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Illinois  
State  
Medical  
Society



Illinois Medicaid Managed Care  
**A Physician Survey**



# Prologue

The transition to managed care organizations for the majority of Illinois Medicaid patients is causing significant concern and confusion, both for patients and for health care professionals. Patients are having a hard time understanding the new system and their responsibilities within it, and physicians are frustrated by the administrative hassles and lack of transparency they are encountering as the transition progresses.

In order to assess these difficulties, the Illinois State Medical Society surveyed nearly 900 health care professionals throughout the state. The results of this survey identify common areas of concern, and reveal several action steps that should be taken to make care coordination within Illinois' Medicaid system work for patients and those who care for them.

# Introduction

From July through September of 2016 a survey of Illinois physicians and practice management professionals was conducted. The purpose was to assess the medical practice impact of the Medicaid managed care transition currently underway. The survey garnered 874 responses from medical professionals throughout the state. More than 90 percent of responses were submitted by physicians. A slight majority of physician respondents identified as primary care doctors, with the rest selecting specialty care.

This project was initiated by the Illinois State Medical Society (ISMS) and was promoted by the Illinois Psychiatric Society (IPS), the Illinois Academy of Family Physicians (IAFP) and the Illinois Chapter of the American Academy of Pediatrics (ICAAP).

# Background

As of July 2016, almost 3.1 million individuals are covered under Medicaid and CHIP in Illinois. Enrollment under the program surged beginning in 2013 due to Illinois' participation in the Medicaid expansion authorized under the *Affordable Care Act (ACA)*. During this period of significant expansion, Illinois' Medicaid program has also been contending with a major transformation, brought about by *Public Act 96-1501*, which passed in 2011. The *Act* initiated a significant shift toward coordinated care organizations for a majority of the Medicaid population.

[Access the ISMS Issue Brief on the transition to mandatory managed care for more information.](#)

During this transition ISMS has helped physicians address areas of concern one-on-one and at the policy level. This 2016 survey was conducted to assess the transition and identify further areas for potential improvement.

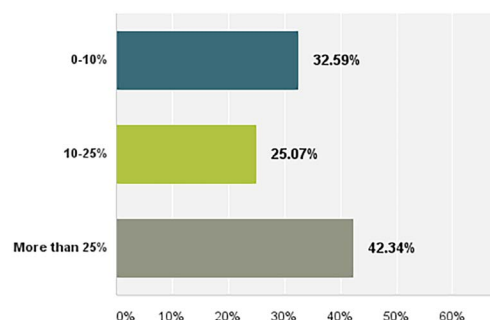
# About Participants

To participate in the survey, participants had to affirm that they accept Medicaid.

Four in five survey participants indicated they participate in a Medicaid Managed Care Organization (MCO). Of those, most participate in 2-5 MCOs.

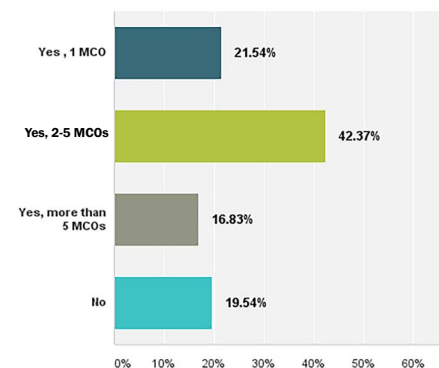
## Practice Medicaid Volume

Physicians were asked to estimate the percentage of Medicaid patients seen through their practices.



## Medicaid MCO Participation

Most practices that participate in Medicaid indicated they are also participating in at least one MCO.



# Findings

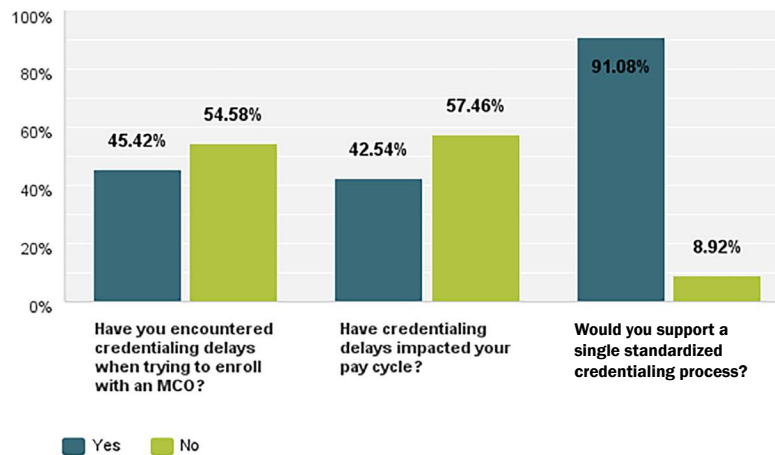
Illinois medical practices have found the Medicaid managed care transition to be complicated and identified several areas of concern related to administrative function and transparency. Unlike traditional Medicaid where there is one payer, one set of rules and one patient population, medical practices now must routinely deal with conflicting policies and reimbursement practices for the various MCOs, including the need to verify *which* of the various MCOs the physician participates.

## MCO Credentialing is Cumbersome

Significant concern was raised over the length of time required to apply for MCOs and the need to credential with multiple entities within the Medicaid program.

- Forty-five percent of doctors encountered delays when attempting to enroll with an MCO and 43 percent indicated the delays impacted their reimbursement cycle.
- Sixty-three percent of respondents indicate it took longer than 60 days on average to activate an MCO contract as “in-network.”
- An overwhelming number of doctors support a standardized MCO credentialing process.

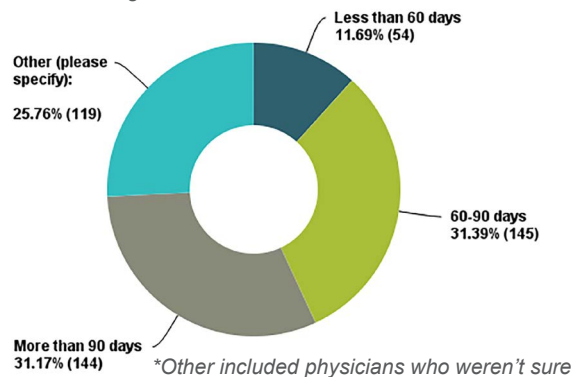
## Physicians Support a Uniform Credentialing Process



## Communication, Transparency and Information Sharing Must Improve

“ For some MCOs, it is difficult to find an individual who can answer your question - it is typical to be transferred multiple times, spending 30+ minutes on the phone, and ending the call without an answer. ”

Credentialing wait times:



Medical practices do not perceive that MCOs are effectively providing adequate administrative information.

- Almost 49 percent of respondents said they do not have timely access to a staff contact with their MCOs.
- Forty-five percent of respondents indicated that their issues are not adequately addressed then they contact an MCO with a concern.
- Only 13 percent of respondents indicated being able to access a plan handbook for all of the MCOs in which they participate.

### Patients and Physicians Experiencing Significant Burdens with Drug Formularies

- Seventy-two percent of respondents indicate that MCO drug manuals are not clearly posted or easy to navigate.
- There are significant issues related to prior authorization:
  - Roughly half of all prescriptions require prior authorization;
  - Two-thirds of respondents indicate that prior approval criteria are not clear for the MCO(s) with which they contract; and
  - Only 56 percent of physicians indicated that at least some of the MCOs offer formularies that include products widely used by their specialty.

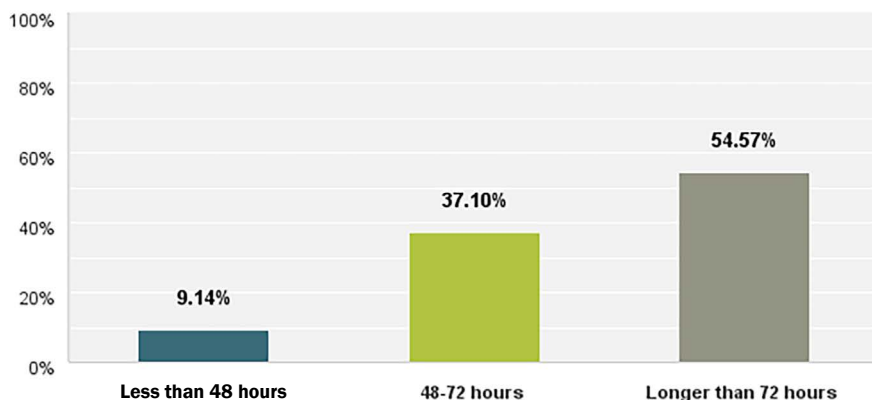
### Formulary Clarity and Prior Authorization Requirements Must Improve

Significant concern was raised over the length of time required to apply for plans and to credential with multiple entities within the Medicaid program.



*It was a rude awakening to find out that medications that were covered under regular public aid now are denied under the MCO.*

*In your experience, how long (on average) does the MCO take to grant prior approval?*

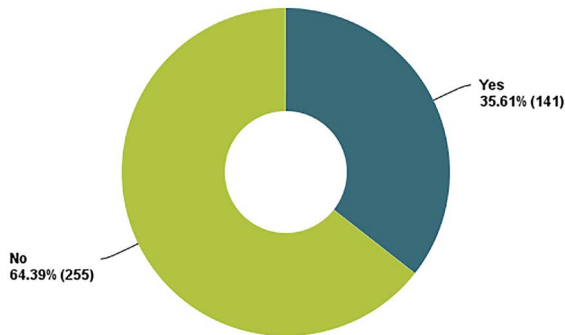


## Patients Are Often Confused About the MCOs, their Assignment and How the Coverage Works

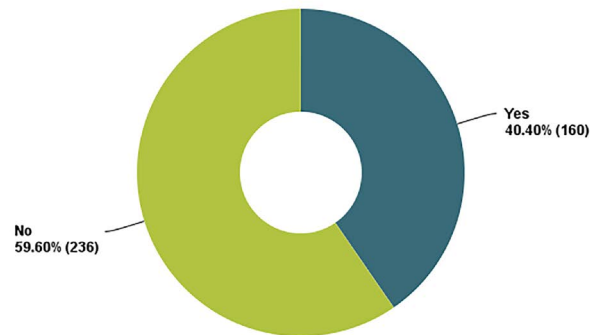
- More than 90 percent of respondents indicate their patients have a general lack of understanding of their MCO's prescription medication limitations and the fact that the medications may require prior authorization.
- Only 20 percent of respondents believe their MCO patients understand the "in-network" limitations of their coverage.

## Patient Education Needs to Be a Priority

Do your patients generally know the MCO to which they belong or are assigned?



Do your patients generally know which primary care physician they have chosen or been assigned?



“ I don't know if they understand all the details, but they don't like them. And neither do we. It causes particular difficulty when a high acuity patient is seen in the hospital and needs close follow-up but can't be seen in a timely manner because of the MCO restrictions. ”

# Conclusion

The ISMS Medicaid Managed Care Survey shows there is a great deal of concern, confusion and angst with the transition to managed care organizations for the majority of the Medicaid population. The responses leave no doubt about the perception that Medicaid patients do not know how this system is supposed to work, and do not understand their individual responsibilities with regard to selecting a primary care physician. Physicians are frustrated by the hassles they are experiencing as they try to communicate with various MCO entities about their processes and policies, including payment levels, timeliness, patient assignment and more.

Last April the ISMS Council on Economics, acting on a report from its Sub-Committee on Medicaid Managed Care, highlighted a series of concerns with the MCO transition and made recommendations to address them:

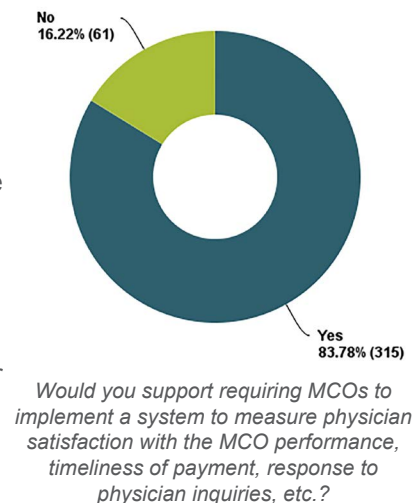
- A **common credentialing system** is desperately needed to reduce hassles and duplication of effort by busy physicians.
- A **baseline state-maintained drug manual** would protect patients by requiring MCOs to abide by the coverage guidelines and product offerings included on the existing Medicaid drug manual and preferred drug list.
- **Greater transparency** is vital, including **consistent staff contacts** within the MCOs for physicians to obtain information, determine patient eligibility, clarify complex issues, and discuss coverage of medically necessary treatment and drugs.
- **Widespread public reporting** on the quality and effectiveness of these entities is critical to assessing the success of the program and shaping the future of Medicaid in Illinois; as evidenced by the survey, physicians would welcome the opportunity to have input into the plans' overall evaluations.

The physician feedback gathered by this survey broadly supports these recommendations.

While the Illinois Department of Healthcare and Family Services (DHFS) is working with the MCOs address many issues including network adequacy and access to specialty care, as well as some of the issues identified by ISMS, more needs to be done.

The results of this survey have been shared widely with medical stakeholders including IPS, IAFP and ICAAP. They have also been shared with DHFS, the Illinois Association of Medicaid Health Plans, individual MCOs, legislators, regulators, and other stakeholder entities, to promote quality care and seek necessary improvements in this process. Additionally, ISMS staff members are willing to meet with county medical societies and practice manager groups to discuss member experiences and share survey data.

The concept of managed care is being embraced by state Medicaid programs and legislatures across the country. It is imperative that ISMS take the lead, working with all stakeholders to encourage improvements and ensure quality and continuity of care in the Medicaid program. These survey results are a great beginning, and ISMS thanks all who took the time to provide their input.





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