IAMHP
ILLINOIS ASSOCIATION OF MEDICAID HEALTH PLANS

Op-Ed

State of Illinois Medicaid Managed Care
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In 2011, Illinois moved away from a one-size fits all, fee-for-service Medicaid program and transitioned to Medicaid Managed Care. Illinois expanded the program with the January 1, 2018, launch of HealthChoice Illinois, emphasizing individualized and preventative community-based healthcare, which increased the focus on patient safety.

The transition from a fee-for-service program to a Medicaid managed care system came with challenges. In order to address those challenges and move the needle toward quality healthcare, Managed Care Organizations (MCOs) and Providers (Hospitals) must take accountability and work together to create higher standards of care and improve the quality of data provided to MCOs.

Quality healthcare means more than direct access to healthcare professionals, it also means straightforward billing for the hospital and its patients; that's why in past 6 months the Illinois Association of Medicaid Health Plans (IAMHP) has:

- Created the first ever standardized billing guide to help providers understand the rules and regulations for billing for services to Medicaid beneficiaries.
- Coordinated regular meetings between MCOs and hospitals to discuss solutions to challenges they face.
- Worked closely with the Illinois Critical Access Hospital Network and their billing and coding expert to help teach their member hospitals how to bill.

Recently there has been an increased focus on denial rates and the challenges providers are facing. The Department of Healthcare and Family Services reported the average hospital denial rate was 10.62% and the rate of denial based off of medical necessity was .4%*, which is in line with averages seen on the commercial side (between 7 & 11%). Also, there are hospitals with 2 or 4% denial rates. Hospitals who have shared access to their electronic medical record with health plans have seen decreased administrative burden and decreased denial rates.

It's important to note, the reasons for many denials are because MCOs are billed for members who are not eligible for Medicaid, for non-Medicaid related services (i.e. Medicare), or for services not covered by Medicaid. Medicaid health plans are the stewards of taxpayer resources and are charged with ensuring limited resources are spent appropriately.

IAMHP conducted a deeper dive into the report to better understand the cause for denials and found some common areas for a large portion of denials including additional information. Meaning claims are denied because the provider failed to supply required information (i.e. doctor's notes to support an enhanced level of service). We also learned a reason for these high rates stem from the same incorrectly submitted claims being resubmitted several times with the same incorrect information.

While we experienced some challenges, we have definitely seen managed care work for many providers. Some providers reinvested in their people and infrastructure and have achieved a total cost per patient that was more than $110 lower than the state average for Federally Qualified Health Centers (FQHCs) and where monthly claims have been at times nearly 60 percent ($450) lower than the MCO's average. A lot of safety nets could decrease denials by 70 percent* by simply submitting additional information with their claim.

The Medicaid Program could benefit from more accountability, but providers should not be exempt from this accountability. We all need to do our part to make our Medicaid program successful and to ensure Medicaid members receive the quality care they deserve to live longer, healthier, happier lives.