Robert would like to come back to this committee and to other stakeholders on how to make this work; will require a fair amount of programming from HFS; hope to come to agreement by end of 2016 and implement by Q2 2017.

HFS is currently tracking number of clean claims, but Robert doesn't think that this is a good measure; tracking another set of metrics such as pending claims, denials; it's possible that some of these will be include, but nothing has been decided

VI. **Adjournment:** The meeting was adjourned at 12:00p.m.

Draft Quality Auto-Assignment Algorithm

Quality Algorithm Assignment Outline

PCP/Client Relationship – looks back 6 months

Band 1 – Highest Quality Performance Plan(s)	• Assignment defaults to the band 1 plan(s) first. • If multiple plans have the same PCP in network, the assignment will default by a round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 2 – High Quality Performance Plan(s)	• Assignment defaults to the band 2 plan(s) second • If multiple plans have the same PCP in network, the assignment will default by a round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 3 – Average Quality Performance Plan(s)	• Assignment defaults to the band 3 plan(s) third • If multiple plans have the same PCP in network, the assignment will default by a round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 4 – Lowest Quality Performance Plan(s)	• No default assignment to band 4 plan(s)

PCP/Client Relationship based on claims – looks back 6 months

Band 1 – Highest Quality Performance Plan(s)	• Assignment defaults to the band 1 plan(s) first. • If multiple plans have the same PCP in network, the assignment will default by a round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 2 – High Quality Performance Plan(s)	• Assignment defaults to the band 2 plan(s) second • If multiple plans have the same PCP in network, the assignment will default by a

	round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 3 – Average Quality Performance Plan(s)	• Assignment defaults to the band 3 plan(s) third • If multiple plans have the same PCP in network, the assignment will default by a round robin process. • If PCP is in plan of family member closest in age, will default assignment to that health plan to attempt to keep family in same plan.
Band 4 – Lowest Quality Performance Plan(s)	• No default assignment to band 4 plan(s)

Family Member –closest in age

Band 1 – Highest Quality Performance Plan(s)	• Assignment defaults to the band 1 plan if family member closest in age is assigned to a band 1 plan and PCP of family member is an open and assignable PCP.
Band 2 – High Quality Performance Plan(s)	• Assignment defaults to the band 2 plan if family member closest in age is assigned to a band 2 plan and PCP of family member is an open and assignable PCP.
Band 3 – Average Quality Performance Plan(s)	• Assignment defaults to the band 3 plan if family member closest in age is assigned to a band 3 plan and PCP of family member is an open and assignable PCP.
Band 4 – Lowest Quality Performance Plan(s)	• No default assignment to band 4 plan(s)

Geomapping – based on radius for mandatory region

Band 1 – Highest Quality Performance Plan(s)	• Assignment will favor band 1 plan(s) first. • Highest quality performance assignment rate (%) to be determined.
Band 2 – High Quality Performance Plan(s)	• Assignment defaults to the band 2 plan(s) second • High quality performance assignment rate (%) to be determined.
Band 3 – Average Quality Performance Plan(s)	• Assignment defaults to the band 3 plan(s) last. • Average quality performance assignment rate (%) to be determined.
Band 4 – Lowest Quality Performance Plan(s)	• No default assignment to band 4 plan(s)

NOTE: Data presented in tables for provider credentialing, provider disputes and member and provider customer services contain dummy data. Data presented for grievances and appeals, prior authorization and utilization statistics consist actual data submitted by plans.

Illinois Department of Healthcare and Family Services (HFS)
Bureau of Managed Care (BMC): *MCO Performance Dashboard*

Program: ICP
Reporting Period: **Reporting SFY:**
Illinois State Fiscal Year (SFY) runs July 1 of a calendar year through June 30 of the next calendar year (e.g., SFY 2016 is July 1, 2015 through June 30, 2016).

Table 1. Number of Total Provider Credentialing Applications Received and Processed from all Providers Types By MCO (for Current Quarter Cumulative)

MCO	FY 2017 Q1						
	Total Received #	Total Approved #	Total Denied #	Total Pending #	% Approved	% Denied	% Pending
Aetna	500	300	50	150	60.00%	10.00%	30.00%
BCBS	500	300	50	150	60.00%	10.00%	30.00%
CCAI	500	300	50	150	60.00%	10.00%	30.00%
CountyCare	500	300	50	150	60.00%	10.00%	30.00%
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	500	300	50	150	60.00%	10.00%	30.00%
HealthSpring	500	300	50	150	60.00%	10.00%	30.00%
Humana	500	300	50	150	60.00%	10.00%	30.00%
IlliniCare	500	300	50	150	60.00%	10.00%	30.00%
Meridian	500	300	50	150	60.00%	10.00%	30.00%
Molina	500	300	50	150	60.00%	10.00%	30.00%
NextLevel	500	300	50	150	60.00%	10.00%	30.00%
Average	500	300	50	150	60.00%	10.00%	30.00%
Total	5,500	3,300	550	1,650	60.00%	10.00%	30.00%

Table 2. Number of Days for Provider Credentialing Applications to be Processed by MCO (Current Quarter Cumulative).

MCO	FY 2017 Q1							
	0-30 Days		31-60 Days		61-90 Days		>90 Days	
	Total Approved #	Total Denied #	Total Approved #	Total Denied #	Total Approved #	Total Denied #	Total Approved #	Total Denied #
Aetna	200	20	50	10	20	10	30	10
BCBS	200	20	50	10	20	10	30	10
CCAI	200	20	50	10	20	10	30	10
CountyCare	200	20	50	10	20	10	30	10
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	200	20	50	10	20	10	30	10
HealthSpring	200	20	50	10	20	10	30	10
Humana	200	20	50	10	20	10	30	10
IlliniCare	200	20	50	10	20	10	30	10
Meridian	200	20	50	10	20	10	30	10
Molina	200	20	50	10	20	10	30	10
NextLevel	200	20	50	10	20	10	30	10
Average	200	20	50	10	20	10	30	10
Total	2,200	220	550	110	220	110	330	110

Number of days taken to take action on applications regardless of when the application was received.

Table 3. Number and % Percentage of Member and Provider Customer Services Call Center Statistics by MCO (Current Quarter)

	FY 2017 Q1			
	Member and Provider			
MCO	Total Calls Received	% Answered Calls within 30 seconds	% Abandoned Calls	Average Speed of Phone Calls Answered
Aetna	2000	95.00%	5.00%	30
BCBS	2500	95.00%	5.00%	25
CCAI	3000	95.00%	5.00%	29
CountyCare	1000	95.00%	5.00%	40
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	1500	95.00%	5.00%	20
HealthSpring	500	95.00%	5.00%	30
Humana	600	95.00%	5.00%	28
IlliniCare	5000	95.00%	5.00%	25
Meridian	2000	95.00%	5.00%	29
Molina	3500	95.00%	5.00%	30
NextLevel	1500	95.00%	5.00%	30

Table 4. Total Number of Provider Disputes Received, Resolved and Pending/ 1000 members and % Disputes Resolved by MCO within that Quarter

MCO	Disputes/1000 Members			%Disputes Resolved and Pending/1000 Member	
	Received	Resolved	Pending	% Resolved	% Pending
Aetna					
BCBS					
CCAI					
CountyCare					
FHN	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A
HAC					
HealthSpring					
Humana					
IlliniCare					
Meridian					
Molina					
NextLevel					
Average					
Total					

Grievances and Appeals

Data from 2016 Q1

Table 5. Total Appeals and Grievances Received and Resolved By MCO (Data from 2016 Q1)

MCO	FY 2016 Q1		FY 2016 Q2		FY 2016 Q3		FY 2016 Q4	
	# Received	% Resolved	# Received	% Resolved	# Received	% Resolved	# Received	% Resolved
Aetna	431	77%	N/A	N/A	N/A	N/A	N/A	N/A
BCBS	53	92%	N/A	N/A	N/A	N/A	N/A	N/A
CCAI	106	80%	N/A	N/A	N/A	N/A	N/A	N/A
CountyCare	19	47%	N/A	N/A	N/A	N/A	N/A	N/A
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	62	95%	N/A	N/A	N/A	N/A	N/A	N/A
HealthSpring	49	86%	N/A	N/A	N/A	N/A	N/A	N/A
Humana	10	100%	N/A	N/A	N/A	N/A	N/A	N/A
IlliniCare	136	86%	N/A	N/A	N/A	N/A	N/A	N/A
Meridian	12	75%	N/A	N/A	N/A	N/A	N/A	N/A
Molina	590	95%	N/A	N/A	N/A	N/A	N/A	N/A
NextLevel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average	147	83%	N/A	N/A	N/A	N/A	N/A	N/A

Table 5. Grievances and appeals received (grievances, appeals, expedited appeals, fair hearings and external independent reviews) and resolved (grievances, appeals, expedited appeal, fair hearings and external independent reviews) for the Total ICP Population.

Table 6. Total Appeals and Grievances Received, Resolved and % Percent Resolved By MCO regardless of timeframe (Data from 2016 Q1)

MCO	Grievances			Appeals			Expedited Appeals			External Independent Reviews			Fair Hearings		
	# Received	# Resolved	% Resolved	# Received	# Resolved	% Resolved	# Received	# Resolved	% Resolved	# Received	# Resolved	% Resolved	# Received	# Resolved	% Resolved
Aetna	215	188	87%	169	103	61%	40	38	95%	2	3	150%	5	1	20.00%
BCBS	43	41	95%	6	4	67%	4	4	100%	0	0	N/A	0	0	N/A
CCAI	89	75	84%	7	7	100%	10	3	30%	0	0	N/A	0	0	N/A
CountyCare	10	1	10%	4	3	75%	3	3	100%	1	1	100%	1	1	100.00%
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	51	48	94%	9	9	100%	2	2	100%	0	0	N/A	0	0	N/A
HealthSpring	44	37	84%	2	2	100%	3	3	100%	0	0	N/A	0	0	N/A
Humana	1	1	100%	7	7	100%	2	2	100%	0	0	N/A	0	0	N/A
IlliniCare	87	72	83%	34	32	94%	11	11	100%	3	2	67%	1	0	0.00%
Meridian	11	8	73%	1	1	100%	0	0	N/A	0	0	N/A	0	0	N/A
Molina	549	526	96%	38	3	8%	3	0	0%	0	0	N/A	0	0	N/A
NextLevel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average	110	100	80.66%	28	17	80.46%	8	7	N/A	1	1	N/A	1	0	N/A

Note: Appeals and Grievances resolved as a percentage can exceed 100% due to Appeals and Grievances received from previous quarter which is resolved in the current quarter.

Table 7. Percentages of Appeals and Grievances Resolved for Total ICP Population within Required Timeframe (Data from 2016 Q1)

MCO	FY 2016 Q1										
	Grievances Outcomes			Appeals Outcomes				Expedited Appeals Outcomes			
	Total # of Grievances Resolved	# Resolved within 90 Days	% Resolved within 90 Days	Upheld	Overturned	# Resolved within 15 Days	% Resolved within 15 Days	Upheld	Overturned	# Resolved within 24 Hours	% Resolved within 24 Hours
Aetna	188	188	100.00%	74	29	92	89.32%	30	8	28	73.68%
BCBS	41	41	100.00%	1	4	5	100.00%	1	3	4	100.00%
CCAI	75	74	98.67%	2	3	5	100.00%	2	5	7	100.00%
CountyCare	1	1	100.00%	1	2	3	100.00%	1	2	3	100.00%
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	48	48	100.00%	7	2	9	100.00%	-	2	2	100.00%
HealthSpring	37	37	100.00%	1	2	3	100.00%		3	2	66.67%
Humana	1	1	100.00%	3	4	-	0.00%	-	2	-	0.00%
IlliniCare	72	72	100.00%	10	22	32	100.00%	3	8	11	100.00%
Meridian	11	8	72.73%	1	-	1	100.00%	-	-	-	N/A
Molina	526	526	100.00%	26	10	36	100.00%	2	1	3	100.00%
NextLevel	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Average	100.00	99.60	97.14%	6.38	5.63	11.13	88.93%	4.33	3.40	6.00	82.26%

Table 6. Percentage includes the number of grievances resolved within 90 days, the number of appeals resolved within 15 business days and the number of expedited appeals resolved within 24 hours.

Prior Authorization

Previously reported data below taken from Feb 2016

MCO Comparison % Approved

Table 8. Percentage of Inpatient Routine Prior Authorizations Approved			
MCO	**Dec**	**Jan**	**Feb**
Aetna	83.0%	85.9%	83.4%
BCBS	99.2%	99.2%	97.3%
CCAI	98.5%	97.6%	98.3%
CountyCare	100.0%	94.7%	100.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	98.0%	97.4%	96.5%
HealthSpring	98.1%	96.6%	96.9%
Humana	87.3%	88.4%	90.1%
IlliniCare	98.4%	95.8%	100.0%
Meridian	97.5%	99.1%	100.0%
Molina	92.9%	95.9%	96.2%
NextLevel	N/A	N/A	N/A
Average	95.3%	95.1%	95.9%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 9. Percentage of Outpatient Routine Prior Authorizations Approved			
MCO	**Dec**	**Jan**	**Feb**
Aetna	99.4%	99.0%	98.8%
BCBS	99.9%	99.4%	98.7%
CCAI	92.6%	99.6%	97.8%
CountyCare	100.0%	100.0%	94.2%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	97.2%	97.9%	97.8%
HealthSpring	98.3%	99.1%	98.1%
Humana	99.0%	99.5%	99.4%
IlliniCare	98.3%	98.3%	97.4%
Meridian	96.1%	98.6%	98.0%
Molina	91.1%	89.1%	88.5%
NextLevel	N/A	N/A	N/A
Average	97.2%	98.1%	96.9%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 10. Percentage of Inpatient Expedited Prior Authorizations Approved			
MCO	**Dec**	**Jan**	**Feb**
Aetna	86.5%	75.6%	82.7%
BCBS	98.5%	95.2%	97.4%
CCAI	100.0%	100.0%	100.0%
CountyCare	100.0%	100.0%	100.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	0.0%	100.0%	100.0%
HealthSpring	N/A	N/A	N/A
Humana	90.9%	87.9%	96.4%
IlliniCare	97.2%	100.0%	100.0%
Meridian	80.1%	81.0%	75.9%
Molina	90.0%	100.0%	100.0%
NextLevel	N/A	N/A	N/A
Average	82.6%	93.3%	94.7%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 11. Percentage of Outpatient Expedited Prior Authorizations Approved			
MCO	**Dec**	**Jan**	**Feb**
Aetna	100.0%	100.0%	100.0%
BCBS	N/A	N/A	N/A
CCAI	100.0%	N/A	100.0%
CountyCare	100.0%	100.0%	100.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	92.2%	95.4%	82.9%
HealthSpring	100.0%	100.0%	100.0%
Humana	100.0%	100.0%	100.0%
IlliniCare	97.7%	97.6%	100.0%
Meridian	98.5%	95.8%	95.7%
Molina	91.0%	92.5%	90.3%
NextLevel	N/A	N/A	N/A
Average	97.7%	97.7%	96.5%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

MCO Comparison % Exceeding

Table 12. Percentage of Inpatient Routine Prior Authorizations Exceeding Required Turnaround (10 Days)			
MCO	**DEC**	**JAN**	**FEB**
Aetna	0.6%	1.2%	0.2%
BCBS	8.3%	0.3%	1.2%
CCAI	3.4%	1.0%	1.7%
CountyCare	0.0%	0.0%	0.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	1.2%	4.4%	0.4%
HealthSpring	1.9%	8.6%	3.1%
Humana	0.6%	0.7%	0.7%
IlliniCare	1.6%	6.3%	1.8%
Meridian	7.5%	2.8%	16.0%
Molina	0.0%	0.0%	0.0%
NextLevel	N/A	N/A	N/A
Average	2.5%	2.5%	2.5%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 13. Percentage of Outpatient Routine Prior Authorizations Exceeding Required Turnaround (10 Days)			
MCO	**DEC**	**JAN**	**FEB**
Aetna	27.0%	28.0%	2.8%
BCBS	2.6%	1.5%	12.0%
CCAI	27.5%	3.9%	13.3%
CountyCare	0.0%	0.0%	1.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	10.2%	5.5%	8.3%
HealthSpring	17.0%	8.5%	11.4%
Humana	1.6%	0.3%	0.0%
IlliniCare	0.6%	0.1%	0.2%
Meridian	6.8%	7.9%	2.6%
Molina	0.0%	0.5%	0.5%
NextLevel	N/A	N/A	N/A
Average	9.3%	5.6%	5.2%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 14. Percentage of Inpatient Expedited Prior Authorizations Exceeding Required Turnaround (3 Days)			
MCO	**DEC**	**JAN**	**FEB**
Aetna	10.8%	0.0%	1.0%
BCBS	2.3%	8.1%	0.6%
CCAI	2.5%	0.0%	0.0%
CountyCare	0.0%	0.0%	0.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	0.0%	0.0%	0.0%
HealthSpring	N/A	N/A	N/A
Humana	0.0%	0.0%	0.0%
IlliniCare	16.7%	9.1%	13.6%
Meridian	3.4%	0.8%	1.2%
Molina	10.0%	0.0%	0.0%
NextLevel	N/A	N/A	N/A
Average	5.1%	2.0%	1.8%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Table 15. Percentage of Outpatient Expedited Prior Authorizations Exceeding Required Turnaround (3 Days)			
MCO	**DEC**	**JAN**	**FEB**
	% Turnaround Exceeds 3 Days	**% Turnaround Exceeds 3 Days**	**% Turnaround Exceeds 3 Days**
Aetna	25.0%	37.5%	33.3%
BCBS	N/A	N/A	N/A
CCAI	0.0%	N/A	0.0%
CountyCare	0.0%	0.0%	0.0%
FHN	N/A	N/A	N/A
Harmony	N/A	N/A	N/A
HAC	27.5%	7.7%	1.4%
HealthSpring	2.9%	6.3%	0.0%
Humana	0.0%	0.0%	0.0%
IlliniCare	0.0%	0.0%	3.7%
Meridian	1.5%	7.4%	1.7%
Molina	0.0%	1.9%	0.0%
NextLevel	N/A	N/A	N/A
Average	6.3%	7.6%	4.5%

Definition

Routine prior authorizations must be authorized or denied within 10 days. Expedited prior authorizations must be authorized or denied within 72 hours. The requesting provider or the MCO may indicate if an expedited request is warranted if following the ordinary routine prior authorization timeframe could seriously jeopardize the enrollee's life or health.

Utilization Statistics

Previously reported data below taken from September 2016

Table 16. Total IP Admits/1000 Member Months				
	Aug-15	Jul-15	Jun-15	12-Month Weighted Average
Aetna	23.88	51.04	56.49	50.49
BCBS	37.35	46.96	42.17	37.74
CCAI	4.20	4.09	4.00	4.86
CountyCare	28.67	27.00	29.31	28.94
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	38.56	35.15	34.77	34.97
HealthSpring	25.92	30.42	34.04	34.58
Humana	54.29	93.04	86.85	86.41
IlliniCare	33.44	36.97	36.40	34.90
Meridian	17.13	30.80	31.06	27.42
Molina	29.82	34.48	33.35	36.05

Table 17. Total Readmission Rate				
	Aug-15	Jul-15	Jun-15	12-Month Weighted Average
Aetna	0.9%	1.8%	2.2%	1.9%
BCBS	7.4%	9.4%	11.0%	9.8%
CCAI	11.6%	11.0%	11.9%	11.3%
CountyCare	4.9%	3.8%	11.0%	7.2%
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	7.9%	8.1%	8.2%	8.3%
HealthSpring	32.2%	35.3%	32.5%	37.8%
Humana	26.2%	23.4%	27.8%	24.0%
IlliniCare	9.9%	10.0%	10.0%	10.2%
Meridian	5.8%	13.5%	9.3%	10.5%
Molina	6.8%	10.5%	18.5%	12.6%

Table 18. Total ED Visits/1000 Member Months

	Aug-15	Jul-15	Jun-15	12-Month Weighted Average
Aetna	153.82	167.39	159.04	147.14
BCBS	68.85	90.27	82.74	86.14
CCAI	13.82	13.69	13.18	16.15
CountyCare	119.93	112.90	105.79	107.69
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	187.76	193.88	184.88	184.05
HealthSpring	86.32	114.96	113.84	98.50
Humana	48.14	63.91	74.66	66.01
IlliniCare	120.69	129.16	119.43	119.13
Meridian	55.58	85.11	89.72	75.78
Molina	178.24	207.94	194.01	187.76

Table 19.Total OP Visits/1000 Member Months				
	Aug-15	Jul-15	Jun-15	12-Month Weighted Average
Aetna	61.05	63.11	70.74	58.75
BCBS	366.43	438.60	462.15	402.47
CCAI	30.76	37.23	39.04	46.04
CountyCare	264.25	277.70	280.56	253.27
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	63.66	60.30	78.55	70.07
HealthSpring	296.51	340.86	373.99	341.19
Humana	155.46	196.96	208.10	220.56
IlliniCare	298.65	319.86	309.67	292.23
Meridian	242.71	370.01	398.43	340.12
Molina	441.33	465.43	506.42	495.20

Payments/Claims

Table 20. Summary of Claims activity by MCO (Current Quarter)

MCO	FY 2017 Q1						
	Received	Paid $	Paid %	Denied $	Denied %	Rejected $	Rejected %
Aetna	-	-	-	-	-	-	-
BCBS	-	-	-	-	-	-	-
CCAI	-	-	-	-	-	-	-
CountyCare	-	-	-	-	-	-	-
FHN	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A	N/A	N/A	N/A
HAC	-	-	-	-	-	-	-
HealthSpring	-	-	-	-	-	-	-
Humana	-	-	-	-	-	-	-
IlliniCare	-	-	-	-	-	-	-
Meridian	-	-	-	-	-	-	-
Molina	-	-	-	-	-	-	-
NextLevel	-	-	-	-	-	-	-
Total	-	-	-	-	-	-	-

Table 21. Number of Claims Pending 90+ Days Old by MCO (Current Quarter)

MCO	FY 2017 Q1			
	Total Claims Pending			
	All Claims		Clean Claims Only	
	Count (#)	Amount ($)	Count (#)	Amount ($)
Aetna	-	-	-	-
BCBS	-	-	-	-
CCAI	-	-	-	-
CountyCare	-	-	-	-
FHN	N/A	N/A	N/A	N/A
Harmony	N/A	N/A	N/A	N/A
HAC	-	-	-	-
HealthSpring	-	-	-	-
Humana	-	-	-	-
IlliniCare	-	-	-	-
Meridian	-	-	-	-
Molina	-	-	-	-
NextLevel	-	-	-	-
Total	-	-	-	-

Medicaid
Health Plan Report Card

Calendar Year 2015

ILLINOIS DEPARTMENT OF
Healthcare and
Family Services

Health Plan Report Card Overview

Evaluated the performance of 10 Integrated Care Program (ICP) health plans and 9 Family Health Program/Affordable Care Act (FHP/ACA) health plans.

Targeted a consumer audience; therefore, it is user friendly, easy to read, and address areas of interest for consumers.

Utilized HEDIS® (Healthcare Effectiveness Data and Information Set) results and CAHPS® (Consumer Assessment of Healthcare Providers and Systems) data.[1]

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Combined Reporting Measures

- Measures for the 2016 (CY 2015) ICP Report Card were chosen based on a number of factors, such as:
  - Using measures that best approximate the reporting categories that are useful to consumers,
  - Using validated, audited data that are readily available,
  - Using nationally recognized, standardized measures of Medicaid and/or managed care data.
- ICP and FHP/ACA plan performance was combined and evaluated at the measure level. For purposes of the presentation, measures were organized into distinct categories, but category-level ratings were not presented.

	Combined Reporting Category
Categories	Doctors' Communication and Service
	Getting Care
	Behavioral Health
	Keeping Kids Healthy (FHP/ACA Only)

Report Card Approach

One combined report card that includes both the ICP and FHP/ACA populations.

The reporting categories and measures are the same for both populations, with the exception of the *Keeping Kids Healthy* measures.

Comparing Plan Performance

Methodology

Step 1: Data

- Extracted HEDIS rates from the auditor-locked data sets.
- Used NCQA CAHPS member-level data files and converted each individual response to a score of 1, 2, or 3 to calculate a rate for each CAHPS measure.
- Calculated the average of the individual three-point means scores to reach a plan average for each CAHPS item.
  - For the CAHPS global rating measures this plan average acts as the CAHPS measure score.
  - For the CAHPS composite measures, the CAHPS measure score is the average of the three-point means for each CAHPS item.
- Combined the ICP and FHP/ACA data, where appropriate. For CAHPS measures and HEDIS hybrid measures, HSAG calculated a weighted average using the eligible population size.

Comparing Plan Performance

Methodology

Step 2: Statewide means and standardization

- Computed the statewide mean and standard deviation for each CAHPS and HEDIS measure.
- Standardized each plan mean (CAHPS or HEDIS) by subtracting the mean of the plan means and dividing by the standard deviation of the plan means.

Step 3: Consumer friendly rating scale

- Used the standardized scores to assign ratings using an image of the state of Illinois.
  - The standardized score represents how many standard deviations the plan fell above or below the mean.
- The five-level rating scale provides consumers with an easy-to-read “picture” of quality performance across plans and presents data in a manner that emphasizes meaningful differences between plans.
- The rating scale on the next slide provides an overview of how ratings were assigned to each plan for a given measure based on their standardized score.

Comparing Plan Performance

Rating Scale

Rating	Plan Performance Compared to Statewide Average	
	**Highest Performance**	The plan's performance was 1.96 standard deviations above the Illinois Medicaid Health Plan average.
	**High Performance**	The plan's performance was 1 standard deviation above the Illinois Medicaid Health Plan average.
	**Average Performance**	The plan's performance was average compared to all Illinois Medicaid Health Plan average.
	**Low Performance**	The plan's performance was 1 standard deviation below the Illinois Medicaid Health Plan average.
	**Lowest Performance**	The plan's performance was 1.96 standard deviations below the Illinois Medicaid Health Plan average.

Draft Report Card

ILLINOIS MEDICAID

DRAFT 2015 ILLINOIS MEDICAID PLAN REPORT CARD

Comparing Illinois Medicaid Plans

This report card is for individuals in the Illinois Medicaid Family Health Plan (FHP) program or the Integrated Care Program (ICP) for seniors and individuals with disabilities. The report card shows how each plan does in providing care and services to their members for specific measures in key performance areas. The ratings for each plan are to help an individual pick a plan that is best for them. Not all plans may be available to pick based on geographic location.

Key

Highest Performance | High Performance | Average Performance | Low Performance | Lowest Performance

Performance Area Measures	Aetna Better Health	Blue Cross Community	Cigna-Health Spring	Community Care Alliance	County Care	Family Health Network	Harmony Health Plan	Humana Health Plan	IlliniCare Health	Meridian Health Plan	Molina Healthcare	NextLevel Health
Doctors' Communication and Service												
How Well Doctors Communicate												New*
Shared Decision Making								NA				New*
Rating of Personal Doctor												New*
Rating of Specialist Seen Most Often								NA				New*
Getting Care												
Getting Needed Care												New*
Getting Care Quickly												New*
Outpatient or Preventive Care Visits												New*
Cervical Cancer Screening												New*

NA not enough data available. * New health plan (data not available yet). — These perfomance area measures do not apply to the ICP-only plans.

What is Rated in Each Performance Area?

Doctors' Communication and Service

- How Well Doctors Communicate—How well do doctors listen and explain things to their members
- Shared Decision Making—How well do doctors involve members in choices about their care
- Rating of Personal Doctor—How do members in the plan rate their doctor
- Rating of Specialist Seen Most Often—How do members in the plan rate the doctor they see for special services

Getting Care

- Getting Needed Care—Members get the care they need
- Getting Care Quickly—Members get the care they need, when they need it
- Outpatient or Preventive Care Visits—Members have an outpatient or preventive care visit
- Cervical Cancer Screening—Members get screened for cervical cancer when needed

Draft Report Card

Performance Area Measures	Aetna Better Health	Blue Cross Community	Cigna-Health Spring	Community Care Alliance	County Care	Family Health Network	Harmony Health Plan	Humana Health Plan	IlliniCare Health	Meridian Health Plan	Molina Healthcare	NextLevel Health
Behavioral Health												
Initiation of Alcohol and Other Drug Addiction Treatment	3	3	3	4	3	2	3	4	3	3	2	New*
Follow-Up Care to a Hospital Visit for Members with Mental Illness	3	3	2	3	3	4	3	1	3	3	3	New*
Keeping Kids Healthy												
Kids Received Vaccinations	3	3	—	—	2	3	3	—	3	4	3	New*
Doctor Visits for Kids Younger than 15 Months	2	3	—	—	NA	3	3	—	3	4	3	New*
Doctor Visits for Kids Ages 3 to 6 Years	3	2	—	—	3	4	3	—	3	4	3	New*
Human Papillomavirus Vaccine (HPV) for Teenage Girls	3	3	—	—	2	3	3	—	3	4	3	New*
Body Mass Index (BMI) Percentile for Children/ Teenagers	3	1	—	—	3	3	3	—	3	3	3	New*

NA not enough data available. * New health plan (data not available yet). — These perfomance area measures do not apply to the ICP-only plans.

What is Measured in Each Performance Area?

Behavioral Health

- Initiation of Alcohol and Other Drug Addiction Treatment—Members get help for alcohol and other drug addiction
- Follow-Up Care to a Hospital Visit for Members with Mental Illness—Members get follow-up care 30 days after being in the hospital for mental illness

Keeping Kids Healthy

- Kids Received Vaccinations—Kids get vaccinations to help them stay healthy
- Doctor Visits for Kids Younger than 15 Months—Kids younger than 15 months old have 6 or more check-up visits with their doctor to help them stay healthy
- Doctor Visits for Kids Ages 3 to 6 Years—3 to 6-year-old kids have one or more check-up visits with their doctor to help them stay healthy
- Human Papillomavirus Vaccine (HPV) for Teenage Girls—Members get HPV shots when needed
- Body Mass Index (BMI) Percentile for Children/Teenagers—Members have their BMI measured at check-ups or when needed

Choosing a Medicaid Plan

Choosing the plan that best meets your health care needs is important. Here are some questions to ask before you pick a plan:

- **How did each plan rate in each area of the report card?**
- **Do the doctors in the plan I like communicate with their members?**
- **Do the members in the plan I like get care when they need it?**
- **Do members with behavioral health conditions get the care they need?**
- **Do kids get the care they need to stay healthy?**

Have more questions about picking a Medicaid plan?

When it is time to pick a plan, you can contact **Illinois Client Enrollment Services** at 1-877-912-8880 (TTY: 1-866-565-8576). The call is free. Or you can go online at www.enrollhfs.illinois.gov. They will provide you with more information about each plan available to you. They can also tell you what doctors are in a plan and what extra benefits they offer. You can also contact the plans directly for more information about their plan using the information below. Not all plans listed may be available to you.

Draft Report Card

Plans	Contact Information	Available in the Following Counties
Aetna Better Health ■▲	1-866-212-2851 | TTY: 1-800-526-0844 www.aetnabetterhealth.com	Boone, Cook, DuPage, Kane, Kankakee, Lake, McHenry, Will, and Winnebago
Blue Cross Community ■▲	■ 1-888-657-1211 | ▲ 1-877-860-2837 TTY: 1-800-526-0844 ■ www.bcbsilcommunityicp.com ▲ www.bcbsilcommunityfamilyhealthplan.com	Cook, DuPage, Kane, Kankakee, Lake, and Will
Cigna-HealthSpring ■	1-866-487-4331 | TTY: 1-800-526-0844 www.specialcareil.com	Cook, DuPage, Kane, Kankakee, Lake, and Will
Community Care Alliance ■	1-866-871-2305 | TTY: 1-888-461-2378 www.ccaillinois.com	Boone, Cook, DuPage, Kane, Kankakee, Lake, McHenry, Will, and Winnebago
CountyCare ■▲	1-855-444-1661 | TTY: 1-800-526-0844 www.countycare.com	Cook
Family Health Network ▲	1-888-346-4968 | TTY: 1-800-422-1942 www.fhnchicago.com	Cook, DuPage, Kane, Kankakee, Lake, and Will
Harmony Health Plan ▲	1-800-608-8158 | TTY: 1-877-650-0952 www.harmonyhpi.com	Clinton, Cook, DuPage, Jackson, Kane, Kankakee, Lake, Madison, Perry, Randolph, St. Clair, Washington, Will, and Williamson
Humana Health Plan ■	1-800-764-7591 | TTY: 1-800-526-0844 www.humana.com	Cook, DuPage, Kane, Kankakee, Lake, and Will
IlliniCare Health ■▲	1-866-329-4701 | TTY: 1-866-811-2452 www.illinicare.com	Boone, Cook, DuPage, Henry, Kane, Kankakee, Lake, McHenry, Mercer, Rock Island, Will, and Winnebago
Meridian Health Plan ■▲	1-866-606-3700 | TTY: 1-800-526-0844 www.mhplan.com	Adams, Brown, Boone, Champaign, Christian, Clinton, Cook, DeKalb, DeWitt, DuPage, Ford, Henderson, Henry, Kane, Kankakee, Knox, Lake, Lee, Livingston, Logan, Macon, Madison, McLean, McHenry, Menard, Mercer, Peoria, Piatt, Pike, Rock Island, Sangamon, Scott, St. Clair, Stark, Tazewell, Vermilion, Warren, Will, Winnebago, and Woodford
Molina Healthcare ■▲	■ 1-855-766-5462 | ▲ 1-855-701-4886 TTY: 1-800-526-0844 www.molinahealthcare.com	Champaign, Christian, Clinton, Cook, DeWitt, Ford, Knox, Logan, Macon, Madison, McLean, Menard, Peoria, Piatt, St. Clair, Sangamon, Stark, Tazewell, and Vermilion
NextLevel Health ■▲	1-844-807-9734 | TTY: 1-800-526-0844 www.NextLevelHealthIL.com	Cook

■ ICP plan. ▲ FHP Program plan.

Information as of October 2016.

ILLINOIS DEPARTMENT OF Healthcare and Family Services

Need More Information on Your Medicaid Plan Choices?

Visit the Illinois Department of Healthcare and Family Services online at: www.illinois.gov/hfs and Illinois' Client Enrollment Services online at: www.EnrollHFS.Illinois.gov

About This Report Card

The information in this report card was collected from the plans and their members. The information was reviewed for accuracy by independent organizations. The 2016 National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®) and Consumer Assessment of Healthcare Providers and Systems (CAHPS®) data was used in this report card to rate the ICP plans. HEDIS® is a registered trademark of NCQA and CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

THANK YOU!

ANY QUESTIONS?