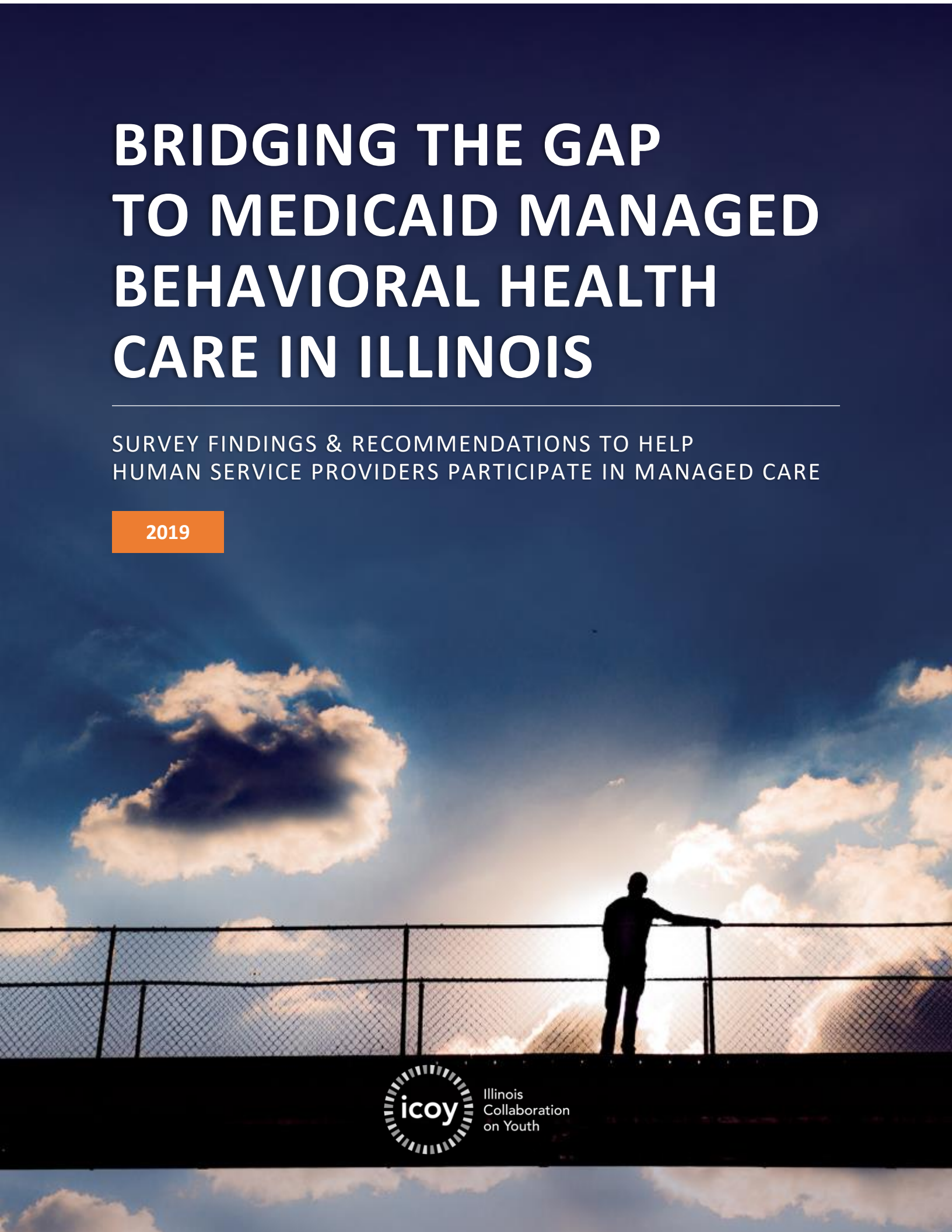
# BRIDGING THE GAP TO MEDICAID MANAGED BEHAVIORAL HEALTH CARE IN ILLINOIS

SURVEY FINDINGS & RECOMMENDATIONS TO HELP HUMAN SERVICE PROVIDERS PARTICIPATE IN MANAGED CARE

2019



icoy Illinois Collaboration on Youth

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## Introduction

Illinois moved to Medicaid managed care (MMC) as a strategy to improve healthcare outcomes for low-income individuals and reduce healthcare costs, a state that has long struggled with financial sustainability. As a trusted advocate for children, youth, and family providers, Illinois Collaboration on Youth (ICOY) has listened to the concerns around billing Medicaid, and now MMC. These are the same community-based providers that were devastated by the Illinois' historic and destructive two-year budget impasse yet continued to serve the state's low-income families. Our mission is to support human service providers, and right now a primary need is to help them build the administrative and technical infrastructure to bill MMC and prepare for the future of value-based payment (VBP).

This report presents a snapshot of Medicaid readiness among human service organizations who provide behavioral or social determinants of health services in Illinois, and a reality check on the state's plans for rapid transition to a new billing environment for human service providers who serve low-income children and adults. Providers are eager to deliver services that improve healthcare outcomes for the individuals, families, and communities they serve, but, on the whole, are not well-prepared for this administrative change. The ripple effects from the budget impasse are still being felt, with providers struggling to rebuild their capacity, recruit and train qualified staff, and develop the infrastructure needed to successfully participate in MMC.

The people who depend on these organizations for essential behavioral and social health services need the entire MMC system to be functioning well because no single organization can serve all needs for all people. For example, a biological parent may need to access substance abuse treatment and maintain sobriety to regain custody of their children from foster care. A person experiencing homelessness may need access to stable housing to be able to refrigerate their medications. A family escaping domestic violence may need counseling to address their trauma, and so on. At a systems level, we need providers across the continuum to be able to successfully bill MMC if we want the system to work.

What does it mean to successfully participate in MMC? At a minimum, providers must be able to contract with Managed Care Organizations (MCOs), deliver Medicaid-billable services, gather client and service information in electronic health records systems, submit bills through a Medicaid-compatible billing system, and—importantly—get paid for their work.

Illinois can be a leader in healthcare by supporting provider networks that uplift behavioral and social health care and prioritize racial equity. If our MCO provider networks are strong, we can reduce the cost of Medicaid, increase regular access to integrated healthcare, and help all individuals to thrive.

We want to thank our funders: the Conant Family Foundation, Grant Healthcare Foundation, the Illinois Legislative Black Caucus (through the Illinois Department of Human Services), an anonymous donor, and Polk Bros. Foundation. Their generosity, vision, and responsiveness will help ensure health equity and that Medicaid clients can access quality care in their communities from organizations they know and trust, and that understand and respect their needs, culture, and life experiences. We could not have started this process without you. We say "start" meaningfully, because this is only the beginning.

Andrea Durbin, CEO of Illinois Collaboration on Youth (ICOY)
Carrie Muehlbauer, Director of ICOY Medical Technical Assistance Center (MTAC)

## Key Findings

To understand the current Medicaid readiness of human service providers (providers), we identified two factors as important indicators of readiness: their participation in Medicaid and their billing infrastructure capabilities. Here are the six key findings from our survey.

- Medicaid Readiness: Most (60%) of the providers surveyed do not have an MMC contract.
- Billing Infrastructure: Only 33% of providers report they are comfortable with their billing systems.
- Medicaid Readiness and Infrastructure: There is a clear connection between having contracts with MCOs and having stronger billing infrastructure.
- Smaller providers and providers serving predominantly communities of color are the least prepared to bill MMC, in both measurements of readiness and billing infrastructure capabilities.
- Experience with MCOs: Only 7% of organizations report their experience with MCOs went fairly smoothly.
- VBP: Only a small group of providers (8%) are participating in VBP.

## The Need

Behavioral health disorders can impact anyone. The Centers for Disease Control (CDC) estimates that each year one in five Americans experience mental illness and one in 25 live with a serious mental illness (SMI) (e.g. schizophrenia, bipolar disorder, or major depression).[1] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), around 8.4% of adults have a substance use disorder.[2] While behavioral health disorders are recurrent and often serious, they are also common, preventable, and treatable.[3]

Despite effective treatment modalities, only 41% of adults in the U.S. with a mental health condition receive services and only 62.9% of those with a SMI.[4] Common reasons people do not receive treatment are stigma[5] and cost.[6] For individuals receiving care through MMC, access is dependent on the network adequacy of their MCO. In comparison to white Americans, African and Hispanic Americans use mental health services at about one-half and Asian Americans at about one-third the rate.[4] Most of the Illinois Medicaid population (~59%) are not white.[7]

To make MMC a success in Illinois, we need a healthcare system that works for everyone. And so, while ICOY represents providers who serve children, youth, and families, our Medicaid readiness survey was for providers serving, or who may serve in the future, all Medicaid beneficiaries. We expanded our scope because we know that for children and youth to be best supported, their caregiver(s) also need easy access to healthcare. In fact, the single biggest predictor of a child's health is the health of their caregiver(s).[8] In addition, we expect that the children and youth served by our coalition will one day grow up to be adults who may need to access a functioning behavioral healthcare system.

The healthcare landscape in Illinois is in an exciting time of significant change. There are numerous efforts underway in the state to improve the integration of physical healthcare with behavioral healthcare, and social services. This includes a myriad of new programs and a long-term vision to move to VBP. All of these state initiatives will require the provider community to bill MMC. If providers cannot, they will either lose or miss out entirely on, much needed revenue. Most importantly, Medicaid beneficiaries will continue to experience poor network adequacy, including limited or no choice of providers, and lack of access to providers that can provide culturally-competent care.

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[1] Centers for Disease Control and Prevention (CDC). Learn About Mental Health. (2018). Retrieved from https://www.cdc.gov/mentalhealth/learn/index.htm

[2] Lipari, R. and Van Horn, S. (2017). The CBHSQ Report. Retrieved from https://www.samhsa.gov/data/sites/default/files/report_2790/ShortReport-2790.html

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[7] Henry J. Kaiser Family Foundation. (2013). Medicaid Enrollment by Race/Ethnicity. Retrieved from https://www.kff.org/medicaid/state-indicator/medicaid-enrollment-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[8] Murphey, D., Cook, E., Beckwith, S., & Belford, J. (2018). The Health of Parents and Their Children: A Two Generation Inquiry. Retrieved from https://www.childtrends.org/publications/the-health-of-parents-and-their-children-a-two-generation-inquiry.

## Survey Methods & Outreach

In early fall 2018, ICOY contracted with Health Management Associates (HMA) to conduct an assessment on provider readiness to bill MMC. The survey was developed by HMA with the support of a diverse steering committee of seven organizations. The survey had two parts, an online survey to gather information on organizational structure and capabilities, as well as a revenue spreadsheet. The survey itself was beta-tested by the members of the steering committee, whose feedback contributed significantly to the final product.

The survey was initially distributed in the first week of December 2018 and was open to all human service providers or other providers that were currently billing, or may in the future bill, MMC. In this report human service organizations (providers) represent an entire organization that participated in the survey, even if they have several service locations. The survey closed in January 2019; a total of 160 online survey responses were received. Of those, 134 were considered suitable for analysis due to incomplete or duplicate responses. See Appendix A for a list of providers that participated in the survey.

ICOY sent the survey to over 455 individuals and also engaged our community partners and funders to help spread the word about the opportunity. We spoke to several groups and coalitions, including Illinois Partners for Human Service, and the annual conference of the Illinois Association of Medicaid Health Plans, to raise awareness. We also conducted a webinar which was posted on our website, to help providers understand what the survey was trying to accomplish. While we are under no illusions that we were able to reach the entire universe of community-based human service providers, we believe that these results document a representative cross-section of the human service provider community and provide a useful snapshot of the state of Medicaid readiness in Illinois at this time.

## Findings & Analysis

Our goal was to best reflect the Illinois human service provider community and we were glad a range of organizations participated in the survey. Here is a summary of their characteristics across five categories.

1. **Services Provided:** Each provider indicated the services they provide from a list of 37 (see Table 1, Appendix B). The most represented service was case management (77%).
2. **Target Population:** Each provider indicated their target population(s) from a list of 22 (see Table 2, Appendix B). The most represented target population was children and youth with mental health disorders (57%).
3. **Geographic Regions:** Each provider indicated the geographic regions they serve from a list of seven (see Table 3, Appendix B). Several organizations provided services throughout the entire state; 78% provide services in Cook or the Collar Counties and 22% do not.
4. **Revenue/Organization Size:** Each provider reported their general revenue which was used as an indication of organization size (see Table 4, in Appendix B). Revenue size was fairly evenly distributed, with most providers (31%) falling between the $1 Million to $5 Million range.
5. **Client Demographics:** Each provider indicated the client demographics by race (see Table 5, Appendix B). Similar percentages for White (33%), Multi-Racial (31%) and Black (28%) were reported, however, there was much less for Latino (5%) and Asian (1%).

## Medicaid Participation

The first category of Medicaid readiness is participation. We defined five categories of participation seen in Table 6 below. Our survey indicates significant variations in Medicaid participation.

**Key Finding:** A majority (60%) of providers are not enrolled in MMC.

| **Table 6. Medicaid Participation Status (N=130)** | | |
|---|---|---|
| **Medicaid Participation Category** | **Number** | **Percentage** |
| 1. **No Medicaid + No Action** Not enrolled in Medicaid and not taking action | 50 | 39% |
| 2. **No Medicaid + Action** Not enrolled in Medicaid but anticipate doing so | 5 | 4% |
| 3. **Medicaid Only** Enrolled in Medicaid, but not in managed care | 22 | 17% |
| 4. **MMC** Have Medicaid managed care contract(s) | 42 | 32% |
| 5. **MMC & VBP** Managed care with some value-based payment | 11 | 8% |

Interestingly, 91% of those not participating in MMC (groups 1 and 2) indicated they do not plan on taking action to enroll. However, about a quarter of this group reported MMC has impacted them adversely—either materially (10%) or somewhat (14%). We take this as a reflection of the strained relationship between providers and the State of Illinois' Medicaid program because even though these organizations reported no specific plans to bill MMC, only a very small group indicated a firm position about not ever enrolling in MMC. [9]

**Key Finding:** Smaller providers and providers serving predominantly communities of color are the least prepared to bill Medicaid managed care, in both measurements of readiness and billing infrastructure capabilities.

Large providers are more like to have MMC, and smaller providers are more likely to not bill Medicaid. See Figure 1 (and Table 10 in Appendix B) and organizations serving predominantly white populations are more likely to participate in MMC (and Table 11 in Appendix B) and Figure 2.

[9] Table 7 (In Appendix B) shows the Medicaid participation categories across service population categories. For example, 83% of organizations that provide shelter care do not bill MMC, followed by afterschool programming at 74%.

Table 8 (Appendix B) shows the Medicaid participation categories across target populations. Nearly three-fourths -- 72% -- of providers that serve adults with mental health disorders do not bill MMC, followed by older adults at 63%.

Table 9 (Appendix B) shows the Medicaid participation for geographic regions. Two-thirds of providers that bill MMC have sites in Cook County or the Collar counties.

**Figure 1: Medicaid Participation for Providers with Less than $1 Million in Revenue:** This chart shows the Medicaid participation for the smallest providers ($1 million in revenue or less). No Medicaid-No Action (46%), No Medicaid – Action (8%), Medicaid Only (17%), MMC (29%) and MMC & VBP (0%).

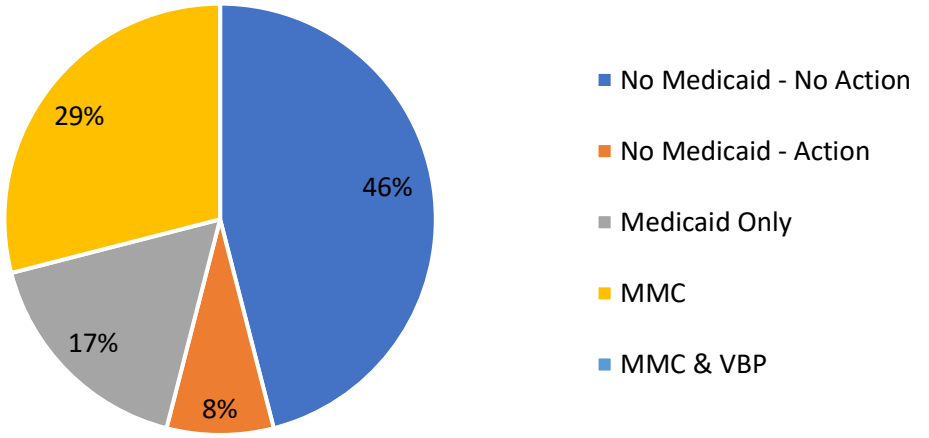
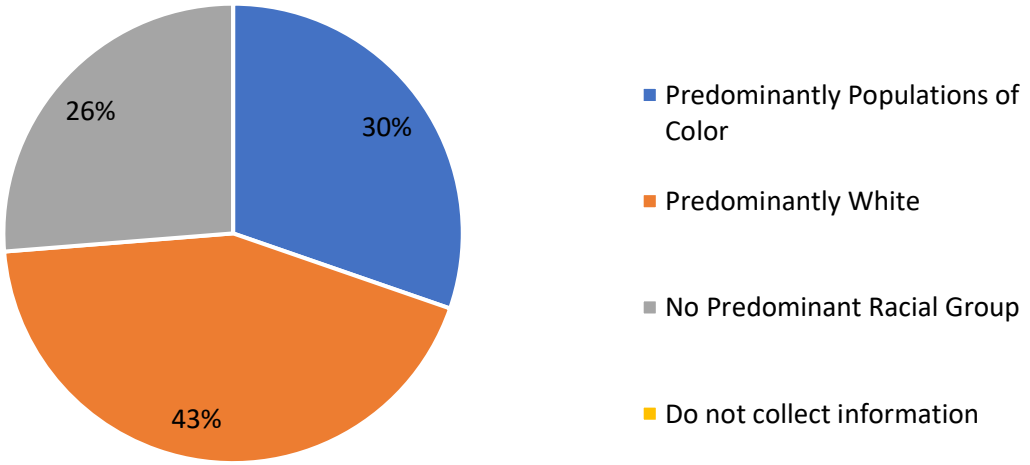



**Figure 2: MMC Participation by Client Demographics:** This chart shows participation in MMC and/or VBP by client's race, with predominantly populations of color (36%), predominantly white (54%), and no predominant racial group (35%). Please note communities of color are displayed together so to not identify providers due to sample size.



## Infrastructure Capability

The second category of Medicaid readiness is infrastructure capability. Infrastructure capability categories were determined from organizations' answers to four survey questions about their current billing infrastructure. We categorized each respondent into one of four categories as seen in Table 12 below.

| Table 12. Infrastructure Capability Among All Providers Enrolled in Medicaid (N=79) | | |
|---|---|---|
| **Infrastructure Category** | **Number** | **Percentage** |
| **1. Largely manual billing** or using MBS/DARTS without much other computerization | 12 | 15% |
| **2. Some electronic billing** but little confidence it would be sufficiently robust for future | 19 | 24% |
| **3. Reasonable degree of electronic billing** but some uncertainty that the applications were sufficient for both billing and clinical data analysis | 22 | 28% |
| **4. Relatively comfortable with their electronic billing** | 26 | 33% |

**Key Finding:** Notably, only 33% of providers report they are comfortable with their billing systems.

Billing infrastructure is closely related to the functionality and comfort with a provider's electronic billing system. A total of 15 respondents indicated they are thinking about installing a new electronic system or upgrading current systems; of those, 86% reported that they were not sure what system to get. The concerns of these providers are reflected in Table 13 (in Appendix B). See additional characteristic information in footnote.[10]

**Key Finding:** Smaller providers and providers serving predominantly communities of color are the least prepared to bill MMC, in both measurements of readiness and billing infrastructure capabilities.

Smaller providers are significantly less likely to be comfortable with their billing infrastructure than larger providers, see Figure 3 below (and Table 17, Appendix B), and organizations serving predominantly communities of color are less comfortable with their degree of infrastructure capabilities than providers with mixed or predominantly white clients, see figure 4 (and Table 18, Appendix B).

[10] Table 14 (in Appendix B) shows the infrastructure categories across service population categories. Half of the organizations that provide adult day care services largely use manual billing, followed by 33% of providers that provider shelter care.

Table 15 (in Appendix B) shows the infrastructure categories across target populations. A quarter of providers that serve older adults do not bill MMC, followed by 25% of providers that serve survivors of sexual assault.

Table 16 (in Appendix B) shows the infrastructure categories across geographic regions, providers that are in Cook or Collar Counties are somewhat more likely to be comfortable with their systems than providers that are outside of the Chicago metropolitan area.

**Figure 3: Infrastructure Capability for Providers with less than $1 Million in Revenue:** The following chart shows the infrastructure capability for the smallest providers ($1 million in revenue or less). Largely manual billing (8%), some electronic billing (33%), reasonable degree of electronic billing (50%), relatively comfortable with electronic billing (8%).

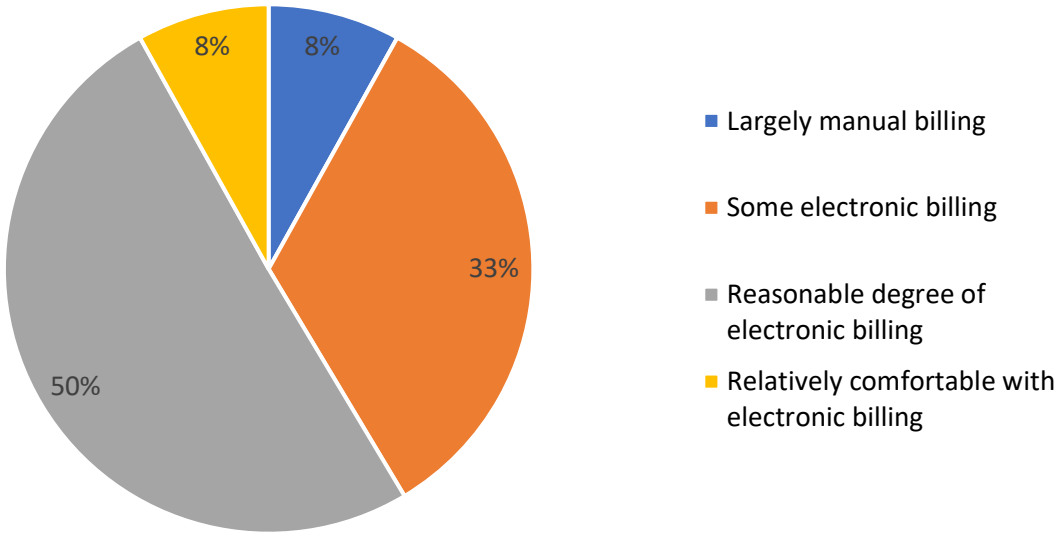
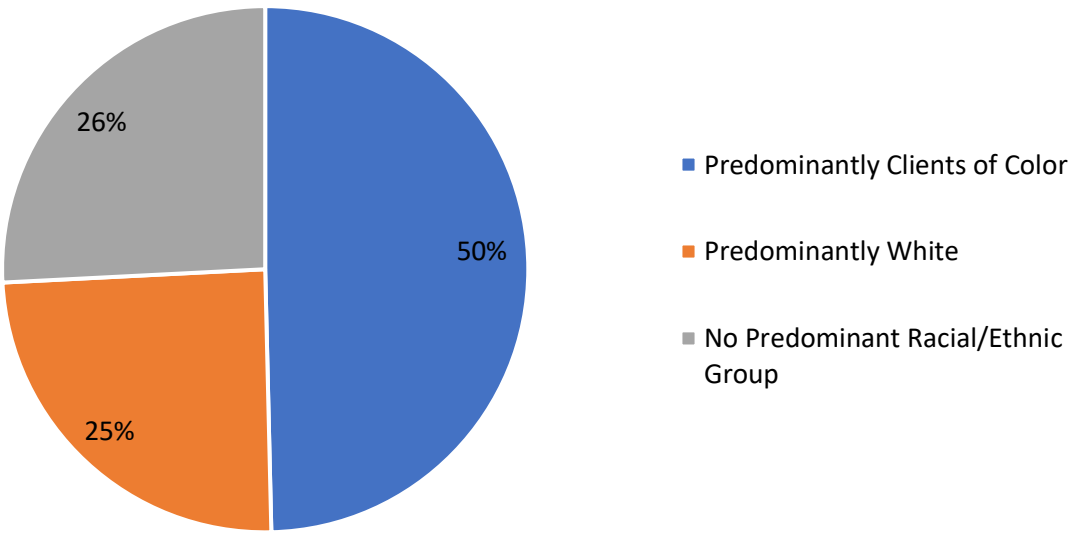



**Figure 4: Percentage of Largely Manual Billing by Client Demographic**: This chart shows the infrastructure capability by client demographics, with predominantly populations of color (50%), predominantly white (25%), and no predominant racial group (26%). Please note communities of color are displayed together so to not identify providers due to sample size.



## Medicaid Participation & Infrastructure Capability

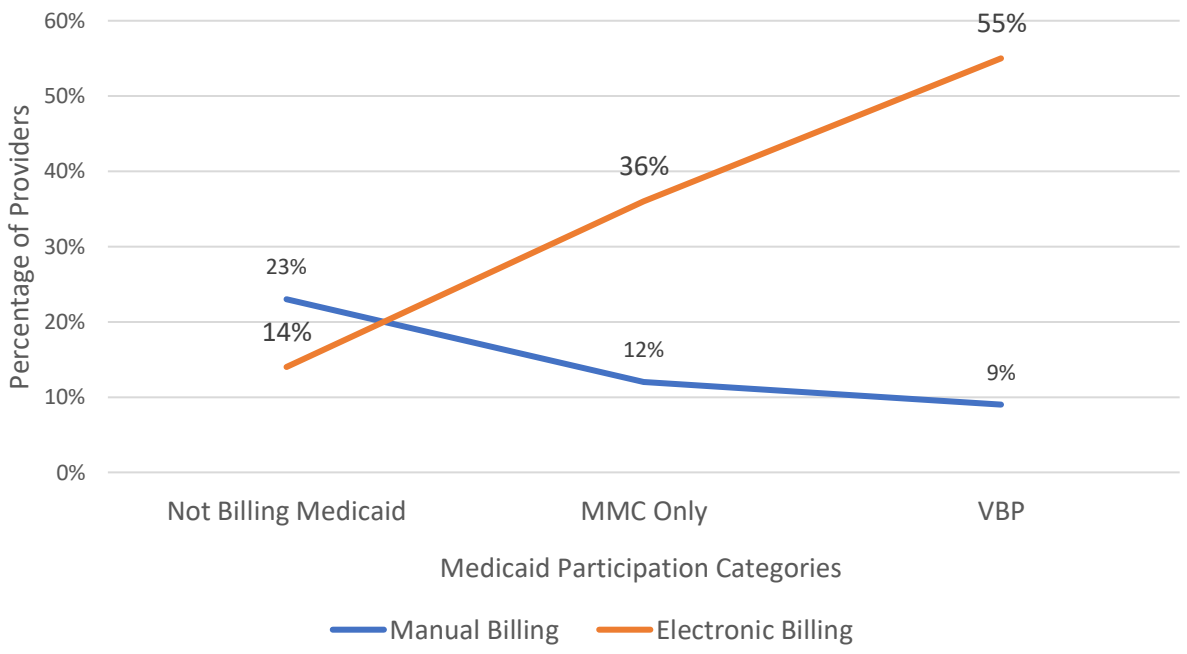
Finally, we compare Medicaid participation and infrastructure capabilities.

**Key Finding:** There is a clear connection between having contracts with MCOs and having stronger billing infrastructure. See Table 19 and Figure 5 below.

**Table 19. Infrastructure Capability Among All Providers Enrolled in Medicaid (N=75)**

| Category | No Contract with MCO | MMC Contract(s) | MCO Contract + VBP |
|---|---|---|---|
| Largely manual billing | 23% | 12% | 9% |
| Some electronic billing | 41% | 17% | 18% |
| Reasonable degree of electronic billing | 23% | 36% | 18% |
| Relatively comfortable with their electronic billing | 14% | 36% | 55% |
| TOTAL (N) | 22 | 42 | 11 |

**Figure 5: Percentage of Medicaid Participation for Providers who are Manual Billing (blue) and Electronic Billing (orange):** This chart shows two line graphs. The ascending line shows the percentage of providers comfortable with their electronic billing compared to Medicaid infrastructure: not billing (14%), MMC only (38%) and VBP (55%). The descending line shows the percentage of providers who are billing manually compared to Medicaid infrastructure: not billing (23%), MMC only (10%) and VBP (9%).



## Managed Care Sentiment

**Key Finding:** Organizations indicated their highest concerns and frustrations around clean claims. Table 20 below shows provider's experiences with MCOs.

| Table 20. Experience with MCOs Among Providers with MMC Contracts (N=29) | |
|---|---|
| **Response** | **Percentage** |
| Gone Fairly Smoothly | 7% |
| Hard At First, But Has Improved | 31% |
| Been Rocky From Start, But We're Managing | 55% |
| Been Awful | 7% |

Interestingly, among the lower levels of concern was getting credentialed (27%), while the greatest concern was about clean claims (59%). Nearly 60% also indicated following up with claims after submission as an area of concern, including addressing rejected or denied claims. In open-ended comments, there were numerous complaints about slow payments and administrative hassles.

Provider concerns with MCOs were spread over a range of issues and are detailed in Table 21 and 22 (Appendix B). **More than 50% of the respondents reported the biggest concerns were around delays in getting paid.** Note, because not all respondents are billing managed care, their experiences are in Medicaid billing through the state of Illinois.

## Value-Based Payment (VBP)

**Key Finding:** Only a small group of providers (8%) are participating in VBP.

A significant number of providers were unsure of how well they would be able to collect, analyze, and present data on clinical outcomes. Organizations reported their ability to report clinical data in Table 23 (Appendix B).

## Recommendations

Given that 70% of providers will soon be navigating MMC for the first time, the State of Illinois needs to support them to successfully transition to MMC. Here are our recommendations for how to help Illinois' MMC behavioral health system succeed. It is important to note that, if set up correctly, Illinois could draw down Federal Medicaid reimbursement to support some of these Medicaid capacity building initiatives, as other states do. This could help ease the burden on the state's financial challenges while still building a robust MMC service delivery system.

- **The need for a Medicaid Technical Assistance Center (MTAC):** Survey respondents indicated a broad consensus for technical assistance and training in Medicaid operations and MMC contracting (Table 24 & 25, Appendix B). This is underscored by the high number (90%) that identified topics they would like to review with the MTAC, many of them around the basics of Medicaid enrollment (76%). ICOY is developing a MTAC that will be available for all providers that may bill, or are currently billing MMC, and will include:
    - **In-person and web-based training** organized into tiers of beginner, intermediate, and advanced. In-person group training will be repeated throughout the state on critical topics, while web-based training will be more frequent and on both major and minor topics. See Table 26 below for an overview of the potential MTAC training curriculum.

**Table 26: Draft Of MTAC Training Curriculum**

| Tier | Target For Participating Providers | Examples |
|---|---|---|
| Basic Resources | For providers that are not Medicaid providers | • Overview of MMC in IL<br>• Should my organization bill MMC?<br>• Medicaid Enrollment<br>• Contracting with MCOs |
| Intermediate Resources | For providers that bill Medicaid but either do not have MMC contracts or believe they need help with current contracts | • Getting started with MMC<br>• Trouble-shooting with Medicaid and MCOs<br>• Integrated health homes (IHH) |
| Advanced Resources | For providers with MMC contracts but want to become better prepared for the future, including value-based purchasing | • Embracing quality measurement<br>• VB contracting in MMC |

    - **Learning Collaboratives** will supplement the MTAC training curriculum to bring together groups of stakeholders to share issues, best practices, and escalate issues that require multi-stakeholder solutions via the State Ombudsman.
    - **Online Tools** maintain information, tools, guidance, and running list of frequently asked questions and answers to create a common database of resources for providers billing MMC will be maintained online. Much of the content will be guided by the discussion from training and learning collaboratives.

- **A State Ombudsman** needs to be identified to unify providers, MCOs, and State government to have regular in-person communications to streamline workflow, address real-time MMC transition issues, and develop systemic solutions to common problems. It will also create productive and expedited feedback loops around the unified goal to make Illinois' MMC successful. In-person meetings with decision makers must be required of all parties.
- **Enforce MCO Network Adequacy Requirements to Support Racial Equity and Reduce Disparities** Beneficiaries have a right to timely access to care, provider choice, and culturally competent services. The MCO network adequacy requirements must be upheld as a tenant of healthcare equity. Measures of network adequacy must include cultural competency, provider choice, and wait times. We stress the need for public reporting of network adequacy including service wait-times (beyond intake) and regulatory oversite. This is an issue of parity and of overall healthcare adequacy. The MCO network adequacy requirements must be upheld as a tenant of healthcare equity – the MCO report cards are not enough. We must hold MCOs accountable.
- **Billing Systems Support** As noted, there is a connection between managed care participation and stronger infrastructure capability. Providers need financial assistance to purchase or upgrade their electronic health record systems to ease MMC billing and eventually report analytics to participate in VBP. We recommend Illinois establish a behavioral health information technology grant (or less preferable, no-interest capital loan) to purchase or upgrade community-based providers' electronic health record system.
- **Grants for Providers** Provider capacity building grants should be developed to acknowledge the incredible administrative lifts necessary to account for changes in billing infrastructure, with focus on providers this survey indicated are most vulnerable – those that are smaller or serve predominantly communities of color.
- **Help-Line** It would be useful to offer customer technical support – an expert on Medicaid and MMC available to troubleshoot or answer questions for individual participating providers. This could be structured as a "helpline" email or call-line, with a guaranteed response within a specified timeframe.
- **Shared Services** Smaller organizations may find that collaboration with other similar organizations provides efficiencies, reduces costs, and increases quality. Back-office supports could help providers (e.g. billing, contracting, analytics) but providers still need start-up support and they need to be affordable or free of charge. This could be obtained by group purchasing. The key issue is evaluating the benefit and cost in comparison. Shared services such as back-office billing cannot go without infrastructure support and contract negotiations proposed in the MTAC.

## Research Limitations

Throughout this research process, we could have benefited from a larger sample size of survey respondents. Due to ICOY's network, our survey participants slightly overrepresented children, youth and family providers. The survey information was all self-reported and based on the interpretation of the individual completing the survey. In hindsight, the branching questions in the survey limited some respondents from answering questions that may have been helpful. More granular data in some areas would have been helpful. We look forward to improving the survey next year.

## Glossary

- **Behavioral Health** encompasses both mental health and substance use disorders.
- **Culturally Competent Care** health care that meets social, cultural, and linguistic needs of clients.
- **Human Service Provider** community-based behavioral health or social service organization.
- **Integrated Health Care** refers to a healthcare system that considers and treats both behavioral health, physical health, and social determinants of health
- **Managed Care Organization (MCO)** is the Medicaid product line of an insurance provider. Illinois' MMC program is called HealthChoice Illinois and consists of six MCOs, two cover Cook County only (CountyCare Health Plan and NextLevel Health Partners) and four cover the entire state (Blue Cross Community Health Plans, IlliniCare Health, Meridian Health Plan, and Molina Healthcare). For more information, visit illinois.gov/hfs/medicalclients/managedcare.
- **Medicaid Managed Care (MMC)** is a payment model for Medicaid benefits through contracted arrangements with the state (known as MCOs). They accept capitated (per member per month) payments for services and are responsible for payment to an adequate network of contracted providers.
- **Social Determinants of Health** are social and economic factors that significantly influence an individual's health, such as employment and housing.
- **Value-Based Payment (VBP)** is a payment model based off provider outcome metrics for populations to incentivize care quality over volume. In our survey, a provider was deemed participating in VBP if they accepted any capitated (or fixed) payment and reimbursed based on outcome measures.

**Stay updated on ICOY's MTAC by signing up for our email list at MTAC.ICOYouth.org**

## Appendix A – Providers That Participated In The MMC Readiness Survey

We thank those organizations that participated in the survey. Organizations on the Steering Committee are marked with an asterisk (*)

| | |
|---|---|
| 360 Youth Services | Illinois Coalition Against Domestic Violence |
| Ada S. McKinley Community Services, Inc. | Illinois Valley Center for Independent Living |
| AgeOptions | Indian Oaks Academy* |
| AIDS Foundation of Chicago | Inner Voice |
| Albany Park Community Center | Introspect Youth Services, Inc. |
| Allendale Association | Jewish Child and Family Services |
| Alternatives, Inc.* | Juvenile Protective Association |
| Anixter Center | Kaleidoscope |
| Antioch Area Healthcare Accessibility Alliance | Kankakee School-Based Health Centers |
| Arden Shore Child and Family Services | Kemmerer Village |
| Arrowhead Youth & Family Services | Kendall County Health Department |
| Association for Individual Development | La Casa Norte |
| Aunt Martha's Health & Wellness* | Lake County Crisis Center for the Prevention and Treatment of Domestic Violence, Inc. |
| Avenues to Independence | Lakeside Community Committee |
| The Baby Fold | Lawrence Hall |
| Bethany for Children & Families | Lazarus House |
| The Bobby Buonauro Clinic | Little City |
| Bobby E. Wright Comprehensive Behavioral Health Center, Inc. | Lutheran Child and Family Services of Illinois |
| Breakthrough Urban Ministries | Lutheran Social Services of Illinois |
| The Bridge Youth and Family Services | LYDIA Home Association |
| Canine Therapy Corps | Massac County Mental Health & Family Counseling Center |
| Caritas Family Solutions | Mercy Housing Lakefront |
| Casa Central | Metropolitan Family Services* |
| Catholic Charities of the Archdiocese of Chicago | Midwest Asian Health Association |
| Center for Independence | Midwest Youth Services |
| The Center for Youth & Family Solutions* | Mobile Care Chicago |
| Center on Halsted | Mosaic |
| Centerstone* | MYSI Corporation |
| Chaddock | National Youth Advocate Program |
| Chicago Area Project | New Life Transitions of Northern Illinois |
| Chicago Recovering Communities Coalition | New Moms* |
| Child Abuse Council | Norman C. Sleezer Youth Home |
| Children's Home & Aid | Northeast DuPage Family and Youth Services |
| Children's Home Association of Illinois | Oak-Leyden Developmental Services |
| Children's Place Association | OMNI Youth Services |
| ChildServ | Onarga Academy |
| Community Assistance Programs | One Hope United |

| | |
|---|---|
| Community Youth Network (CYN) Counseling Center | Opportunity House, Inc. |
| Cornerstone Services, Inc. | Ounce of Prevention Fund |
| CTF Illinois | Outreach Community Ministries, Inc. |
| Cunningham Children's Home | Pioneer Center for Human Services |
| Deborah's Place | Project Oz |
| DeKalb County Youth Service Bureau | Rincon Family Services |
| Dental Lifeline Network | Safer Foundation |
| DuPage County Health Department | Sankofa Safe Child Initiative |
| Easterseals Central Illinois | Shelter, Inc. |
| Easterseals Joliet Region | Sinai Community Institute |
| Erie Neighborhood House | Smart Policy Works |
| Erikson Institute's Center for Children and Families | St. John's Healing Community Board (dba St. John's Community Care) |
| Evangelical Child and Family Agency | St. Leonard's Ministries |
| Family Counseling Center, Inc. | Teen Living Programs |
| Family Focus, Inc. | Thresholds |
| Family Service Association of Greater Elgin Area | Tracy L. Cooper LCSW |
| FamilyCore | Transitions of Western Illinois |
| Garden of Prayer Youth Center | Treatment Alternatives for Safe Communities (TASC) |
| Gateway Foundation | Treatment of Domestic Violence (dba A Safe Place) |
| Glenwood Academy | UCAN |
| The Harbour | Union County Counseling Services, Inc. |
| Healthcare Alternative Systems, Inc. | Universal Family Connection, Inc. |
| Heartland Alliance Health | Volunteers of America of Illinois |
| Heartland Human Services | Youth & Family Counseling |
| Helping Hands of Springfield | Youth Crossroads, Inc. |
| Hephzibah Children's Association | Youth Guidance |
| Hispanic American Community Education and Services | Youth Outreach Services |
| Housing Forward | Youth Service Bureau of Illinois Valley |
| Hoyleton Youth and Family Services | Youth Services Network |
| Human Service Center of Southern Metro East | YouthBuild Lake County |

## Appendix B – Additional Tables

| Table 1. Services Provided (N=134) | | |
|---|---|---|
| **Services Provided** | **Number** | **Percentage** |
| Adult Day Care | 4 | 3% |
| Afterschool Programming | 24 | 18% |
| Assertive Community Treatment (ACT) | 3 | 2% |
| Assessment | 71 | 53% |
| Case Management | 103 | 77% |
| Child Welfare Program | 47 | 35% |
| Counseling | 92 | 69% |
| Crisis Intervention Services: CCBYS | 24 | 18% |
| Crisis Intervention Services: Intensive Placement Stabilization | 16 | 12% |
| Crisis Intervention Services: Mobile Crisis Response | 12 | 9% |
| Crisis Stabilization Services | 24 | 18% |
| Community Integrated Living Arrangement | 22 | 16% |
| Detoxification Services | 3 | 2% |
| DCFS Child Welfare Services | 52 | 39% |
| Domestic Violence Services | 15 | 11% |
| Early Intervention (EI) | 25 | 19% |
| Head Start | 15 | 11% |
| HIV/AIDs | 8 | 6% |
| Home Visiting | 39 | 29% |
| Housing Assistance | 35 | 26% |
| Medical Care | 8 | 6% |
| Medication Management | 33 | 25% |
| Mental Health Services (Community-Based) | 71 | 53% |
| Mental Health Services (Outpatient/Office-Based) | 72 | 54% |
| Mental Health Services (Residential) | 36 | 27% |
| Other Early Learning Services | 9 | 7% |
| Psychological Rehabilitation (PSR) | 10 | 7% |
| Psychiatry | 23 | 17% |
| Peer Support | 21 | 16% |
| Residential | 40 | 30% |
| School Based Social/Emotional Educational Services | 47 | 35% |
| Shelter Care | 17 | 13% |
| Substance Abuse Treatment: Intensive Outpatient (Level II) | 24 | 18% |
| Substance Abuse Treatment (MAT) | 8 | 6% |
| Substance Abuse Treatment: Intensive Outpatient (Level I) | 31 | 23% |
| Substance Abuse Treatment: Residential | 5 | 4% |
| Workforce Development | 33 | 25% |
| Other | 38 | 28% |

| Table 2. Target Populations (N=134) | | |
|---|---|---|
| **Target Populations** | **Number** | **Percentage** |
| Adults Returning from Incarceration | 26 | 19% |
| Adults with Mental Health Disorders | 59 | 44% |
| Adults with Substance Abuse Disorders | 39 | 29% |
| Children and Youth with Substance Use Disorders | 35 | 26% |
| Children and Youth with Mental Health Disorders | 76 | 57% |
| Early Childhood | 44 | 33% |
| Families, Children, and Youth in Child Welfare | 72 | 54% |
| Homeless Adults | 38 | 28% |
| Homeless Families | 32 | 24% |
| Homeless or Runaway Youth | 41 | 31% |
| Immigrants, Undocumented and/or Refugees | 24 | 18% |
| Intact Families | 45 | 34% |
| Non-English Speaking Youth | 20 | 15% |
| People with Developmental Disabilities | 40 | 30% |
| People with Physical Disabilities | 22 | 16% |
| Post-Adoption Youth | 22 | 16% |
| Pregnant/Parenting Women | 39 | 29% |
| Older Adults | 32 | 24% |
| Survivors of Domestic Violence | 36 | 27% |
| Survivors of Sexual Assault | 28 | 21% |
| Veterans | 21 | 16% |
| Youth in the Juvenile Justice System | 48 | 36% |
| Other | 21 | 16% |

| Table 3. Geographic Distribution (N=134) | | |
|---|---|---|
| **Geographic Area** | **Number** | **Percentage** |
| Cook County | 85 | 63% |
| Collar Counties | 61 | 46% |
| North of I-80 – Urban | 33 | 25% |
| North of I-80 – Rural | 30 | 22% |
| I-80 to I-64 – Urban | 33 | 25% |
| I-80 to I-64 – Rural | 35 | 26% |
| South of I-64 | 22 | 16% |

| Table 4. Total Organization Revenue (FY17) from All Sources (N=133) | | |
|---|---|---|
| **Revenue** | **Number** | **Percentage** |
| Less than $500,000 | 18 | 14% |
| $500,000 to $1 Million | 7 | 5% |
| $1 Million to $5 Million | 41 | 31% |
| $5 Million to $10 Million | 28 | 21% |
| $10 Million to $20 Million | 20 | 15% |
| Greater than $20 Million | 19 | 14% |

| Table 5. Total Organization by Client Race Composition (N=134) | | |
|---|---|---|
| **Predominant Client Racial Composition** | **Number** | **Percentage** |
| Asian | 1 | 1% |
| Latino | 6 | 5% |
| Black | 36 | 28% |
| White | 43 | 33% |
| Mixed Racial Composition | 45 | 31% |
| Organization Does Not Collect | 3 | 2% |

| Table 7. Services Provided by Medicaid Enrollment Status (N=130) | | | | | | |
|---|---|---|---|---|---|---|
| **Service** | **No Medicaid + No Action** | **No Medicaid + Action** | **Medicaid Only** | **MMC** | **MMC & VBP** | **Total (N)** |
| Adult Day Care | 0% | 0% | 50% | 50% | 0% | 4 |
| Afterschool Programming | 48% | 4% | 22% | 13% | 13% | 23 |
| Assertive Community Treatment | 0% | 0% | 0% | 67% | 33% | 3 |
| Assessment | 24% | 4% | 16% | 43% | 13% | 68 |
| Case Management | 37% | 4% | 15% | 33% | 10% | 99 |
| Child Welfare Programming | 22% | 4% | 18% | 44% | 11% | 45 |
| Counseling | 30% | 4% | 15% | 39% | 11% | 89 |
| Crisis Intervention Services: CCBYS | 41% | 0% | 9% | 41% | 9% | 22 |
| Crisis Intervention Services: Intensive Placement Stabilization | 7% | 0% | 7% | 40% | 47% | 15 |
| Crisis Intervention Services: Mobile Crisis Response | 0% | 0% | 0% | 64% | 36% | 11 |
| Crisis Stabilization Services | 9% | 0% | 14% | 55% | 23% | 22 |
| Community Integrated Living Arrangement | 5% | 0% | 24% | 57% | 14% | 21 |
| Detoxification Services | 0% | 0% | 33% | 33% | 33% | 3 |
| DCFS Child Welfare Services | 24% | 6% | 18% | 40% | 12% | 50 |
| Domestic Violence Services | 38% | 0% | 15% | 38% | 8% | 13 |

| Table 7. Services Provided by Medicaid Enrollment Status (N=130) (continued) | | | | | | |
|---|---|---|---|---|---|---|
| **Service** | **No Medicaid + No Action** | **No Medicaid + Action** | **Medicaid Only** | **MMC** | **MMC & VBP** | **Total (N)** |
| Early Intervention (EI) | 13% | 4% | 17% | 43% | 22% | 23 |
| Head Start | 29% | 0% | 21% | 36% | 14% | 14 |
| HIV/AIDs Services | 50% | 0% | 17% | 33% | 0% | 6 |
| Home Visiting | 20% | 9% | 14% | 43% | 14% | 35 |
| Housing Assistance | 47% | 6% | 15% | 26% | 6% | 34 |
| Medical Care | 33% | 0% | 0% | 33% | 33% | 6 |
| Medication Management | 3% | 0% | 20% | 57% | 20% | 30 |
| Mental Health Services (Community Based) | 22% | 3% | 10% | 50% | 15% | 68 |
| Mental Health Services (Outpatient/Office-Based) | 22% | 3% | 10% | 52% | 13% | 69 |
| Mental Health Services (Residential) | 11% | 0% | 20% | 51% | 17% | 35 |
| Other Early Learning Services | 38% | 0% | 13% | 25% | 25% | 8 |
| Psychosocial Rehabilitation | 0% | 0% | 11% | 78% | 11% | 9 |
| Psychiatry | 0% | 0% | 9% | 68% | 23% | 22 |
| Peer Support | 26% | 11% | 21% | 32% | 11% | 19 |
| Residential | 18% | 5% | 26% | 37% | 13% | 38 |
| School Based Social/ Emotional Educational Services | 29% | 4% | 16% | 38% | 13% | 45 |
| Shelter Care | 59% | 6% | 18% | 12% | 6% | 17 |
| Substance Abuse Treatment: Intensive Outpatient (Level II) | 0% | 5% | 5% | 59% | 32% | 22 |
| Substance Abuse Treatment: MAT | 0% | 0% | 0% | 67% | 33% | 6 |
| Substance Abuse Treatment: Outpatient (Level I) | 3% | 0% | 10% | 62% | 24% | 29 |
| Substance Abuse Treatment: Residential | 0% | 0% | 0% | 67% | 33% | 3 |
| Workforce Development | 39% | 3% | 21% | 27% | 9% | 33 |
| Other | 49% | 5% | 19% | 22% | 5% | 37 |

| Table 8. Medicaid Participation Status by Target Population (N=130) | | | | | | |
|---|---|---|---|---|---|---|
| **Target Populations** | **No Medicaid + No Action** | **No Medicaid + Action** | **Medicaid Only** | **MMC** | **MMC & VBP** | **Total (N)** |
| Adults Returning from Incarceration | 38% | 8% | 4% | 25% | 25% | 24 |
| Adults with Mental Health Disorders | 27% | 36% | 9% | 52% | 11% | 56 |
| Adults with Substance Abuse Disorders | 19% | 3% | 5% | 51% | 22% | 37 |
| Children and Youth with Substance Use Disorders | 21% | 3% | 9% | 39% | 27% | 33 |
| Children and Youth with Mental Health Disorders | 23% | 1% | 21% | 42% | 12% | 73 |
| Early Childhood | 32% | 5% | 15% | 34% | 15% | 41 |
| Families, Children, and Youth in Child Welfare | 29% | 4% | 21% | 32% | 13% | 68 |
| Homeless Adults | 46% | 8% | 0% | 30% | 16% | 37 |
| Homeless Families | 40% | 10% | 10% | 30% | 10% | 30 |
| Homeless or Runaway Youth | 49% | 5% | 5% | 26% | 15% | 39 |
| Immigrants, Undocumented and/or Refugees | 41% | 5% | 9% | 36% | 9% | 22 |
| Intact Families | 38% | 10% | 14% | 26% | 12% | 42 |
| Non-English Speaking Youth | 47% | 0% | 6% | 35% | 12% | 17 |
| People with Developmental Disabilities | 20% | 3% | 20% | 40% | 18% | 40 |
| People with Physical Disabilities | 41% | 5% | 14% | 32% | 9% | 22 |
| Post-Adoption Youth | 14% | 14% | 14% | 43% | 14% | 21 |
| Pregnant/Parenting Women | 30% | 8% | 5% | 38% | 19% | 37 |
| Older Adults | 50% | 3% | 10% | 27% | 10% | 30 |
| Survivors of Domestic Violence | 35% | 6% | 12% | 35% | 12% | 34 |
| Survivors of Sexual Assault | 42% | 0% | 12% | 35% | 12% | 26 |
| Veterans | 37% | 0% | 5% | 42% | 16% | 19 |
| Youth in Juvenile Justice System | 29% | 4% | 22% | 24% | 20% | 45 |
| Other | 43% | 10% | 14% | 19% | 14% | 21 |

| Table 9. Medicaid Participation Status by Geographic Distribution (N=130) | | |
|---|---|---|
| **Medicaid Participation Category** | **Presence in Cook County & Collar Counties (%)** | **No Presence in Cook County & Collar Counties (%)** |
| No Medicaid + No Action | 41% | 30% |
| No Medicaid + Action | 4% | 3% |
| Medicaid Only | 18% | 13% |
| MMC | 30% | 40% |
| MMC & VBP | 7% | 13% |

| Table 10. Medicaid Participation Status by FY17 Revenue (N=130) | | | |
|---|---|---|---|
| **Medicaid Participation Category** | **Less than $1 Million (%)** | **$1 Million - $10 Million (%)** | **More than $10 Million (%)** |
| No Medicaid + No Action | 46% | 51% | 13% |
| No Medicaid + Action | 8% | 3% | 3% |
| Medicaid Only | 17% | 13% | 21% |
| MMC | 29% | 27% | 45% |
| MMC & VBP | 0% | 6% | 18% |
| TOTAL (N) | 24 | 68 | 38 |

| Table 11. Medicaid Participation Status by Predominant Client Race (N=130) | | | | | | |
|---|---|---|---|---|---|---|
| **Predominant Client Racial Composition** | **No Medicaid + No Action** | **No Medicaid + Action** | **Medicaid Only** | **MMC** | **MMC & VBP** | **Total (N)** |
| All Populations of Color | 43% | 4% | 16% | 32% | 4% | 44 |
| *Black** | *43%* | *5%* | *16%* | *30%* | *5%* | *37* |
| White | 23% | 2% | 21% | 42% | 12% | 43 |
| No Predominant Racial Group | 45% | 5% | 15% | 25% | 10% | 40 |
| Do not collect information | 100% | 0% | 0% | 0% | 0% | 3 |

**This is a subset of the larger category: Predominantly Clients of Color. Other groups were not broken down to avoid identifying providers due to low sample size.*

| Table 13. Areas of Concern Among Providers in Considering a New Electronic System (N=79) | | |
|---|---|---|
| **Response** | **Number** | **Percentage** |
| Cost | 24 | 30% |
| Not Sure What System(S) to Get | 15 | 19% |
| Difficulty In Getting Clinical Personnel to Use | 7 | 9% |
| Ability To Provide Proper Training | 13 | 16% |
| Insufficient Technical Staff | 13 | 16% |
| Not Enough Time | 12 | 15% |
| Other | 10 | 13% |

| Table 14. Services Provided by Infrastructure Capability (N=83) | | | | | |
|---|---|---|---|---|---|
| **Service** | **Largely manual billing** | **Some electronic billing** | **Reasonable degree of electronic billing** | **Relatively comfortable with their electronic billing** | **Total (N)** |
| Adult Day Care | 50% | 0% | 25% | 25% | 4 |
| Afterschool Programming | 31% | 31% | 15% | 23% | 13 |
| Assertive Community Treatment | 0% | 33% | 33% | 33% | 3 |
| Assessment | 15% | 22% | 35% | 29% | 55 |
| Case Management | 17% | 23% | 29% | 31% | 65 |
| Child Welfare Programming | 16% | 32% | 22% | 30% | 37 |
| Counseling | 15% | 26% | 28% | 31% | 65 |
| Crisis Intervention Services: CCBYS | 27% | 20% | 27% | 27% | 15 |
| Crisis Intervention Services: Intensive Placement Stabilization | 20% | 27% | 20% | 33% | 15 |
| Crisis Intervention Services: Mobile Crisis Response | 8% | 17% | 33% | 42% | 12 |
| Crisis Stabilization Services | 14% | 23% | 32% | 32% | 22 |
| Community Integrated Living Arrangement | 14% | 14% | 33% | 38% | 21 |
| Detoxification Services | 0% | 33% | 33% | 33% | 3 |
| DCFS Child Welfare Services | 13% | 30% | 28% | 30% | 40 |
| Domestic Violence Services | 20% | 10% | 10% | 60% | 10 |
| Early Intervention (EI) | 9% | 23% | 27% | 41% | 22 |
| Head Start | 9% | 18% | 36% | 36% | 11 |
| HIV/AIDs Services | 0% | 60% | 0% | 40% | 5 |
| Home Visiting | 13% | 28% | 28% | 31% | 32 |
| Housing Assistance | 16% | 26% | 26% | 32% | 19 |
| Medical Care | 17% | 0% | 50% | 33% | 6 |
| Medication Management | 22% | 16% | 31% | 31% | 32 |

| Table 14. Services Provided by Infrastructure Capability (N=83) (continued) | | | | | |
|---|---|---|---|---|---|
| **Service** | **Largely manual billing** | **Some electronic billing** | **Reasonable degree of electronic billing** | **Relatively comfortable with their electronic billing** | **Total (N)** |
| Mental Health Services (Community Based) | 14% | 21% | 29% | 36% | 56 |
| Mental Health Services (Outpatient/Office-Based) | 14% | 23% | 30% | 33% | 57 |
| Mental Health Services (Residential) | 16% | 25% | 38% | 22% | 32 |
| Other Early Learning Services | 20% | 0% | 0% | 80% | 5 |
| Psychosocial Rehabilitation | 11% | 22% | 33% | 33% | 9 |
| Psychiatry | 9% | 9% | 35% | 48% | 23 |
| Peer Support | 13% | 33% | 20% | 33% | 15 |
| Residential | 19% | 31% | 28% | 22% | 32 |
| School Based Social/ Emotional Educational Services | 9% | 29% | 35% | 26% | 34 |
| Shelter Care | 33% | 17% | 17% | 33% | 6 |
| Substance Abuse Treatment: Intensive Outpatient (Level II) | 4% | 22% | 30% | 43% | 23 |
| Substance Abuse Treatment: MAT | 13% | 25% | 25% | 38% | 8 |
| Substance Abuse Treatment: Outpatient (Level I) | 10% | 20% | 30% | 40% | 30 |
| Substance Abuse Treatment: Residential | 20% | 0% | 20% | 60% | 5 |
| Workforce Development | 15% | 15% | 20% | 50% | 20 |
| Other | 11% | 32% | 26% | 32% | 19 |

| Table 15. Infrastructure Capability by Target Population (N=83) (Medicaid enrolled only) | | | | | |
|---|---|---|---|---|---|
| **Target Populations** | **Largely manual billing** | **Some electronic billing** | **Reasonable degree of electronic billing** | **Relatively comfortable with their electronic billing** | **Total (N)** |
| Adults Returning from Incarceration | 6% | 13% | 31% | 50% | 16 |
| Adults with Mental Health Disorders | 9% | 23% | 33% | 35% | 43 |
| Adults with Substance Abuse Disorders | 6% | 23% | 26% | 45% | 31 |
| Children and Youth with Substance Use Disorders | 14% | 21% | 21% | 64% | 28 |
| Children and Youth with Mental Health Disorders | 15% | 27% | 27% | 31% | 59 |
| Early Childhood | 16% | 16% | 32% | 35% | 31 |
| Families, Children, and Youth in Child Welfare | 15% | 29% | 27% | 29% | 52 |
| Homeless Adults | 10% | 15% | 20% | 55% | 20 |
| Homeless Families | 20% | 10% | 20% | 50% | 20 |
| Homeless or Runaway Youth | 23% | 27% | 23% | 27% | 22 |
| Immigrants, Undocumented and/or Refugees | 20% | 20% | 20% | 40% | 15 |
| Intact Families | 10% | 28% | 38% | 24% | 29 |
| Non-English Speaking Youth | 17% | 25% | 33% | 25% | 12 |
| People with Developmental Disabilities | 16% | 22% | 25% | 38% | 32 |
| People with Physical Disabilities | 8% | 31% | 23% | 38% | 13 |
| Post-Adoption Youth | 5% | 21% | 32% | 42% | 19 |
| Pregnant/Parenting Women | 14% | 18% | 39% | 29% | 28 |
| Older Adults | 25% | 19% | 31% | 25% | 16 |
| Survivors of Domestic Violence | 17% | 17% | 35% | 30% | 23 |
| Survivors of Sexual Assault | 24% | 12% | 35% | 29% | 17 |
| Veterans | 7% | 21% | 29% | 43% | 14 |
| Youth in Juvenile Justice System | 20% | 29% | 29% | 23% | 35 |
| Other | 8% | 42% | 25% | 25% | 12 |

| Table 16. Infrastructure Capability by Geographic Region (N=79) (Medicaid enrolled only) | | |
|---|---|---|
| **Infrastructure Category** | **Presence in Cook and/or Collar Counties** | **No Presence in Cook or Collar Counties** |
| Largely Manual Billing | 15% | 15% |
| Some Electronic Billing | 27% | 15% |
| Reasonable Degree of Electronic Billing | 20% | 50% |
| Relatively Comfortable With Their Electronic Billing | 37% | 20% |
| TOTAL (N) | 59 | 20 |

| Table 17: Infrastructure Capability Among by Revenue (N=78) (Medicaid enrolled only) | | | |
|---|---|---|---|
| **Infrastructure Category** | **Less than $1 Million** | **$1 Million - $10 Million** | **More than $10 Million** |
| Largely Manual Billing | 8% | 24% | 9% |
| Some Electronic Billing | 33% | 21% | 24% |
| Reasonable Degree of Electronic Billing | 50% | 21% | 24% |
| Relatively Comfortable With Their Electronic Billing | 8% | 33% | 42% |
| TOTAL (N) | 12 | 33 | 33 |

| Table 18. Infrastructure Capability Among All Providers by Client Race (N = 83) | | | | | |
|---|---|---|---|---|---|
| **Predominant Client Racial Composition** | **Largely Manual Billing** | **Some Electronic Billing** | **Reasonable Degree of Electronic Billing** | **Relatively Comfortable With Their Electronic Billing** | **Total (N)** |
| All Populations of Color | 25% | 42% | 17% | 17% | 24 |
| *Black** | *25%* | *45%* | *10%* | *20%* | *20* |
| White | 9% | 12% | 42% | 36% | 33 |
| No Predominant Racial Group | 12% | 27% | 19% | 42% | 26 |

**This population is a subset of the larger category: Predominantly Clients of Color. Other groups were not broken down to avoid identifying participants due to low sample size.*

| Table 19. Infrastructure Capability Among All Providers Enrolled in MMC (N=73) | | | |
|---|---|---|---|
| **Infrastructure Category** | **No Contract with MCO** | **Contracted with MCO** | **MCO Contract + VBP** |
| Largely Manual Billing | 23% | 12% | 9% |
| Some Electronic Billing | 41% | 17% | 18% |
| Reasonable Degree of Electronic Billing | 23% | 36% | 18% |
| Relatively Comfortable With Their Electronic Billing | 14% | 36% | 55% |
| TOTAL (N) | 22 | 42 | 11 |

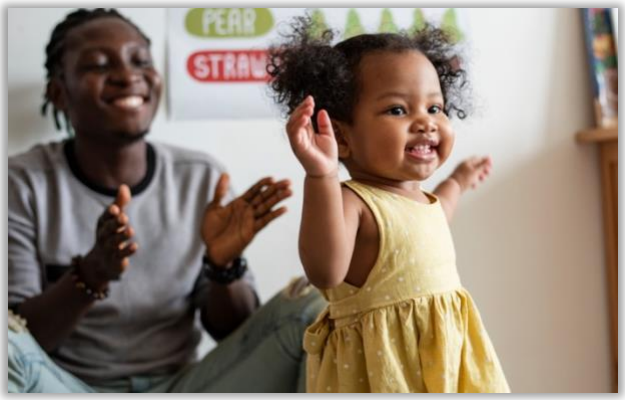
| Table 21. Concerns with MCOs Among Providers with Current Contracts (N=29) | | |
|---|---|---|
| **Response** | **Number** | **Percentage** |
| Trouble Arriving At Contractual Language | 8 | 29% |
| Reimbursement Rates Unacceptably Low | 5 | 18% |
| Difficult Getting Established As An HFS Medicaid Provider (Had Difficulties With Getting Approved In IMPACT System) | 7 | 25% |
| Had Trouble Getting Staff Credentialed | 7 | 25% |
| Had Trouble Verifying Client Eligibility In Medicaid or an MCO | 16 | 57% |
| Found It Very Hard To Get Together Data To Bill | 3 | 11% |
| Many Claims Rejected | 15 | 54% |
| Not Sure Why Claims Were Rejected | 16 | 57% |
| Hard to Re-Submit Claims | 12 | 43% |
| Long Delays To Get Paid | 20 | 71% |
| Had Rejections Due To Utilization Review (Service Denied As Not Medically Necessary) | 6 | 21% |
| Amount Of Data Required Simply Too Large | 3 | 11% |
| Had Trouble Contacting MCO Staff to Resolve Claims Payment Issues | 16 | 57% |

| Table 22. Areas of Concern (Score of 1 or 2) Among Providers without Current Contracts (N=22) | | |
|---|---|---|
| **Response** | **Number** | **Percentage** |
| Figuring out with whom and for what to contract | 6 | 27% |
| Actually negotiating a contract | 10 | 45% |
| Medicaid provider enrollment | 7 | 32% |
| Other credentialing | 6 | 27% |
| Making sure we know what services we can actually bill to Medicaid (or an MCO) | 9 | 41% |
| Training and organizing our staff to accommodate different billing requirements | 12 | 55% |
| Collecting the right data to develop a clean bill | 13 | 59% |
| Being able to record services with the proper codes | 7 | 32% |
| Having a computer system to bill for services provided | 9 | 41% |
| Working claims after submission, including addressing rejected or denied claims | 13 | 59% |
| Providing quality and other data to MCOs and State | 10 | 45% |

| Table 23. Ability to Provide Data on Clinical Quality Among Providers Enrolled in Medicaid (N=73) | | |
|---|---|---|
| **Response** | **Not Currently Contracting** | **Contracting** |
| Our electronic systems are well suited to this | 18% | 26% |
| We have electronic systems, but we don't yet have enough experience to know how well it will meet future needs | 23% | 28% |
| We can provide such data manually but are enough concerned about the long-run viability of this approach that we are taking specific steps to address | 23% | 20% |
| We can provide such data manually but are enough concerned about the long-run viability of this approach that we are considering possible alternatives | -- | 8% |
| We can provide such data manually and are confident/optimistic that will remain sufficient for our purposes | 14% | 4% |
| We would be hard put to provide much data like this at this time; will resolve in future—if necessary | 23% | 6% |
| Other | -- | 8% |
| TOTAL (N) | 22 | 51 |

| Table 24. Interest in MTAC Among All Providers (N=134) | | |
|---|---|---|
| **Topic** | **Number** | **Percentage** |
| Basics of Medicaid | 57 | 43% |
| Enrolling as an HFS Medicaid Provider | 57 | 43% |
| Impact Enrollment | 51 | 38% |
| Basics Of Managed Care and the IL Landscape | 69 | 51% |
| Negotiating a Contract | 82 | 61% |
| Credentialing | 64 | 48% |
| Mechanics of Billing MCOs for Services | 68 | 51% |
| Staffing and Reorganizing Workflows | 56 | 42% |
| Collecting the Right Data to Develop A Clean Claim | 62 | 46% |
| VBP Contracting With MCOs | 83 | 62% |
| Providing Data to MCOs And State | 81 | 60% |

| Table 25. Interest in MTAC Among Providers Not Enrolled in Medicaid + No Action (N=50) | | |
|---|---|---|
| **Topic** | **Number** | **Percentage** |
| Basics of Medicaid | 38 | 76% |
| Enrolling as an HFS Medicaid Provider | 37 | 74% |
| Impact Enrollment | 29 | 58% |
| Basics Of Managed Care and the IL Landscape | 37 | 74% |
| Negotiating a Contract | 32 | 64% |
| Credentialing | 31 | 62% |
| Mechanics of Billing MCOs for Services | 29 | 58% |
| Staffing and Reorganizing Workflows | 21 | 42% |
| Collecting the Right Data to Develop A Clean Claim | 26 | 52% |
| VBP Contracting With MCOs | 22 | 44% |
| Providing Data to MCOs And State | 24 | 48% |




## ABOUT ICOY

Illinois Collaboration on Youth (ICOY) promotes the safety, health, and success of Illinois' children, youth, and families by acting as a collective voice for policy and practice, and by connecting and strengthening the organizations that serve them.

## ABOUT MTAC

The ICOY Medicaid Technical Assistance Center (MTAC) is launching in 2019 to help all Illinois providers thrive in a Medicaid Managed Care billing environment. We plan to ease the burden of Medicaid billing for providers at all readiness levels – this includes those organizations that have never billed Medicaid.

## CONTACT INFO

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