

Medicaid Managed Care Task Force

Final Report



State of Illinois
93rd General Assembly

November 2004

Senator Dale A. Righter, *Co-chairman*

**Senator Christine Radogno
Senator Donne E. Trotter
Senator Patrick Welch**

Representative Frank Mautino, *Co-chairman*

**Representative Patricia R. Bellock
Representative Dan Brady
Representative Karen A. Yarbrough**

Table of Contents

Introduction.....	3
Legislation creating Task Force.....	6
General Medicaid Information.....	8
Task Force Findings.....	15
Proposals presented to Task Force.....	18
Task Force Recommendations.....	28
Task Force Meeting Schedule.....	30
Task Force Meeting Participants.....	31
Task Force Testimony Summations.....	32

Introduction

The Fiscal Year 2005 (FY05) budget process addressed a deficit that the Governor estimated at \$1.7 billion. The Governor identified the deficit as a “structural deficit”, defining a structural deficit as “certain major expenses grow faster than revenues over time” (*State of Illinois Fiscal Year 2005 Budget Book, p. 1-3*). Budget negotiations during the 2004 Spring Legislative Session between the Governor and the General Assembly reached an impasse because of differences over the strategy for resolving the deficit. Although a final budget was adopted for FY05, major problems remain.

The FY05 Budget Book identified Illinois’ Medicaid program as one of the causes of the structural deficit faced by the State. Throughout the late 1990’s, the Department of Public Aid (DPA) was able to provide a financially stable Medicaid program by taking a number of steps. DPA utilized inter-governmental transfers, provider assessments, provider rate controls, adjustments to the payment cycle, and welfare reform to stabilize Medicaid spending and curtail liability growth. Many of these mechanisms have reached their maximum potential and cannot be counted on to sustain continued Medicaid growth, especially considering the liability pressures faced by the State, including provider rate increases, the long payment cycle and pressure to expand coverage. The Governor has characterized the current Medicaid program as “unsustainable” with “the costs of the Medicaid Program continu(ing) to grow at a rate in excess of state revenue growth” (*State of Illinois Fiscal Year 2005 Budget Book, p. 1-7*). In response, lawmakers enacted legislation that attempts to address part of the structural deficit by curtailing Medicaid liability growth.

Many states have used managed care to curtail the growth of their Medicaid programs. Those experiences are varied, and therefore difficult to compare and assess. Available research and the evaluations of other states' plans show mixed results. Nevertheless, there is a disparity between the Illinois Medicaid managed care experience and the experience of other states. Illinois, for example, has less than 10% of its Medicaid population in a voluntary managed care plan, while the national average for Medicaid recipients participating in all types of managed care plans is over 50%. Illinois attempted to implement a mandatory Medicaid managed care program in the mid-1990's and was unsuccessful, while other states successfully implemented similar plans. Federal authorities share the concerns about Medicaid growth and new laws governing Medicaid managed care have since been enacted to encourage states to implement, modify and expand programs aimed at controlling utilization and costs. It was a deliberate decision of the General Assembly to focus on managed care as one strategy, among many, that have been attempted throughout the nation to curtail Medicaid liability growth.

Lawmakers also expressed concern about the quality of care received by Medicaid recipients. There is a general consensus among lawmakers, health care and welfare advocates that Medicaid recipients need a stable "medical home" – i.e., connection to a primary care medical provider.

Managed care was considered one strategy to address the two central issues identified as major concerns:

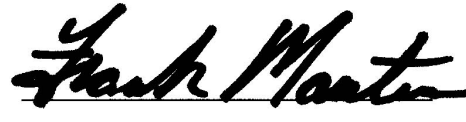
1. Could managed care help curtail Medicaid liability growth?
2. Could managed care provide a better continuum of care to Medicaid recipients?

Lawmakers interested in exploring these two questions requested the creation of a Task Force to explore, without predisposition, the use of managed care within the Illinois Medicaid program to determine what, if any, improvements would be applicable and feasible. For this reason, the Managed Care Medicaid Task Force was created in House Bill 953. This legislation passed by a vote of 57-1-0 in the Senate and 114-0-0 in the House. HB953 was signed by the Governor on June 10, 2004.



Senator Dale Righter

Co-Chair



Representative Frank Mautino

Co-Chair



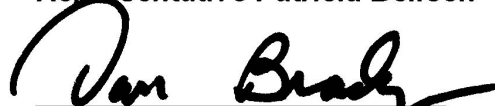
Senator Christine Radogno



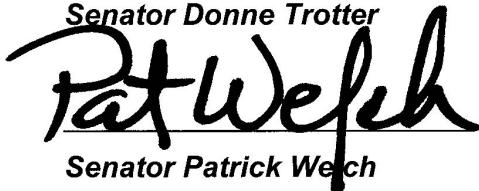
Representative Patricia Bellock



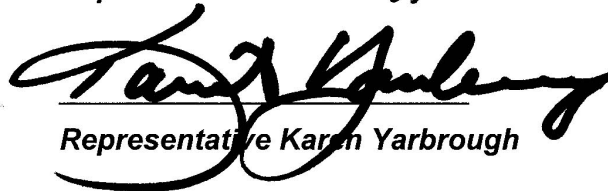
Senator Donne Trotter



Representative Dan Brady



Senator Patrick Welch



Representative Karen Yarbrough

NOTE: An Appendix to this Report, containing all testimony presented to the Task Force, will be forthcoming.

Excerpt from Public Act 93-674 – Creating the Task Force

Section 20. The Illinois Public Aid Code is amended by adding Section 5-16.13 as follows:

(305 ILCS 5/5-16.13 new)

Sec. 5-16.13. Medicaid Managed Care Task Force.

(a) Medicaid, the medical assistance program jointly administered by the State of Illinois and the United States governments for low-income and uninsured populations, is the largest single insurance provider in the State. In Illinois, one in every 7 adults, one in 3 children, and 2 of every 3 nursing home residents are all provided health care under the State's Medicaid program. Over the past 10 years, Medicaid in Illinois has grown an average of 8% annually, which requires at least \$500,000,000 in additional State resources every year. Medicaid in Illinois is a cost-reimbursement system that does little to promote health or encourage improvements in the quality of health care services being delivered to the growing populations needing assistance. The advent of managed care plans in the insurance industry has driven down health care costs for many while amply managing individual needs in a system to deliver cost-efficient health care services.

(b) To better examine and evaluate the application of managed care within the State's Medicaid program, there is hereby established the bipartisan Medicaid Managed Care Task Force. The Task Force shall consist of 8 voting members, as follows: 2 members of the Senate appointed by the President of the Senate, 2 members of the Senate appointed by the Senate Minority Leader, 2 members of the House of Representatives appointed by the Speaker of the House of Representatives, and 2 members of the House of Representatives appointed by the House Minority Leader. All actions of the Task Force require the affirmative vote of at least 5 voting members. Members appointed to the Task Force shall elect from among themselves 2 co-chairs. Members appointed by the legislative leaders shall be appointed for the duration of the Task Force; in the event of a vacancy, the appointment to fill the vacancy shall be made by the same legislative leader who made the original appointment. The following persons shall serve, ex officio, as nonvoting members of the Task Force: the Director of the Governor's Office of Management and Budget, the Director of Public Aid, and the Secretary of Human Services. The Task Force shall begin to conduct business upon the appointment of a majority of the voting members. If the co-chairs have not both been appointed, the co-chair that has been appointed shall preside. Members shall serve without compensation but may be reimbursed for their expenses from appropriations for that purpose.

(c) The Task Force shall gather information and make recommendations relating to the financing and expenditures of the Illinois Medicaid program and the program's level of ability to provide quality health care services in the most cost-efficient manner. The Task Force shall examine and evaluate the application of managed care within the State's Medicaid program. The Task Force shall

further assess whether the State's Medicaid services delivery system meets or exceeds the goals of quality, efficiency, accountability, and financial responsibility and shall make recommendations in keeping with those goals concerning the cost-efficient delivery of Medicaid services throughout Illinois.

(d) The Task Force shall conduct at least 6 public hearings beginning the later of July 2004 or upon the appointment of a majority of its members, through October 2004. Locations for public hearings are to be different and determined by the co-chairs in consultation with the other members of the Task Force. Comment and testimony at public hearing is to be sought from Medicaid recipients, health care providers and other health care professionals, related advocates, health care finance experts, insurance industry professionals, and public officials from throughout the State.

(e) The Governor's Office of Management and Budget, the Department of Public Aid, and the Department of Human Services are directed to provide information and assistance to the Task Force.

(f) The Task Force shall submit a full report of its findings and recommendations to the General Assembly not later than November 8, 2004. It may submit other reports as it deems appropriate.

(g) The Task Force is abolished and this Section is repealed on December 31, 2004.

Section 99. Effective date. This Act takes effect upon becoming law.

GENERAL MEDICAID INFORMATION

Illinois Department of Public Aid

General Background

Illinois Medicaid is a Large HealthCare Program

- Medicaid, KidCare and SeniorCare provide health benefits to 1.8 million individuals
- Over 1 million children are covered by KidCare and Medicaid
- In Calendar Year 2003, Medicaid paid for 40% of the State's 180,000 births
- In FY05, Medicaid and SeniorCare will reimburse pharmacies for over 30 million prescriptions
- 63% of all nursing facility residents qualify for Medicaid
- Medicaid accounts for 17% of all Illinois healthcare spending
- Admin expense accounts for 1% of total program cost

1

What is Medicaid?

Medicaid is a federal-state entitlement program for low-income Americans. Enacted in 1965, at the same time as Medicare, Medicaid makes federal matching funds available to States for the costs they incur in paying health care providers for delivering covered services to eligible individuals.

Illinois Medicaid is a comprehensive health plan. More comprehensive than Medicare, the program provides preventive and primary health care, hospital, pharmacy, long term care, and other medical services.

The Illinois Department of Public Aid is the primary Medicaid agency. There are over 1,000 other government entities (counties, school districts, other State agencies, *etc.*) that administer portions of the program.

2

Mechanics of the State/Federal Partnership

- For every dollar spent on Medicaid services the federal government will, generally, reimburse the State 50 cents. (In certain cases, such as SCHIP, the match is enhanced).
- The Medicaid program must operate within well-defined federal guidelines (Federal Rules, Federal Policy, the State Plan). This greatly constrains and influences how the State manages the program.
- Changes to the program require federal approval and are enacted through State Plan Amendments or waivers.
- Having entered into this partnership, the State is expected to fund this entitlement, regardless of State appropriation.

3

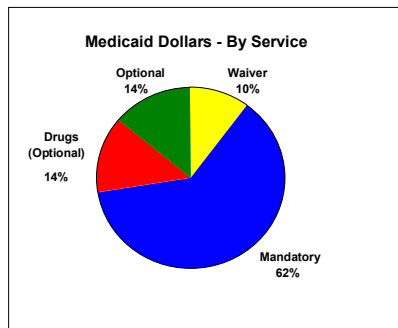
What Does Medicaid Cover?

Mandatory services that Illinois must cover: Most Medicaid beneficiaries are entitled to coverage for the following basic services, if the services are medically necessary, including but not limited to:

- Hospital care (inpatient and outpatient)
- Skilled nursing facility care
- Physician services
- Laboratory and x-ray services
- Health center (FQHC) and rural health clinic (RHC) services
- Transportation
- Home health

Optional services covered by Illinois: Illinois has chosen to cover additional services that are optional under federal law. Illinois receives federal matching funds for those services, which include but are not limited to:

- Prescription drugs
- Intermediate care facility services for the mentally retarded
- Home and community-based services through federal waivers
- Hospice care services
- Podiatric, optometric, chiropractic and dental services
- Other practitioner services
- Speech, hearing and language therapy services

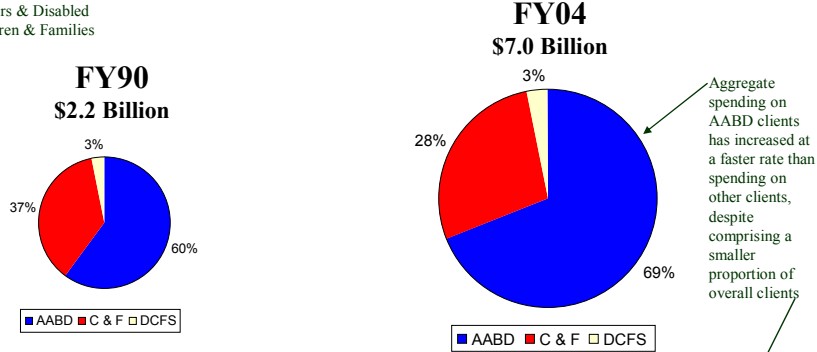


Waiver services: Illinois covers some services through waivers of federal law. These waivers allow federal match on services beyond those allowed as mandatory or optional. Home and community-based services are examples of services provided by Medicaid via federal waiver.

4

Who Is The Money Spent On (IDPA Medical Programs)

AABD = Seniors & Disabled
C & F = Children & Families

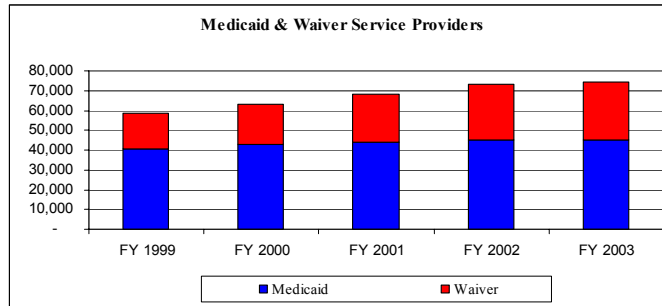


Average Enrollment

	FY90	FY95	FY00	FY03	FY04
AABD	332,875	335,590	314,015	352,364	381,019
Children & Families	768,113	1,028,089	997,961	1,185,258	1,319,468
DCFS	33,258	65,558	71,597	67,109	66,267
SeniorCare				161,328	166,361
TOTAL	1,134,246	1,429,237	1,383,573	1,766,059	1,933,115

5

Who Provides Medicaid Services?



A steadily growing contingent of healthcare providers extend entitlement services to the Medicaid population.

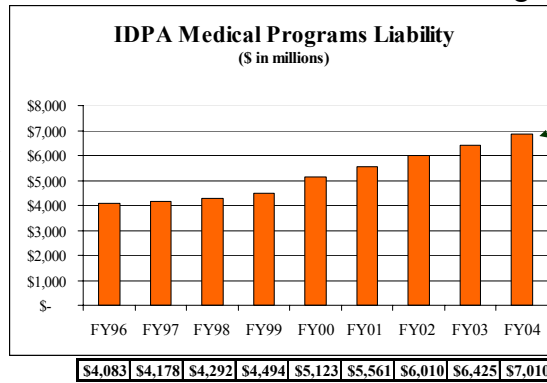
Specifically, qualified healthcare professionals provide healthcare to Medicaid clients whereupon IDPA reimburses for the service. The amount of time it takes IDPA/Comptroller to pay these claims is the *Payment Cycle*.

6

Liability

Medicaid costs have been increasing

- Reasons:
- Eligibility
 - Rate inflation
 - Utilization



Medical Programs liability has been increasing at an annual rate of 7.0%.

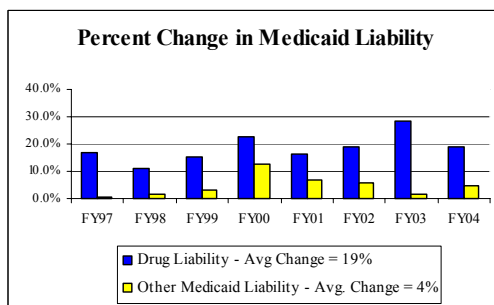
Nevertheless, by comparison, Illinois Medicaid's rate of growth is less than:

- * General healthcare services inflation (11%)
- * The inflationary rate of Medicare (14%)
- * The rate of growth of healthcare services for Illinois State employees (15%)

7

The Primary Medicaid Cost Driver

Spending On Pharmaceuticals Drives the Budget Growth



Expenditures for drugs, which is directly impacted by the movement towards utilizing drug therapies in lieu of institutional care, is increasing much faster than the overall budget. The usage rate per individual is rising as demonstrated by this table...

Year	Scripts/mem
FY00	12.54
FY01	13.07
FY02	13.49
FY03	13.58
FY04	14.72

Year	Avg. Rate
FY00	\$46.01
FY01	\$48.40
FY02	\$52.94
FY03	\$54.98
FY04	\$58.60

...while the average rate per script continues to increase.

New Drug Therapies currently coming to market at an increasing rate are the impetus behind these increases. These innovative drugs increase demand while also being far more expensive than established drug therapies that often have generic alternatives. Two examples of this include spending on anti-psychotic drugs which has increased dramatically to over \$150m in FY03 with a proliferation of new drug alternatives and HIV/AIDS drug spending which has increased from less than \$20m to \$43m during the past five years. **Spending on new drugs exceeded \$100 million in two of the last three fiscal years.**

8

Payment Cycle

- The amount of time that elapses between when a claim is stamped with a document control number (DCN) and when the Comptroller sends a check to the provider is referred to as the **Payment Cycle**.
- The Department often refers to the **Average Payment Cycle**. Some providers are reimbursed faster than the average, while many providers are reimbursed slower than the average.
- High Medicaid providers (based on need) and MCOs (25 days) are currently reimbursed faster than the average.
- Given the current budgetary constraints, the end-of-year average payment cycle for FY05 is estimated to be 75 days.
- Since 75 days is an average and since some providers are paid much faster than 75 days, it follows that some providers are paid much slower than 75 days.

9

Distribution of Costs Across the Population

The medical needs of Medicaid clients varies dramatically within the population.

Stratification of Medicaid Costs (Decile 1 = highest cost)

DECILE	CLIENTS	CUM.	ELIGIBLE MONTHS	% Of Total	CUM. %	PAYMENTS	CUM. %	PMPM
1	3,590	3,590	35,189	0.23%	0.23%	\$579,514,543	10%	\$16,469
2	9,721	13,311	105,476	0.68%	0.90%	\$579,548,778	20%	\$5,495
3	14,353	27,664	164,277	1.05%	1.96%	\$579,502,155	30%	\$3,528
4	18,247	45,911	209,961	1.35%	3.30%	\$579,558,494	40%	\$2,760
5	23,791	69,702	265,422	1.70%	5.01%	\$579,554,152	50%	\$2,184
6	36,775	106,477	381,605	2.45%	7.46%	\$579,537,010	60%	\$1,519
7	65,919	172,396	698,131	4.48%	11.93%	\$579,505,027	70%	\$830
8	111,874	284,270	1,184,741	7.60%	19.54%	\$579,465,867	80%	\$489
9	215,742	500,012	1,796,475	11.53%	31.06%	\$579,435,611	90%	\$323
10*	1,159,534	1,659,546	10,744,318	68.94%	100.00%	\$579,038,356	100%	\$54
	1,659,546		15,585,595	100.00%		\$5,794,654,995		\$372

*Decile 10 includes 252,022 clients who used no services, with a total of 1,625,168 eligible months

5% of Medicaid clients account for 50% of costs

10

Distribution of FY03 Costs Across the Family Health Plan Population (*TANF, KidCare, FamilyCare*)

The medical costs of FHP clients varies dramatically within the population:

Stratification of FY03 Family Health Plans Medicaid Costs

DECILE	CLIENTS	CUM.	ELIGIBLE MONTHS	% Of Total	CUM %	PAYMENTS	CUM %	PMPM
1	696	696	5,421	0.05%	0.05%	\$153,490,275	10%	\$28,312
2	2,659	3,355	21,357	0.20%	0.25%	\$153,204,699	20%	\$7,174
3	8,441	11,796	79,977	0.75%	0.99%	\$153,368,508	30%	\$1,918
4	17,109	28,905	168,960	1.57%	2.57%	\$153,302,499	40%	\$907
5	24,484	53,389	229,116	2.13%	4.70%	\$153,357,507	50%	\$669
6	31,497	84,886	280,622	2.61%	7.32%	\$153,227,434	60%	\$546
7	43,342	128,228	391,938	3.65%	10.97%	\$153,038,458	70%	\$390
8	81,691	209,919	833,546	7.77%	18.74%	\$153,288,894	80%	\$184
9	172,098	382,017	1,790,263	16.68%	35.42%	\$153,239,941	90%	\$86
10*	825,443	1,207,460	6,930,402	64.58%	100.00%	\$152,986,730	100%	\$22
1,207,460			10,731,602	100.00%		\$1,532,504,944		\$143

*Decile 10 includes 172,922 clients who used no services, with a total of 1,088,319 eligible months.

Given the diversification of the population, the average can be misleading.

11

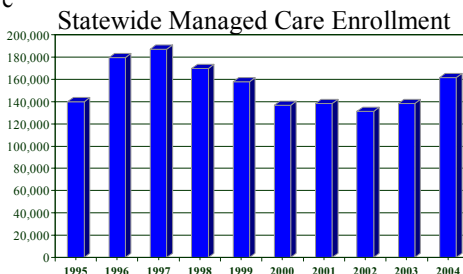
GENERAL MEDICAID MANAGED CARE INFORMATION – DPA

Managed Care

There are currently 5 Medicaid managed care organizations (MCOs) operating in Illinois. This number has remained constant over the past four years although it is down from a peak of 15 attained during 1998. Any client in any of the Family Health plans and living in a county with a participating provider is eligible to enroll in an MCO.

The current MCOs are:

- * Amerigroup
- * Family Health Network
- * Harmony Health Plan
- * Humana Health Plan
- * United Healthcare



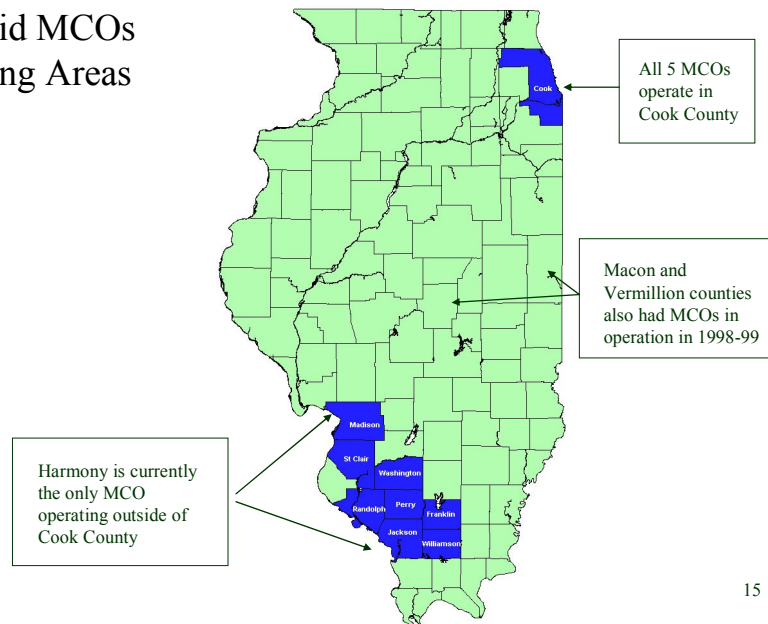
13

Chronology of Important Events

- 1976 - Medicaid Managed Care begins
- July 1994 - Governor signs legislation requiring IDPA to seek a waiver to implement mandatory managed care (MediPlan Plus) PA 88-554
- September 1994 - First Submission of MediPlan Plus waiver to HCFA
- July 1996 - MediPlan Plus waiver approved by HCFA
- February 1997 - Managed Care expanded downstate (St. Clair County)
- August 1997 - President signs Balanced Budget Act of 1997
- December 1997 - Illinois prohibited door-to-door and cold-call marketing
- 1998 – IDPA decides to not go forward with MediPlan Plus
- 1998 - The number of MCOs peaks at 15
- January 2002 - Implement 4.5% Rate Reduction to MCOs to mirror FFS
- August 2002 - Final BBA Regulations
- August 2003 - State required to be in compliance with the BBA
- 2004 – Managed Care expands into six additional downstate counties

14

Medicaid MCOs Operating Areas



15

MMCTF Findings

#1 - The current growth rate of Illinois' Medicaid program is unsustainable.

The State of Illinois, like other states across the country, is facing tough decisions in the near future about the growing impact of the rising costs of the Medicaid program, which are contributing to a worsening budget picture that is threatening the viability of all state programs and services. With no changes to the state's revenue generating structure, the growth of the Illinois Medicaid program is unsustainable in future fiscal years. The costs of the Medicaid program continue to grow at a rate in excess of state revenues. This is not a problem unique to Illinois. As healthcare costs continue to rise at rapid rates, pressure is applied to public and private healthcare plans and programs across the nation.

If allowed to grow at current rates, with no intervention, Illinois' Medicaid program will continue to require a larger allocation of funds from the general treasury. Throughout the mid and late 1990's, Illinois regulated the growth in Medicaid costs predominantly by reducing and/or freezing Medicaid provider rates and payments, by adjusting the payment cycle (now more than 75 days), and by utilizing several unique financing mechanisms such as provider taxes and intergovernmental transfer agreements to leverage more funds from the federal government. Many of these mechanisms have reached their maximum potential and cannot be counted on to sustain continued Medicaid growth. For most provider groups, the negative effects of further reductions in provider rates may offset any cost savings associated with such action, and the federal government has made it clear they will highly scrutinize all new proposals to leverage more Medicaid funding from the federal government. The growth in Federal Medicaid program costs is a continuing concern, which may lead to reforms that could limit future federal financial participation. Further complicating Illinois' Medicaid finances is the uncertainty around the Memisovski court decision, the hospital assessment and Medicare pharmaceutical drug coverage which all bear undetermined consequences for the State's Medicaid program.

If state and federal revenues cannot keep pace with the cost of the existing Illinois Medicaid program, additional cost controls must be found to curb the growth in Medicaid liabilities.

#2 - Managing unnecessary or excessive service utilization is considered to be the most palatable method for curbing the growth in Medicaid costs, given additional evidence of its effectiveness.

Increasing Medicaid liability is attributable to various factors, of which inappropriate or excessive utilization is a part. How contributing factors, including program and coverage expansions (i.e., KidCare, FamilyCare, AABD), Senior Care, targeted and across-the-board increases, and the rising cost of prescription drugs actually affect increased liability requires more analysis.

In general terms, there are a limited number of ways to control costs in the Medicaid program;

- Regulating provider rates;
- Restricting the benefits package (services covered);
- Restricting the number of individuals enrolled in the Medicaid program; and
- Restricting the amount of services utilized (utilization) by enrollees.

Each of the options stated above would have the effect of curbing the growth in Medicaid costs. As stated previously, the negative effects of reducing provider rates may offset any cost savings benefit. Restricting the services offered, or the number of individuals enrolled would certainly reduce costs, but given other available options, this course of action is less desirable. After weighing the negative impacts of reducing provider rates, reducing benefits or reductions in Medicaid enrollment, the task force believes that addressing unnecessary and/or excessive service utilization would be more beneficial given the negative impact of the other choices and the potential positive impact of effective service utilization management.

The task force believes that some level of unnecessary and/or excessive utilization exists in the current Medicaid program, but could not make a definitive judgment as to the extent of this problem. Nor does the task force necessarily draw a correlation between unnecessary or excessive utilization and outright fraud. Much unnecessary utilization may be the result of uninformed choices or the lack of appropriate health care resources in some areas of the state. The task force finds that reducing unnecessary or excessive utilization of Medicaid services is one the primary methods of controlling Medicaid costs, and that further analysis of this matter is necessary to determine if it can be more effective.

#3 – The Medicaid population is not homogeneous. Costs incurred by enrollees have wide variances, with some enrollees requiring few services and others utilizing vast resources.

Medicaid costs incurred by Medicaid recipients vary widely from person to person. For example, Department of Public Aid data for fiscal year 2003 show that within the Family Health Plan population which includes the TANF population, KidCare and FamilyCare, 11% of enrollees accounted for 70% of the costs incurred by the state. Conversely, the remaining 89% of enrollees accounted for just 30% of the costs, including 14% of enrollees who consumed no Medicaid services at all.

This is an important fact to be considered if any plan to expand managed care moves forward. Setting capitation rates based upon simple averages of the Medicaid population as a whole would not be appropriate for any managed care system short of a full mandatory managed care system.

#4 – Medical encounter data for Medicaid enrollees in managed care is incomplete and inadequate.

The lack of reliable encounter data hampered the task force’s ability to make a definitive determination about whether implementing managed care would improve the quality of care for Medicaid recipients or save money for the State of Illinois. The various sets of data and numbers quoted by different parties at the task force hearings served to confuse and cloud the issue. It is the position of the task force that all Medicaid encounter data should be complete and reliable, regardless of its origin or potential function. Encounter data is the primary method of assessing performance and it should be a priority.

#5 – Illinois’ utilization of managed care in the Medicaid program is significantly less than other states.

The task force finds that Illinois’ utilization of managed care is significantly less extensive than other states. The task force states this as a matter of fact, without rendering judgment as to whether this is positive or negative for Illinois.

#6 – Ensuring Medicaid enrollees have a “medical home” as a primary source of care is desirable to provide better access to health care and an improved coordination and continuity of care.

The existing Medicaid program does not adequately encourage Medicaid recipients to have a medical home. There are significant access barriers and there are no limits on recipients’ choices of providers, unless they have voluntarily enrolled in a managed care plan. Assuming that providers are willing to accept them, recipients may seek medical attention from virtually anywhere, at any time, with any level of frequency at their own direction. This can result in visiting different physicians and other providers for each encounter, resulting in a fragmented approach to health care service delivery. Most enrollees would be better served by having a medical professional coordinating their care.

Proposals submitted to MMCTF

INTRODUCTION

Recommendation #1 of the Medicaid Managed Care Task Force is that the Illinois Economic and Fiscal Commission engage a third-party entity to review all proposals that were brought before the Task Force, because the Task Force could not draw any definite conclusions given the information that was provided. These proposals are limited to: 1) the Affirmative Choice proposal, 2) the Primary Care Case Management – Disease Management pilot project proposal, 3) Care Coordination for Complex Cases, and 4) Fee-for-Service -- Elimination of the current Managed Care Organization structure in Illinois. This section of the report will summarize the issues and proposals that should be included in any future analyses.

At Issue: Increased utilization of any type of managed care structure will necessitate a review of the impact on the current Medicaid system that is predominantly fee-for-service (over 90%). Each of the proposals presented to the Task Force must be evaluated in a context that addresses the following issues that were considered by the Task Force.

- Quality/Access Assurance: Finding #6 of the Task Force concludes that Medicaid enrollees are better served by a health care delivery system that provides them with a “medical home” as a primary source of health care services. It is vital to the Task Force that any system of managed care provides a “medical home” setting and improves upon the health care delivered by the current fee-for-service system. Available data regarding the quality of care is not at all favorable with respect to either the existing Illinois Medicaid fee-for-service or the managed care systems. This is clearly a matter that required further attention. It is the intent of the Task Force that a third-party review will provide insight into a proposal’s ability to provide a better quality of care to Illinois’ Medicaid recipients.
- Accurate Savings: Any savings projections associated with increasing the use of managed care should be thoroughly evaluated by the third-party for accuracy. No conclusion on claims of estimated savings could be substantiated by the Task Force. The Task Force believes that it would be difficult to reach a consensus on the validity of the savings projections absent a third-party evaluation.
- Adverse Selection: The issue of “adverse selection” was probably the most hotly contested issue presented to the Task Force. Detractors of managed care organizations make the assertion that managed care organizations “cherry-pick” their clientele to select the least costly

individuals. The capitation rate paid to managed care organizations is generally established on the Medicaid population's average costs. Therefore, if managed care organizations enroll individuals that use less than the average amount of services, they incur a larger profit margin. The Department of Public Aid considers the amount of "adverse selection" and the costliness of the Medicaid population enrolled in managed care plans when establishing the capitation rate paid to managed care organizations. The simplest way to combat adverse selection is to implement a mandatory managed care plan for all Medicaid recipients. That option was not considered by the Task Force. However, the Task Force believes that all managed care proposals should be evaluated for their ability to cover a diverse population enrolled in DPA's Family Health Plan population. All managed care proposals should have the ability to cover all persons eligible for enrollment in DPA's Family Health Plan (TANF, KidCare & FamilyCare) or provide justification and allowance for their inability to cover certain populations.

- Impact on Illinois' Medicaid financial structure: The Task Force repeatedly heard testimony indicating that Illinois is unique in how its Medicaid program is financed. The argument was made that the nature of the State's Medicaid finance system would make expansion of managed care difficult. While it is true that Illinois has utilized many different Medicaid financing mechanisms, not one financing mechanism is unique to the State of Illinois. Other states that utilize managed care to a greater extent than Illinois use similar Medicaid financing mechanisms. Nevertheless, it is an undisputed fact that any expansion of managed care will have to operate within the current Medicaid financing system in Illinois. In no instance did the Task Force receive any precise information indicating how these payment mechanisms or other issues would be addressed. Any third-party evaluation of the managed care proposals should provide precise detail on the impact of the proposals on the following financial mechanisms:
 - **Cook County Inter-governmental Transfer (IGT)** – Illinois benefits from a financial arrangement with Cook County in which Cook County Medicaid expenditures are reimbursed at the highest possible level to maximize Illinois' Federal Medical Assistance Percentage (FMAP). The "enhanced FMAP" is shared by the State and Cook County. This financing mechanism is currently reliant on the State's fee-for-service reimbursement system and any expansion of managed care would have to address this financial arrangement or off-set the loss of federal revenues with greater savings.
 - **University of Illinois Hospital** – The University of Illinois has a financial relationship with the State similar to Cook County. Medicaid eligible health services offered by the university's facilities

are reimbursed at the highest possible level to secure the maximum amount of FMAP. The proceeds are then divided between the State and the university. This arrangement, like the Cook County arrangement, is dependent upon the current fee-for-service system and would have to be addressed by any proposal to expand managed care.

- **Up-front/conversion costs** – The current Medicaid program is dominated by a fee-for service reimbursement system that does not pay a health care provider until after a service is provided. The average payment cycle for fee-for-service providers in the current Fiscal Year is 75 days. Managed care, in any form, will likely bear initial or “up-front” costs that are currently not a factor. Managed care organizations, for example, receive reimbursement from the State in a more timely fashion than fee-for-service reimbursements. The payment cycle for managed care organizations is currently about 15 days. The payment cycle for managed care organizations is lower than the fee-for-service system because the fee-for-service system is a “post-service” billing system and managed care is typically a “pre-service” capitated billing system. The relevance of this fact lies in the cost of switching fee-for-service Medicaid enrollees to a capitated managed care rate. This cost, and any other managed care conversion costs, should be identified for all proposals by a third-party reviewer.
- **Drug Rebate** – The State receives rebates from the drug companies for pharmaceuticals purchased through the State’s Medicaid program. The federal government provides rebates to all states and Illinois also has a supplemental rebate program that brings in additional rebate money to the State. Both rebates are based on the fee-for-service arrangement. If drug coverage is included in any managed care proposal, the managed care proposal must address the potential loss of Drug Rebate revenue to the State.
- **Hospital Assessment** – The State of Illinois adopted a hospital assessment in November of 2003 that will be used to increase Illinois FMAP. The majority of the increased federal funding is to be used to increase reimbursement rates to hospitals. The hospital assessment is based entirely on the State’s fee-for-service system. As of the writing of this report, the State’s hospital assessment has not been approved by the Center for Medicare and Medicaid Services (CMS). Nonetheless, any independent evaluation of the managed proposals should include an analysis of the impact of the proposals on the State’s pending hospital assessment.
- **Third-party liability recoveries** – The Department of Public Aid continually attempts to recover any Medicaid expenditures that are the responsibility of a different party. For example, if DPA finds out that someone enrolled in Medicaid was actually covered by another

form of health insurance, DPA will seek reimbursement from the third-party entity responsible for payment. DPA cannot, however, recover third-party liability for a Medicaid recipient enrolled in a managed care plan. The responsibility for recovering the third-party liability would rest with the managed care organization and not with DPA. DPA concedes this would have minimal financial impact, but the financial impact should be addressed in any review of the managed care proposals.

- Impact on Community Health Centers: Federally Qualified Health Centers (FQHC's) are "safety net" health care providers that provide care not only to those on Medicaid, but also to the uninsured. FQHC's are typically located in areas where there are few health care provider options. Expanded Medicaid funding often enables FQHC's to use limited grant financing for an uninsured population. The increased use of managed care in Illinois could impact the funding for FQHC's. The Task Force is concerned with how any of the managed care proposals will impact the FQHC's and the health care safety net that they provide.
- Unidentified Issues: This section details specific issues that were of concern to the members of the Medicaid Managed Care Task Force. If the entity retained to conduct an independent evaluation of the following proposals becomes aware of any other issues that would be important in accessing the proposals, the Task Force welcomes and anticipates the inclusion of said issues in any independent report.

AFFIRMATIVE CHOICE

The Illinois Association of Health Plans (IAHP), an association that represents managed care organizations in Illinois, proposed a plan to the Task Force that was entitled “Affirmative Choice”. The IAHP proposal is as follows:

Proposal:

- Over the course of the next three years, convert the Family Health Plan population of Cook County, and the “Collar” counties, entirely to managed care with 50% of the population enrolled in privately operated health plans and 50% of the population enrolled in a publicly administered care coordination/disease management program. The following table reflects the anticipated distribution of the Family Health Plan enrollment by type of plan under the Affirmative Choice proposal:

Year	Cook & Collar TANF Population	FFS enrollment	HMO enrollment	PCCM enrollment
2004	770,000.00	645,000	125,000	0
2005	785,400.00	485,400	225,000	75,000
2006	801,108.00	326,108	325,000	150,000
2007	817,130.16	108,565	408,565	300,000
2008	833,472.76	0	416,736	416,736
2009	850,142.22	0	425,071	425,071
2010	867,145.06	0	433,573	433,573
2011	884,487.96	0	442,244	442,244
2012	902,177.72	0	451,089	451,089
2013	920,221.28	0	460,111	460,111
2014	938,625.70	0	469,313	469,313

**2% enrollment growth assumed*

- Establish a 12 month enrollment period. Within this enrollment period, the Medicaid recipient would be “locked-in” to the plan they selected, similar to the State’s Group Health Insurance program. The selection would have a 90-day trial period, in which the Medicaid recipient could change their selection (this is required by federal law).
- For Medicaid recipients that do not specify a choice between the privately administered health plans and the state operated care management

model, an assignment algorithm would be used to determine how to assign the undecided individual. The algorithm would steer individuals to plans that exhibit better quality care and health care access outcomes. The IAHP and the proponents of the Affirmative Choice Plan did not share any information on how this algorithm would be structured.

Potential Savings:

The IAHP asserted that their Affirmative Choice proposal could save the State \$91 million in its first full year of implementation. Cumulative savings over a five-year period of implementation were projected by the IAHP to be over \$300 million and almost \$1.6 billion in savings over a ten year period. The following is a table that details the potential savings of the Affirmative Choice proposal:

Year	PCCM savings	HMO savings	Total Savings	Cumulative Savings
2004				
2005	-2,700,000	18,360,000	15,660,000	15,660,000
2006	-2,025,000	35,934,600	33,909,600	49,569,600
2007	3,585,330	58,360,596	61,945,926	111,515,526
2008	16,934,317	74,481,772	91,416,089	202,931,615
2009	30,970,499	92,897,314	123,867,813	326,799,428
2010	47,239,953	113,879,399	161,119,353	487,918,781
2011	66,019,125	137,729,833	203,748,958	691,667,739
2012	87,615,228	164,783,121	252,398,349	944,066,088
2013	112,369,480	195,409,850	307,779,330	1,251,845,418
2014	140,660,658	230,020,400	370,681,058	1,622,526,477

PRIMARY CARE/DISEASE MANAGEMENT PILOT

A primary care case management system (PCCM) relies on a primary care provider being responsible for approving and monitoring the care of Medicaid recipients. The primary care provider is typically reimbursed with a small monthly case management fee for providing this service. Unlike a managed care system administered by managed care organizations, a PCCM system does not pass on risks to the third-party administrator. Under a risk-based managed care system, the State would pay a capitated rate to a third-party entity and that entity would bear the risk and consequences if the expenses of the services exceeded the rate. In a non-risk based managed care system, the third-party entity (often the primary care provider) assumes no risk, but is simply provided with an administrative fee. The difference between the two systems is the difference between a fully-insured health coverage plan and a self-insured health coverage plan.

Both the Illinois Hospital Association (IHA) and the Illinois Association of Health Plans (IAHP) suggested that the State use a PCCM system in some capacity. IHA proposed that the State set up a pilot PCCM project on a trial basis. The IAHP proposed that the State enroll 50% of the Family Health Plan population in Cook County and the Collar Counties in a PCCM program. Neither organization, however, provided any details of how the PCCM model would be structured. No detail was provided on how primary care providers would be reimbursed or otherwise persuaded to provide case management services. **Therefore, this report contains no details on the ability of a PCCM model to improve the quality of health care or reduce Medicaid costs to the State because no details were presented to the Task Force.**

Included in the IHA proposal is the use of a disease management pilot program, in conjunction with the PCCM pilot project. Disease management is a case management system that targets specific, and chronic, health conditions such as diabetes, asthma and AIDS. Again, the IHA proposed this action without providing any details on how a disease management program would be established or administered by the State. No evidence was presented to the Task Force on the use of a Disease Management program to contain health care costs or improve the quality of health care.

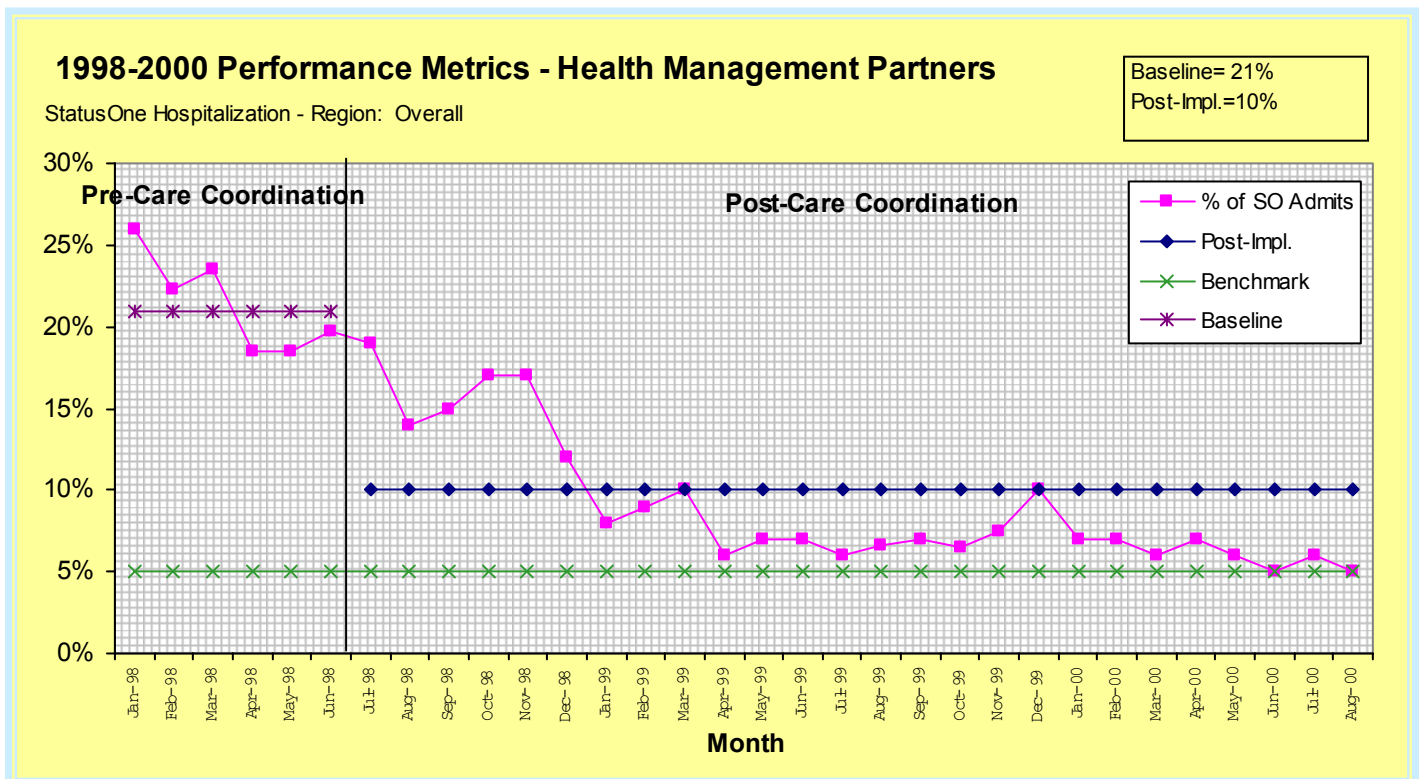
The proposal to use non-risk case and disease management programs to improve the quality of health care and contain health care costs was presented in general terms and lacked specific recommendations.

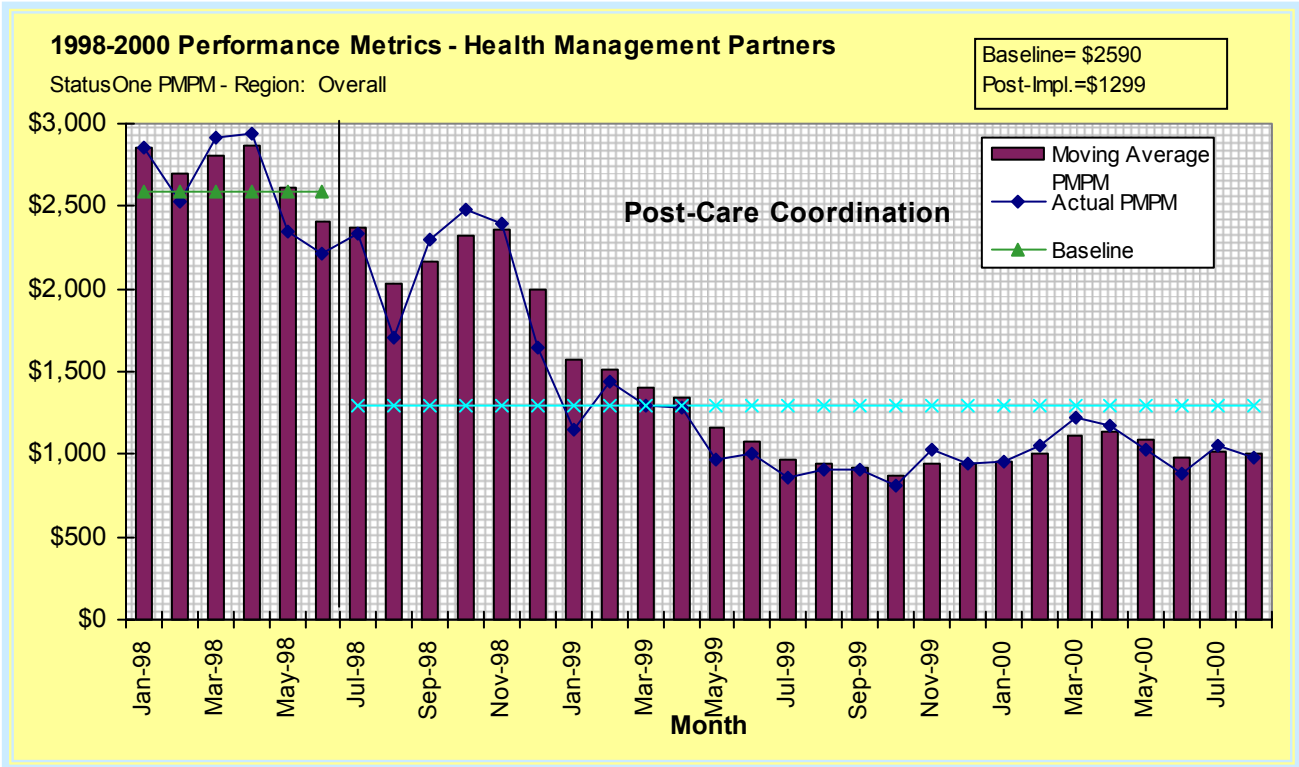
CARE COORDINATION FOR COMPLEX CASES

Dr. John Lynch, the Associate Chairman of Clinical Programs and Medical Director of Washington University Care Coordination, presented testimony to the Task Force detailing a program that he administers in conjunction with the Center for Medicare and Medicaid Services controlling the cost of costly Medicare patients. Dr. Lynch's pilot project coordinates care for individuals on Medicare that consume vast amounts of health care services. The Care Coordination proposal is included in this report because there was considerable interest expressed by members of the Task Force.

Proposal:

Dr. Lynch's care coordination model addresses the sickest 5% in the Medicare program in the St. Louis area. The sickest 5% of participants consume 20 to 30% of the Medicare costs. Dr. Lynch believes that these costs can be anticipated and that aggressive action can produce significant cost savings and improvements to the population's overall health. The program administered by Dr. Lynch relies on various community resources to recognize a person's debilitating medical state (proactive identification). Once these individuals are identified, they are assigned a care manager who assesses their needs and formulates a care plan specifically suited to the individual's needs. Dr. Lynch has been administering his study since 1998 and has produced remarkable results, as the following charts indicate:





As the preceding charts indicate, hospitalization and monthly costs of the projects population were cut in half in only two years.

It should be noted that it is unknown if this model can be used with the Medicaid population. Dr. Lynch is working in conjunction with the Center for Medicare and Medicaid Services (CMS) on his project for the Medicare population. In order to establish this model for Illinois' Medicaid population, DPA would have to discuss the possibility with CMS and possibly apply for a waiver.

It should also be noted that Dr. Lynch's model relies heavily on a social service infrastructure for early detection and intervention for potentially costly patients. If this model is favored by members of the General Assembly, the status of Illinois' social service infrastructure should be considered to ensure that there are sufficient resources to support the model.

Fee-for-Service Only System

During the course of the Task Force hearing, some have raised the issue that the fee-for-service (FFS) system in the State of Illinois may be able to provide a more cost effective and better quality health care system than any managed care system. Since the current Medicaid program is over 90% FFS, it would not be a drastic change to eliminate managed care in Illinois, and therefore, the savings would be minimal. Also, as stated in the Task Force Finding #6, the current FFS system does very little to encourage Medicaid recipients to adopt a “medical home” as a primary source of health care. Nevertheless, the Task Force believes that an independent analysis of the idea is warranted and is including this option within the purview of the third-party evaluation of proposals.

MMCTF Recommendations

#1 – The General Assembly should secure a private, independent consultant to review the managed care proposals presented to the Medicaid Managed Care Task Force.

The Illinois Economic & Fiscal Commission should contract with an objective third party to review the managed care proposals on behalf of the legislature. The consultant would be charged with reviewing the proposals for their ability to; 1) improve the quality of care to Medicaid recipients, and 2) provide cost savings to the State of Illinois. The consultant should have expertise in publicly financed health insurance programs and managed care programs. It would be preferred that the consultant have previous knowledge or experience with Illinois' Medicaid system.

The scope of work will be limited to the proposals presented to the Medicaid Managed Care Task Force. These proposals include the Affirmative Choice Plan, a non-risk case/disease management model, and a high utilization care management model. The proponents of each proposal would be responsible for working with the third party consultant for the purpose of completing the evaluation. Funding for this task shall be determined by the General Assembly. The review should be completed and presented to the Economic & Fiscal Commission no later than March 31, 2005.

#2 – Contract provisions related to the collection and submission of medical encounter data should be strictly enforced.

The Department of Public Aid should enforce the provisions contained within the contracts with managed care organizations concerning the collection and reporting of medical encounter data. Medical encounter data for Medicaid patients in managed care systems is important to any decision regarding whether to expand managed care in Illinois' Medicaid program. Additionally, timely and accurate encounter data will be of critical importance in the evaluation of the performance of existing managed care programs and the evaluation of any future managed care plans, if applicable. The Department of Public Aid, as the state signatory on managed care contracts, is charged with enforcing adherence to the provisions of those contracts.

#3 – The Department of Public Aid shall supply additional information to the General Assembly regarding existing efforts to manage care.

The Department of Public Aid shall submit a report to each legislative leader and each member of this task force detailing:

1. The State's current methods of providing and encouraging a medical home for Medicaid recipients.
2. The State's current efforts to provide a primary care setting for Medicaid recipients.

3. The State's current efforts regarding specific disease management practices for Medicaid recipients.

This information should be made available to the General Assembly no later than March 31, 2005.

#4 – Any future decisions regarding expansion of managed care or implementation of managed care based systems should include additional discussions between all interested parties.

In the event, that at some point in the future, the State of Illinois seriously considers changes to the Medicaid program to implement more managed care systems, all parties participating in the Medicaid Managed Care Task Force including legislators, the Department of Public Aid, Medicaid providers and health care advocates, are encouraged to continue to engage in active debate to ensure that all avenues and arguments are being considered. The issue of how to best provide care for Illinois' 1.8 million Medicaid enrollees in the most efficient manner is a highly complicated issue and is an issue of critical importance to those enrollees and to the taxpayers of Illinois.

Medicaid Managed Care Task Force Hearing Schedule

<u>Hearing Date</u>	<u>Hearing Location</u>	<u>Hearing Subject</u>
July 30, 2004	Springfield	Introduction & Organizational meeting
August 9, 2004	Chicago	Quality Assurance
August 31, 2004	Edwardsville	Access to Health Care
September 15, 2004	Urbana	Savings/Costs associated with expanding Medicaid Managed Care
September 27, 2004	Peoria	Review of Managed Care Proposals
October 18, 2004	Chicago	Structure & Content of Final Report

MMCTF Hearing Participants

Access Living
ALA of Metropolitan Chicago
Alton Hospital
Amerigroup Illinois
Arthur Jones, MD
Center for Medicare and Medicaid Services
Chicago Department of Public Health
Chicago Medical Society
Children's Memorial Hospital
Coventry Health Care
Diedrich Group
East Side Health District
ElderCare Inc.
Harmony Health Plans
Health & Disability Advocates
Illinois Academy of Family Physicians
Illinois Association of Family Physicians
Illinois Association of Health Plans
Illinois Attorney General Office
Illinois Department of Human Services
Illinois Department of Public Aid
Illinois Health Care Association
Illinois Hospital Association
Illinois Maternal and Child Health Coalition
Illinois Pharmacists Association
Illinois Primary Health Care Association
Illinois State Medical Society
Leslie Rosado
Patricia Serpa
Progress Center for Independent Living
Service Employees International Union
Southern Illinois Healthcare Foundation
Southern Illinois Regional Wellness Center
SSM Cardinal Glennon Children's Hospital
Swedish Covenant Hospital
United Healthcare

Medicaid Managed Care Task Force Testimony Summations



October 28, 2004

Medicaid Managed Care Task Force
Attention: Mr. Kurt DeWeese
Room 516 State House
Springfield, Illinois 62706

Dear Mr. DeWeese,

Thank you for the opportunity to comment on the recent Medicaid Managed Care Task Force Hearings. The hearings generated interesting discussions and hopefully, provided sufficient comment / testimony to aid the Task Force in developing their recommendations.

My testimony, on behalf of Coventry Health Care, centered on the experiences of Medicaid managed care in Missouri. Missouri finds financial benefit in the Medicaid managed care program as well as increased provider access and quality for Missouri's Medicaid recipients.

Testimony presented by the Department of Public Aid and other concerned entities questioned the validity of cost savings through managed care. In addition, the speakers often cited lack of providers and delayed payments as obstacles to care. We would like to offer another suggestion for consideration.

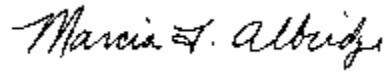
HealthCare USA (HCUSA), a Coventry Health Care plan, is located in St. Louis City and currently manages care for 185,000 members with 145,000 members in the metro St. Louis market, a ten county area. We propose that the Task Force in conjunction with Illinois Department of Public Aid consider a smaller scale mandatory Medicaid project involving the East St. Louis metro area encompassing Franklin, Jackson, Madison, Perry, Randolph, St. Clair, Washington and Williamson counties. Establishing mandatory enrollment for a smaller population provides the State a more manageable opportunity to track, trend and evaluate cost, access and quality.

HealthCare USA would be interested in pursuing discussions for such a program. Historically, St. Louis providers are a major source of medical care for the metro East St. Louis Medicaid recipients. HCUSA maintains a large network of providers in the metro St. Louis market. In addition, another Coventry Health Care plan, Group Health Plan, offers a managed care product in the metro East St. Louis area, with a large provider network. We are well positioned to offer managed care in the market and believe the pilot project would prove the benefits of managed care.

Thank you again for the opportunity to present testimony before the task force. I hope you found it helpful.

I look forward to hearing from you.

Sincerely,

A handwritten signature in cursive script that reads "Marcia F. Albridge".

Marcia F. Albridge
HealthCare USA, a Coventry Health Care plan
VP – Medicaid Business Development and Regulatory Affairs
314-444-7267
malbridge @ cvty.com

Cc: Bobby Jones – Senior VP, Coventry Health Care
Senator Dale Righter
Representative Frank Mautino

Illinois Health Care Association
Bill Kempiners, Executive Director

Advantages Achieved in Managed Care

1. If the right manager is selected and payment is based on sound actuarial decisions, cost savings can occur.
2. The managed care process allows for directing care to the most favorable treatment modality and can control over-utilization of a particular service such as unnecessary emergency room care.
3. The managed care environment would allow for long-term care experimentation.
 - * Implementation of SB 2880
 - * Conversions of all or part of nursing homes for other services to seniors in the community.
 - * Use of multi-level practitioners such as Physician Assistants and Nurse Practitioners for care delivery.
 - * Delivery of in-patient, out-patient, and consultation services to the community.

Areas of Concern under Managed Care

1. As managed care contract negotiations often produce provider rates that bear no relationship to the cost of providing services. It is tempting for providers to cut corners or maybe not provide their typical level of service to managed care patients.
2. Managed care is about shifting risk. Entities often try to shift the risk and the loss to others until there is only one provider left standing holding all of the loss.
3. Managed care works effectively when there is an extensive and concentrated educational program on the features and benefits of the program. The Medicaid population provides a greater educational challenge.

Managed Care for Long-Term Care

- Texas, Arizona and Maryland, have attempted limited Medicaid managed care programs for long-term care providers.
- Innovative pilot and demonstration projects have worked quite well for some segments of the Medicaid population. The downside, however, is that the additional layer of middle management in the program has proven to be costly.
- care eliminates the true “market competition” as neighboring facilities can have significantly different rates based solely on their ability to negotiate with the managed care entity.
- Managed care systems for long-term care have created duplication of survey and enforcement procedures as the managed care entity and the State regulatory agencies conduct many of the same oversight activities, sometimes simultaneously.

**SUMMARY POSITION OF THE ILLINOIS HOSPITAL ASSOCIATION
SUBMITTED TO THE MEDICAID MANAGED CARE TASK FORCE
October 18, 2004**

The Medicaid Managed Care Task Force was appointed earlier this summer to look at the application of expanded Medicaid managed care to control budget growth. At the Task Force's request, following is a summary of the Illinois Hospital Association (IHA) position on the expansion of Medicaid managed care.

The IHA has long supported Managed Care for the Medicaid population if "it is done right." However, **given the historical performance of Illinois HMOs and the issues raised below, any expansion in HMO care should be opposed at this time.**

Medicaid Budget

The Illinois Department of Public Aid (IDPA) indicated that the medical program liability has been increasing at an annual rate of 7%. Some have argued that this rate is "out of control" and "unsustainable." However, based on all the funding components of the Medicaid program (IGTs, provider taxes, drug rebates, etc.), net GRF expenditures for the Medicaid program have grown at/or less than long-term State revenue growth (*see George Hovanec testimony from September 15, 2004 hearing*). The need for continued budget diligence, however, is essential without requiring harsh or precipitous actions.

- The real spending pressures in Medicaid are not hospitalizations, but are the rapid growth of enrollees in Medicaid (29%) and pharmacy (36%).
- Costs in the Illinois Medicaid program are significantly higher for the AABD population (roughly \$9600 per person per year) than the Family Health (TANF) program (roughly \$1300 per person per year).

Medicaid HMOs

It is imperative for the committee to realize when examining the experience of other states that managed care is not limited to HMOs. Managed Care consists of both risk-based (HMO) and non-risk based (Case, Care and Disease Management). IHA OPPOSES any expansion in or changes to enrollment processes associated with risk-based (HMO) managed care as it unravels the current financing system that will cost the State money over and above the current system thereby weakening the overall Medicaid health delivery system for all patients. Expanded HMO coverage simply does NOT hold the promise of improving the quality of health care nor constraining the growth of Medicaid costs.

- HMOs do NOT prevent rapid growth in Medicaid spending and will not curtail liability growth. Those states with mandatory Medicaid HMO enrollment had spending growth between 10.6% and 20.2% per year for FY1998-2002, far higher than Illinois' 7%. There is no evidence that more HMO care leads to less spending (*see George Hovanec testimony from September 15, 2004 hearing*).

- Illinois ranked 43rd in annual percentage spending growth. Illinois' historical choice NOT to go to HMOs has contributed to its success in controlling cost without it (*see George Hovanec testimony from September 15, 2004 hearing*).
- Based on the findings of the *Memisovski vs Maram* lawsuit, current HMOs deliver poorer quality of patient care as measured by delivery of primary health care services for children than does the fee-for-service system.
- Current Illinois HMOs spend much less of total premium (67% on average) on medical care services than do Illinois commercial HMOs (i.e. Amerigroup 48%, Harmony 72.2%, versus HMO Illinois, the dominant commercial HMO, 90%).

Endorsed Managed Care Techniques

During this Committee's tenure IHA looked at managed care programs that balance the needs of beneficiaries, health care providers and taxpayers. IHA SUPPORTS a trial program that looks at (1) managed care techniques -- care/case/disease management on select sub-populations; and (2) other proven cost saving techniques not necessarily related to managed care. The aim of the trial program is to improve quality of patient care, with a portion of the anticipated hospital utilization savings used to improve the rates paid to hospitals.

- Medicaid managed care techniques outside of the traditional risk-based HMO model improve patient care coordination and often garner proven cost-saving effects.
 - (1) Case/care management component to medically manage 0.5 to 5 percent of the Medicaid population that accounts for a large portion of medical costs. Such a change would link those in greatest need to a primary care physician and avoids most of the administrative costs and profit percentages that need to be built into an HMO model. In addition, expanded case/care management creates a point of accountability for access and quality (*see Dr. John Lynch testimony from August 31, 2004 hearing*).
 - (2) Medically managing specific disease categories that account for a high percentage of medical costs. As noted in IHA's September 27, 2004 testimony, a 120,000 subset of the nearly 360,000 AABD patients (of a total of nearly 1.6M Medicaid patients) currently consume over \$3.5 Billion in services annually (of a total Medicaid expenditure of \$5.2 Billion for hospitals, physicians, pharmacies and long term care). Even reducing utilization by 5 percent of this subpopulation could yield over \$175,000,000 annually while improving patient care coordination and service. Such a change focuses interventions in the areas with the potential for the greatest returns, yielding savings and substantially improving patient care coordination (*see Lewin testimony from August 31, 2004 hearing*).
- IHA supports other concrete ways to improve patient access and quality without disbanding Illinois' current financing system.

"Affirmative Choice" Proposal Presented

IHA OPPOSES the “Affirmative Choice” proposal presented by the Illinois Association of Health Plans (IAHP). The plan presented does not account for any of the issues discussed throughout the hearings. Some of those issues include:

- Expanded HMO coverage will have adverse impact on IGTs, the financial underpinnings of the Medicaid system in Illinois. Illinois Medicaid has extensive financing mechanisms dependent on the fee for service payment setting. Illinois currently depends on a complicated set of special financing arrangements that raise more than \$2 billion annually in additional federal Medicaid funds. Eliminating/reducing this additional funding by moving 50% of the population to HMOs would significantly threaten Illinois’ healthcare delivery system. Specifically, reductions or changes above certain levels in state spending will automatically reduce the infusion of federal dollars because the Upper Payment Limit will have been exceeded. Decreases in funding reduce the flow of dollars to providers and reduce the amount of money circulating through the economy, affecting employment, income, state tax revenue and economic output, not to mention beneficiary access to care. *With respect to financing, the proposal does not take into account:*
 - (1) Payment cycle implications of moving from a fee for service environment paid at 75 days to one where the HMOs are paid at a faster rate (estimated impact of up to \$120,000,000);
 - (2) Payment rates and payment adjustments to specific disproportionate share providers under the new system (estimated impact up of to \$400,000,000 annually);
 - (3) Guaranteed payment to Cook County Bureau of Health Services (CCBHS) or University of Illinois (estimated impact of up to \$1 Billion annually);
 - (4) The Illinois Provider Tax currently moving through the federal process (estimated impact of up to \$500,000,000 annually);
 - (5) Pharmaceutical rebates garnered to the State (estimated impact of up to \$225,000,000 annually);
 - (6) Third party recoveries garnered by the State.
- Quality and access to care for Illinois Medicaid beneficiaries will suffer under this proposal. *With respect to quality and access to care, the proposal does not take into account:*
 - (1) Network adequacy and access to care for beneficiaries. It is not clear how plans will obtain adequate community-based provider panels that include sufficient numbers of physicians and hospitals to provide this size of population access to care within their networks. Primary care physician office hours are currently limited and availability is sporadic in the HMOs, and insufficient funding for care in Medicaid has resulted in more physicians closing panels or dropping out of this program. HMOs give the illusion of incremental access and therefore quality services being provided. In Missouri, for example, hospitals indicated that 90% of eligible physicians don’t accept new Medicaid clients. In fact, one of the major benefits stated by providers in other mandatory Medicaid HMO states

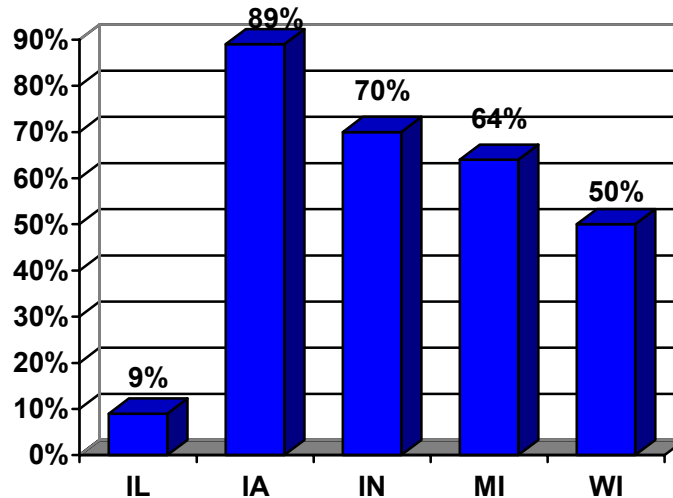
is that they can simply say no to plans and remove themselves from the Medicaid system (*see Cardinal Glennon testimony from August 31, 2004 hearing*).

- (2) “Adverse selection” issues between the systems proposed in the “Affirmative Choice” plan. HMOs currently focus on the TANF population, which is tantamount to cherry picking the healthier population who are not the source of the spending increases. IDPA presented data demonstrating that recent HMO enrollees, when still in the fee-for-service environment, tend to cost \$47.65 and \$48.11 per month for FY03 and FY04, respectively compared to the average Family Health Plan client cost of \$143 per month. (A subsequent presentation placed HMO consumption as low as \$31 per member per month.) This totals nearly \$110,000,000 annually in adverse selection costs (potentially paying twice for the overall care) associated with the current voluntary HMO program (*see Tom Yates testimony, September 15, 2004*). Adverse selection (HMOs enrolling the healthy population while rates are based on overall population costs) will continue under Affirmative Choice because it is a voluntary system with individuals first selecting between an HMO and Case Management and then having random assignment.
- (3) HMO insolvency protection for enrollees and providers;
- (4) Data collection requirements;
- (5) Outreach for well child and prenatal care. *Memisovski v. IDPA* proved that Illinois Medicaid beneficiaries received less care in HMOs than the fee for service system;
- (6) HMO payment reforms on downcoding and denials and slow reimbursement, and arbitrary use of non-contract utilization management standards (*see Children’s Memorial Hospital and Swedish Covenant Hospital testimony from August 9, 2004 and Touchette Regional Hospital and Cardinal Glennon Hospital testimony from the August 31, 2004 hearing*).

In conclusion, IHA urges the Managed Care Task Force to write a report endorsing care/case management and disease management as real alternatives to manage our State’s finite resources and improving patient care and to reject any expansion in HMO services.

SUMMER TASK FORCE ON EXPANDING MANAGED CARE MEDICAID: IAHP SUMMARY

ADJACENT STATES MANAGED CARE MEDICAID PENETRATION¹

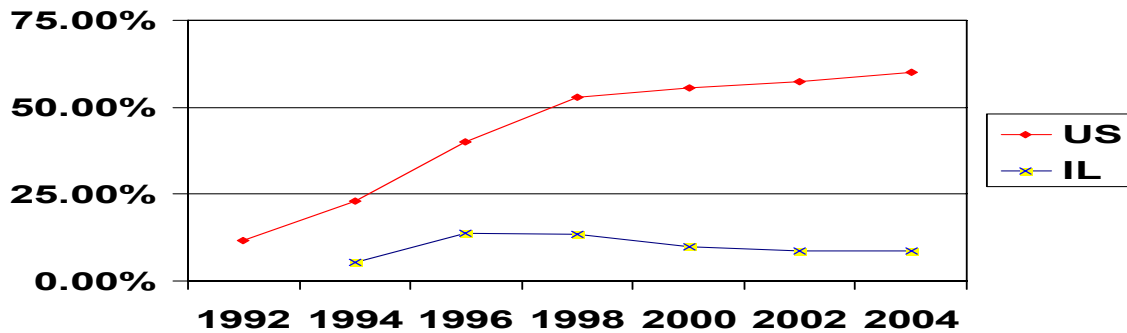


Illinois trails the rest of the country in the growth of its Medicaid managed care program and the gap continues to widen over time. Illinois currently ranks 47th in the country with less than 9% of Medicaid beneficiaries enrolled in managed care compared to a national average of 60%. Other states have moved to managed care to provide a medical home and improve access to care for Medicaid beneficiaries while simultaneously realizing program savings and creating budget predictability.

NATIONAL MANAGED CARE MEDICAID PENETRATION²

¹ CMS, 2003. Percent of Medicaid population enrolled in a managed care plan.

² CMS website.



The continued growth of managed care in state Medicaid programs has made managed care the preferred model for Medicaid health care services across the country.³ Forty-eight states have some form of managed care in their Medicaid program with the overwhelming majority (42) requiring enrollment in a managed care plan for at least a portion of their population.⁴

The National Association of State Medicaid Directors, summarizing the reasons for the growing popularity of Medicaid managed care, stated:

“The Message from the states is clear – Medicaid managed care is good for consumers. For the first time Medicaid members have, on a large scale, a system that is focused on serving them. This is a striking improvement over the “we provide you with a credit card” approach of the past. The new structure guarantees access, encourages medical homes, and provides case and disease management services to improve the health status of Medicaid patients. And the patients like what is happening. We are confident that as prudent purchasers of health care, states’ use of managed care will continue unabated. It is the avenue that offers greatest promise for strengthening health delivery systems and improving health outcomes across the nation.”⁵

ACCESS

States with robust managed care Medicaid programs have found that access to care has been nearly universally improved.⁶ Access to care is crucial to

³ National Association of State Medicaid Directors, “The Good News about Managed Care Medicaid,” 2002.

⁴ Tom Scully, Health Care Industry Market Update, March 2003

⁵ National Association of State Medicaid Directors, “The Good News about Managed Care Medicaid,” 2002.

⁶ Studies from NY, Calif, Texas, Lewin and Urban Institute.

developing a health system that encourages health maintenance and avoidance of costly and unnecessary emergency room visits or hospitalizations for preventable conditions.

To keep its Medicaid program growth in check, Illinois has historically relied on cutting provider rates and delaying provider payment. This is penny-wise but pound-foolish as low reimbursement and slow payment are the most common reasons primary care doctors give for not participating in traditional fee-for-service Medicaid and can reduce beneficiaries’ access to primary care.⁷

REASONS WHY IL PEDIATRICIANS LIMIT PARTICIPATION IN MEDICAID⁸

Reason	Low Reimbursement	Unpredictable Payment
% Responding	55%	44%

URBAN INSTITUTE: PHYSICIAN PARTICIPATION IN MEDICAID TIED TO REIMBURSEMENT⁹

Medicaid Reimbursement	States with Low Medicaid Rates	Moderate Medicaid Rates	States with High Medicaid Rates
% of Primary Care doctors who accept Medicaid patients	47%	58%	61%

Health care providers who do participate in Illinois’ traditional fee-for-service Medicaid program often wait months to receive payment for services rendered to Medicaid patients.¹⁰ While cutting or delaying provider payments may result in short-term savings, it is not without long-term program risks as a recent study points out:

“Low payments drive mainstream physicians out of the Medicaid program, impeding Medicaid beneficiaries’ access to primary and preventive care services and funneling Medicaid care toward more expensive institutional-based services.”¹¹

⁷ American Academy of Pediatrics Study (2000), Urban Institute Study (2004), Lewin Group (2004).

⁸ American Academy of Pediatrics Study, (2000)

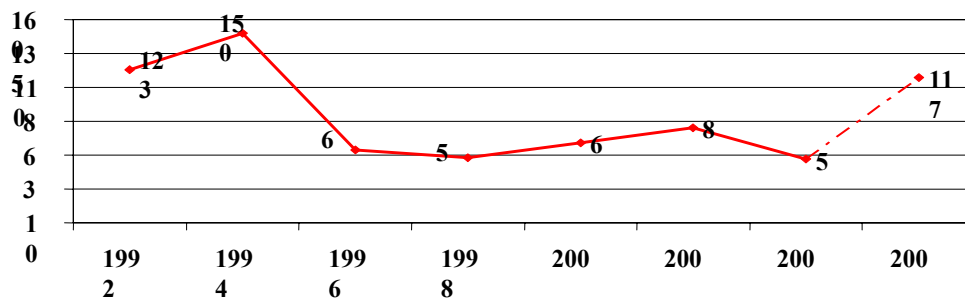
⁹ Urban Institute, Survey (2004) <http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.374/DC1>

¹⁰ George Hovanek testimony. Date of Service to issue of payment is expected to grow to 117 days in 2005.

¹¹ “Medicaid Managed Care – A Synthesis of Fourteen States” The Lewin Group (2004).

There is evidence this shift from preventive and primary care to more costly emergency room and inpatient care is occurring in Illinois. According to an actuarial analysis of fee-for-service Medicaid data, Illinois' emergency room and inpatient hospital utilization is significantly higher than national norms.¹² Milliman and Roberts, the actuarial firm hired by the state, found 32.9% excess inpatient utilization and 28.9% excess emergency room utilization.¹³

ILLINOIS FEE-FOR-SERVICE MEDICAID: DAYS FROM DATE OF SERVICE TO PAYMENT



ACCESS AND MANAGED CARE

Medicaid beneficiaries' access to care is typically improved under a managed care model. With managed care Medicaid providers are paid quicker and often at higher reimbursement levels compared to traditional fee-for-service Medicaid. In Illinois, the average managed care Medicaid claim is paid in well under 30 days with many primary care doctors actually being prepaid through capitation arrangements.

In addition to prompt provider payment, managed care promotes better access to medical care through contract provisions with the provider. In exchange for preferable payment arrangements doctors are required to accept new Medicaid patients, provide 24 hour accessibility, reduce waiting room times, and coordinate enrollees' care. Additionally, 24 hour nurse help lines, transportation to medical appointments, and assistance picking a primary care doctor are offered by the health plans to assure managed care members have unimpeded access to quality health care services. This level

¹² Milliman USA Managed Care rate book – using IDPA data (2002).

¹³ Milliman USA – using IDPA data to estimate the state's fee-for-service program costs (2002).

of assistance simply isn't available under traditional fee-for-service Medicaid.

The Managed Care Task Force heard testimony from Dr. Art Jones, CEO and Founder of the Lawndale Christian Clinic, a clinic many consider a national model for delivering high quality care to the Medicaid population. Dr. Jones testified that he prefers managed care payment arrangements to fee-for-service and encourages all of his Medicaid patients to join a managed care health plan. According to Dr. Jones, managed care discourages "Medicaid mill" volume practices by providing the financial resources and appropriate incentives to spend more time with each patient and deliver better care.¹⁴

The result of managed care program differences is better access to care. Studies and surveys done by the State Medicaid Directors Association, the Lewin Group, the Urban Institute, the state of Texas, the state of California, and the state of New York were presented in the Taskforce hearings demonstrating the improvement in access managed care has brought to Medicaid programs in other states.

*"Medicaid managed care plans achieve savings by improving access to preventive and primary health care by requiring participating doctors and hospitals to meet standards for hours of operation, availability of services, and acceptance of new patients. In the overwhelming majority of cases, the state Medicaid managed care programs were found to have improved Medicaid beneficiaries' access to services."*¹⁵

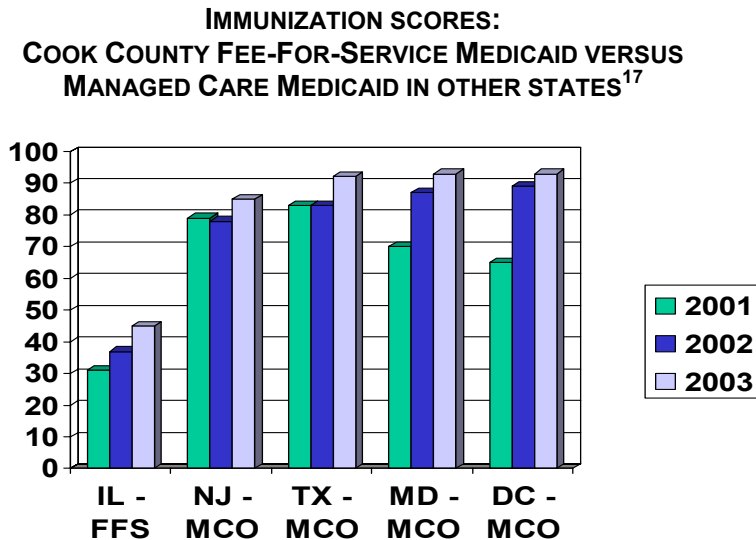
¹⁴ Dr. Art Jones Testimony, Summer Task Force Hearing #2, August 9, 2004.

¹⁵ Lewin Study, 2004. www.ahip.org/content/pressrelease.aspx?docid=1632

Quality

The quality of care provided to Medicaid beneficiaries, particularly states with strong managed care models, is enhanced through improved access, coordination of care, disease management programs, physician credential checks, provider chart audits, and numerous other quality improvement initiatives that are not commonly associated with the fee-for-service program. The United Hospital Fund commented in its assessment of managed care Medicaid in New York:

“Without question, managed care plans provide a framework for measuring the quality of service that had no parallel in the old fee-for-service system. And when problems are discovered, plans provide a vehicle for accountability and improvement.”¹⁶



During the Summer Task Force, data was introduced from the *Memisovski* lawsuit against the state which claims the state’s Medicaid program does not provide timely EPSDT (Early Periodic Screening Diagnostic and Treatment) services. Since 1995 twenty-seven other states have also been sued by advocates for failing to provide required access to EPSDT services.¹⁸

¹⁶ “Managed Medicaid in New York: A work in progress” (2003) www.uhfnyc.org/usr_doc/MMC.pdf

¹⁷ IDPA Cook County CMS 416 Data as of 9/29/04 versus NCQA Hedis scores of MCOs in other states. The scores of Cook County may be skewed low as encounter data tends to underreport services rendered.

¹⁸ GAO Report to Congress, July 2001. GAO-01-749.

In the Illinois suit, *Memisovski v. Maram*, the court ruled that Medicaid payments to Illinois providers are too low to guarantee equal access to care and that the state's Medicaid program fails to provide timely EPSDT services. Although the lowest MCO (Managed Care Organization) scores were higher than fee-for-service scores in 4 out of the 5 EPSDT categories compared in the opinion,¹⁹ opponents of managed care focused on the scores as evidence that managed care is not as effective in Illinois as it might be in other states.

Although each health care market is unique, managed care's focus on improving access to care, providing a medical home, using disease management and case coordination is effective in every market. The variance in scores from state to state is based on reliability of the underlying encounter data, and the degree to which states' use alternative quality measures to supplement encounter data readings.

The primary reason EPSDT scores are low in Illinois is that they are computed solely using encounter data, a method that undercounts services and is widely known as inaccurate and incomplete. Since encounter data is based on claims data, not health records, by definition it is only a proxy for care provided. CMS (Centers for Medicare and Medicaid Services), GAO (Government Accounting Office), the American Academy of Pediatrics, and even the plaintiff's expert witness in the *Memisovski* case have all commented that these encounter-based scores are inaccurate, incomplete, and unreliable.²⁰

Good quality measurement should not be confused with good quality care. The health plans feel there is no question improved access to primary and preventive care results in better health outcomes. For example:

- Asthmatic children in Illinois managed care Medicaid plans are educated on the appropriate use of medication and have fewer emergency room visits and lower hospitalization readmission rates than asthmatic children in fee-for-service Medicaid.
- Children in managed care Medicaid plans have lower asthma-related fatality rates than fee-for-service Medicaid.

¹⁹ *Memisovski v. Maram*, Case 92 C 1982. Judge Lefkow's Memorandum Opinion and Order. Pages 57 to 58.

²⁰ CMS in its "Encounter Protocols"(2002), the GAO in its Report to Congress on Medicaid (July 2001), American Academy of Pediatrics in testimony to the Federal Trade Commission, (Feb. 2003), Dr. Darling, plaintiff's expert witness, on pages 39 and 50 of Judge Lefkow's opinion and ruling on *Memisovski* versus *Maram*.

- Pregnant women in managed care receive prenatal care and education and deliver fewer low birth weight babies than mothers in fee-for-service Medicaid.
- African-American infant mortality rates are lower in managed care Medicaid plans than in fee-for-service Medicaid.²¹

That's not to say health plans don't recognize the importance of improving all quality indicators – including encounter data driven scores. We are encouraged to mention that the Department of Public aid has improvement efforts already underway to create more complete and accurate encounter data submission and acceptance in Illinois.

However, encounter data by itself is only a proxy for care delivered and should be balanced by looking at other quality measures including patient satisfaction, access to care, health outcomes, external quality review audits, physician medical chart audits, HEDIS scores (Health Employer Data Information Set), among others.

Savings

Poor access to primary care and unmanaged utilization in Illinois results in unnecessary emergency room use and preventable hospitalizations.

Available data suggests there may be significant unnecessary or preventable utilization in the current Medicaid program. For example:

- FY03 Medicaid enrollment grew by 7%, but claims filed grew by 11%.²²
- Reimbursement to Medicaid providers is well below average in Illinois, yet per-user costs of these services are above national averages.²³
- IHA (Illinois Hospital Association) estimates that 22% of Illinois Medicaid ER visits are non-emergent (more than twice the national average of 9%).²⁴
- IDPA's data indicates that outpatient utilization is growing faster than Medicaid enrollment.²⁵
- IHA contends that outpatient increases are due to a shift from inpatient to outpatient services. However, data shows inpatient costs are outpacing Medicaid enrollment as well.²⁶
- The state's actuary studied inpatient hospital usage using IDPA data and, after adjusting for IGT, found inpatient utilization was 32.9% above national norms.²⁷

²¹ Comparison of MCO outcomes and population data to Cook County Medicaid population data.

²² IDPA Medicaid Primer (2003)

²³ Urban Institute (2003) and American Academy of Pediatricians survey (2000).

²⁴ IHA Data Points (2003) found 22% non-emergency utilization of ER.

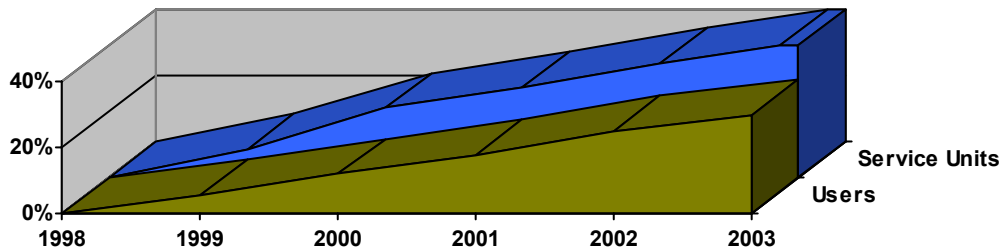
²⁵ IDPA Medicaid Primer (2003). <http://www.dpaininois.com/assets/050504primer.pdf>

²⁶ IDPA Medicaid Primer (2003). <http://www.dpaininois.com/assets/050504primer.pdf>

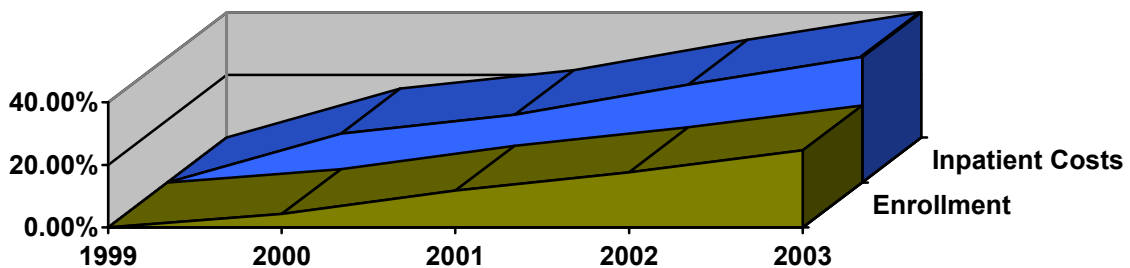
²⁷ Milliman USA – using IDPA data to estimate the state's fee-for-service program costs (2002).

- The Kaiser Foundation reports that Illinois Medicaid inpatient costs are much higher than the national average.²⁸

OUTPATIENT HOSPITAL UTILIZATION GROWING FASTER THAN MEDICAID USERS



INPATIENT COSTS GROWING FASTER THAN ENROLLMENT AS WELL²⁹



These are all indications of possible program inefficiencies and the potential to realize significant budget savings without cutting provider payments or eligibility.

Unlike proposed alternative solutions, managed care provides policy makers with the multiple advantages of directing care to the appropriate setting while providing budget certainty and guaranteed savings. This is an advantage over programs which require a front-end investment but are not at risk for delivering the promised savings.

²⁸ <http://www.statehealthfacts.org/> (Unadjusted for IGT, however the ratio far exceeded IGT's effect)

²⁹ IDPA Medicaid Primer (2003). Cumulative per diem and inpatient admissions increases.

MCOs (Managed Care Organizations) guarantee program savings through a 5% discount to fee-for-service costs and subsequent 1% to 2% additional annual savings on medical cost trends.³⁰ With these assumptions, moving just one-fourth of the state's TANF (Transitory Assistance to Needy Families) population to managed care would save over \$1 billion over the next 10 years.³¹ Moving the state's AABD (blind and disabled) population to managed care could save an additional \$1.5 billion in just 3 years.³²

Given the adverse budget pressures confronting Illinois, we believe that reining in utilization through the expansion of managed care to be far more palatable than the more draconian options of cutting eligibility, eliminating benefits, or reducing provider payment levels.

IAHP commends the Task Force for the hard work and insight that members brought to the study of this issue. Because other states have paved the way with successful Medicaid managed care programs, Illinois has a unique opportunity to build a system that adopts the best ideas from other states and allows for the kinds of program improvements that managed care can bring. A well-built, stronger managed care system can expand access to more providers, improve service quality, lower costs and protect IGT and special financing arrangements.

IAHP agrees with the Task Force's findings and recommendations and encourages all interested parties to consider the quality of care and financial successes that other states have seen as a result of making managed care a significant portion of their Medicaid programs.

³⁰ Reden and Anders Actuarial analysis of 10 years of CMS data estimates 1.5% trend savings through managed care.

³¹ IAHP estimates based on 5% managed care discount and 1.5% medical trend savings. Similar savings found in Health Management Associates study (2002), and UIC Public Policy Institute Study (2003).

³² Assuming savings estimated by Lewin study of Texas SSI population could be replicated in Illinois.

IAHP RECOMMENDATIONS

IMPROVING THE CURRENT PROGRAM:

- At enrollment inform Medicaid beneficiaries of all of their options including managed care and provide a check box allowing the beneficiary to choose HMO or Fee for Service.
- Commission an independent third party review of potential savings opportunities available in the State's Medicaid program and make recommendations to the General Assembly in 2005.
- Pass Legislative changes in 2005 to improve the collection and acceptance of encounter data.

REALIZING SAVINGS IN THE TANF PROGRAM:

- Increase managed care penetration in the TANF program by 16% to 81%.
- Managed Care guarantees state budget savings of 5% over traditional Medicaid and annual 1% to 3% reductions in medical trend.
- Moving just 25% of the state's TANF beneficiaries into managed care would save \$1 billion over 10 years. Savings under a mandatory program or SSI population would be even greater.

REALIZING SAVINGS IN THE SSI PROGRAM:

- Introduce the use of managed care in Illinois' SSI/AABD program in FY05.
- A recent study by Lewin Group in Texas found that HMOs reduced SSI costs by 10% -- from \$829 per member per month to \$742 per member per month.
- Similar results in Illinois could generate savings of \$388 million per year if the Illinois SSI population were enrolled in HMOs.

TASK FORCE RECOMMENDATIONS & FINDINGS

#1 - The current growth rate of Illinois' Medicaid program is unsustainable.

- IAHP agrees. The health plans believe they can work with the state to bring Medicaid growth rates closer in line with state revenue growth and add to the predictability of Medicaid budgets.

#2 - Managing unnecessary or excessive service utilization is considered to be the most palatable method for curbing the growth in Medicaid costs, given additional evidence of its effectiveness.

- IAHP agrees.

#3 – The Medicaid population is not homogeneous. Costs incurred by enrollees have wide variances, with some enrollees requiring few services and others utilizing vast resources.

- IAHP agrees. There are numerous programmatic and actuarial adjustments which can be made to address this issue.
- IAHP is willing to consider a risk-based managed care model for any of the populations in the Medicaid program.

#4 – Medical encounter data for Medicaid enrollees in managed care is incomplete and inadequate.

- IAHP agrees. Joint efforts between IDPA and the health plans are already underway to address the issue.
- However, poor measurement of quality does not equate to poor delivery of quality health care. A number of equally important quality scores should be looked at to get a full picture.

#5 – Illinois' utilization of managed care in the Medicaid program is significantly less than other states.

- IAHP agrees, Illinois ranks 47th in the country in terms of its use of managed care.

#6 – Ensuring Medicaid enrollees have a “medical home” as a primary source of care is desirable to provide better access to health care and an improved coordination and continuity of care.

- IAHP agrees. Significant studies, such as the United Hospital Fund, Special Report, 2003, and the National Association of State Medicaid Directors, 2002 report, detail the importance in the managed care plans' efforts to assign primary care doctors to enrollees and the positive impact this strategy has on health outcomes.

Recommendations

#1 – The General Assembly should secure a private, independent consultant to review the managed care proposals presented to the Medicaid Managed Care Task Force.

- IAHP agrees, although we are not aware of any other proposal formally presented to the committee by the third hearing deadline and did not have an opportunity to publicly comment on them.

#2 – Contract provisions related to the collection and submission of medical encounter data should be strictly enforced.

- IAHP agrees. The health plans are currently in compliance with contract provisions related to the collection and submission of the encounter data and will continue to work with the state to maintain compliance with those provisions.
- A collaborative effort between the health plans, providers, and IDPA is needed (and is underway) to improve collection, submission, and acceptance of encounter data.

#3 – The Department of Public Aid shall supply additional information to the General Assembly regarding existing efforts to manage care.

- IAHP has no position.

#4 – Any future decisions regarding expansion of managed care or implementation of managed care based systems

- IAHP welcomes all entities who are interested in crafting and improving a risk-based system of care.

**Health & Disability Advocates' Response to Findings and
Conclusions of Medicaid Managed Care Task Force
October 25, 2004**

205 West Monroe Street
3rd Floor
Chicago, IL 60606-5013
T: (312) 223-9600
F: (312) 223-9518
TTY: (800) 427-0766
www.hdadvocates.org

Health & Disability Advocates offers the following response to the Findings and Recommendations announced by the Medicaid Managed Care Task Force meeting in Chicago, Illinois on October 18, 2004.

Findings:

1. The current growth of Illinois' Medicaid program is unsustainable.

We believe that this statement should be changed to state as follows:

The State, because of the risk that it may incur unsustainable growth in Medicaid spending in the future, must take steps to identify factors fueling such growth and employ strategies to minimize the impact of these factors and maintain fundable Medicaid spending levels.

This reformulation is based on the following:

A. Through state fiscal year 2004, Illinois has done a good job of controlling the impact of Medicaid spending increases on its general revenue fund:

i. Illinois's spending growth per year in its Medicaid programs for federal fiscal years 1998-2002 was 9.2%, ranking it 43rd among all states, and lower than the growth rates in all neighboring states of Missouri, Iowa, Wisconsin, Indiana, and Kentucky. Illinois' Medicaid growth rates are also lower than other large industrialized states—Pennsylvania, Texas, California, Michigan, Florida, and New York. See G. Hovanec, *The Medicaid and the Odyssey*, Powerpoint presentation, Sept. 15, 2004.

ii. During the period of fiscal years 2001-2005, net General Revenue Growth grew at 3%. Illinois was able to rely upon provider taxes and intergovernmental transfers to cover the increased costs. See G. Hovanec, *The Medicaid and the Odyssey*, Powerpoint presentation, Sept. 15, 2004.

B. Increases in Illinois' Medicaid spending during the period of fiscal years 1997-2003 were due to the combination of governmental decisions to expand the categories of persons eligible for Medicaid; increases in the number of services utilized per Medicaid recipient, particularly in the area of pharmaceuticals; and prices paid to providers. See G. Hovanec, The Medicaid and the Odyssey, Powerpoint presentation, Sept. 15, 2004.

C. Legislative decisions that increased Medicaid spending achieved worthy goals including providing health care access to thousands of uninsured pregnant women and children; providing access to prescription drugs to thousands of seniors who did not have prescription drug coverage; providing health care to thousands of persons with disabilities and older adults with incomes under 100% of the federal poverty level.

2. Managing unnecessary or excessive service utilization is considered to be the most palatable method for managing the growth in Medicaid costs, given additional evidence of its effectiveness.

HDA agrees with this finding, but believes that it is not the only palatable way to manage Medicaid spending. George Hovanec, in testimony to the Task Force on September 15, 2004, opined that increases in Illinois' Medicaid spending during the period of fiscal years 1997-2003 were due to increases in the number of enrolled Medicaid recipients (29%); changes in utilization per eligible (15%); and prices paid to service providers (56%). We think that this means that Illinois must look at several different factors as it manages its Medicaid budget.

First, Illinois should scrutinize future proposed Medicaid expansions to ensure that it can afford their costs. Having said this, Illinois should set forth factors to consider before it embarks on future expansions. Such factors might be:

- Would the proposed increase in Medicaid eligibility allow Illinois to provide medical eligibility to a particular group or for a particular service that achieves an important public health goal? For example, past expansions of Medicaid coverage to pregnant women achieved the public health goal of ensuring that expectant mothers have access to prenatal health care to ensure the birth of healthy babies.

- Would the proposed increase in Medicaid eligibility permit provision of more effective health care with possible benefits in other areas funded by state dollars? For example, investing resources in providing coverage for children ages 3-5 who have developmental, cognitive, and mental deficits may save education dollars when these children enter school.

- Would the proposed increase in Medicaid eligibility allow Illinois to lower costs in other budget lines by transferring coverage to Medicaid with its corresponding 50% federal match? An example of this might be expansion of Medicaid eligibility for persons with mental illness to allow shift of mental health dollars from 100% state funding to 50-50% state-federal funding.

■ Are there any other solutions that achieve the desired coverage that do not rely on state funds? For example, taking steps to encourage or assist employers in providing health care coverage to workers and their families provides them with an alternative to government-funded medical care.

Second, spending increases due to increased utilization has primarily been fueled by pharmaceutical costs. In this, the State should take steps to avoid unnecessary or excessive pharmaceutical utilization as a prudent step that the State must investigate. Medicaid recipients who use 10 or more prescriptions may benefit from such a medication management program.

Illinois should also realize that its ability to control pharmaceutical costs will be impacted greatly by implementation of prescription drug benefit in Medicare, scheduled now to start on January 1, 2006, as well as how that program affects SeniorCare. The Legislature, in partnership with DPA, must closely monitor the roll-out of Medicare prescription drug coverage and how it impacts Illinois' Medicaid spending.

Third, Illinois may also be able to control costs through disease management. However, the thrust of disease management must be two-pronged: provide better medical care through coordination and management; and eliminate unnecessary costs through such coordination and management.

Fourth, Illinois should reinvest savings from medication and disease management back into the Medicaid program to provide rate increases to providers to secure the health care network that provides medical services to Medicaid recipients.

3. The Medicaid population is not homogenous. Costs incurred by enrollees have wide variances, with some enrollees requiring few services and others utilizing vast resources.

HDA agrees with this finding. The data provided by Andrew Kane of the Illinois Department of Public Aid in Powerpoint presentations on September 15, 2004 and September 27, 2004 provides evidence that, even within the Family Health Plans, there are great disparities in costs incurred by different Medicaid enrollees.

Two important factors should also be considered. Mr. Kane testified on both September 15 and September 27 that the most accurate way to determine the health care and service utilization rates for persons currently enrolled in Medicaid managed care was to obtain accurate and complete encounter data from the MCOs. Thus, ensuring collection of complete and accurate encounter data will help Illinois track usage within the Medicaid population.

Second, Mr. Kane also hypothesized, based on the encounter data of MCO members in the 12 months prior to MCO enrollment, that due to the current voluntary enrollment scheme, MCO members tend to cluster at the low end of a distribution of

Family Health Plan members based on cost. Put another way, it costs far less per month per member for actual medical costs of MCO members than for all other Family Health Plan members now receiving medical care in fee-for-service settings. That factor is critical to determining, as Illinois moves forward, appropriate monthly capitated reimbursement rates.

4. Medicaid encounter data for Medicaid enrollees in managed care is incomplete and inadequate.

HDA agrees with this finding. Indeed, during the hearings, HDA provided testimony that the current voluntary Medicaid managed care organization system has been shown to be substandard in the provision of necessary health services to Medicaid recipients. At the Chicago hearing, Thomas Yates presented testimony and exhibits that showed the following.

Data analyses compiled by the Illinois Department of Public Aid ([DPA](#)) as part of its [required Federal](#) CMS-416 reporting indicate that the percentage of children enrolled in Medicaid managed care organizations (MCOs) who receive well-child screening examinations have lagged behind well-child screening levels for Medicaid-enrolled children who receive medical care in fee-for-service settings and have not complied with [federal benchmarks nor](#) the MCOs' [own](#) contractual obligations with the Illinois Department of Public Aid (DPA). See Thomas Yates testimony dated 8-9-04 and reports provided with testimony.

Additional data analyses from Cornerstone, a database operated by the Illinois Department of Human Services (DHS), likewise shows that the percentage of children enrolled in the MCOs who have received the 4:3:1:3 shot series by 36 months of age has lagged behind the same numbers for children [in](#) Medicaid in Cook County generally. Finally, HEDIS reports (based on a [national set of standards for quality in MCOs](#)) from two of the MCOs: United Healthcare and Amerigroup show low rates of health screening for MCO members.

Members of the Task Force were also provided copies of October 2002 correspondence sent by DPA to the MCOs that indicates that they have not complied with contractual terms in providing preventive health care services to children. That correspondence compiles data on both child and adult screening measures and concludes that the MCOs have not achieved the participation goals set forth in their contracts with DPA.

Collection of complete encounter data from the MCOs will allow the best evaluation of how the MCOs have done in providing necessary medical care to their members. Testimony presented by Coventry Health Plans in Peoria demonstrated that sanctions can be an effective tool for Illinois to use to obtain complete and accurate encounter data.

5. Illinois' utilization of managed care in the Medicaid program is significantly less than other states.

HDA believes that this statement, standing alone, provides little guidance to Illinois decisionmakers in determining how Illinois should manage its Medicaid budget. Certainly, the evidence provided at the hearings would also support the following statements:

- Illinois has done a better job in the years of 1998-2002 of controlling Medicaid spending than all but seven other states, despite having one of the lowest percentages of Medicaid enrollees in managed care.
- Illinois is unable to properly evaluate the effectiveness of managed care in controlling Medicaid spending because it is unable to obtain adequate data from those MCOs to allow informed analysis.
- Data provided by the MCOs now operating in Illinois suggests that they have done worse than fee-for-service providers in providing preventive health care to children--care that might prevent more costly expenditures over time.

We believe that this Task Force is committed to identifying those options that Illinois can pursue to control Medicaid spending and ensure that Illinois is receiving optimum value for the dollars it invests in Medicaid. As such, Illinois must do its own investigations and make its own decisions on how it will manage its Medicaid program. Illinois must focus on identifying and utilizing models of care delivery that best manage and control costs. The focus should not be on achieving a certain level of managed care enrollment whatever the costs.

6. Ensuring Medicaid enrollees have a medical home as a primary source of care is desirable to provide better access to health care and an improved coordination and continuity of care.

HDA heartily endorses this finding. Our work representing Medicaid recipients has convinced us that people who have "medical homes" that manage and coordinate medical care, regardless of the payor for such care, receive better medical care. Illinois' Medicaid program should emphasize that its recipients find and rely upon a medical home. The Medicaid program should also reinforce, through reimbursement policies, that doctors serving Medicaid recipients should offer Medicaid recipients a medical home.

Recommendations:

1. The General Assembly should secure a private, independent consultant to review the managed care proposals presented to the Medicaid Managed Care Task Force.

HDA agrees with this recommendation and urges that the consultant review four different options:

- a) the IAHP proposal to enroll the Family Health Plan members in Cook County and the collar counties in 50% managed care and 50% PCCM models.
- b) The two disease and case management proposals; and
- c) Elimination of the current voluntary managed care program in Illinois.

2. Contract provisions related to the collection and submission of medical encounter data should be strictly enforced.

HDA agrees with this recommendation and believes that the General Assembly should send a strong signal that it expects that DPA will enforce the terms of its contracts and ensure that the MCOs comply with their contractual terms.

3. The Department of Public Aid shall supply additional information to the General Assembly regarding existing efforts to manage care.

HDA believes that the General Assembly must obtain and review accurate data regarding efforts to manage care. HDA also believes that DPA will endeavor to provide such information to the General Assembly.

4. Any future decision regarding expansion of managed care or implementation of managed care based systems should include additional discussions between all interested parties.

HDA supports this recommendation and stands ready and willing to work with the General Assembly to assist it in effectively managing the Medicaid budget so that Medicaid recipients are able to receive medical care.

Testimony
to the State of Illinois
Medicaid Managed Care Task Force
by
Illinois Maternal and Child Health Coalition
September 27, 2004

Good Morning, Thank you for the opportunity to speak to you today about Illinois' Medicaid program.

After listening to the testimony and reading the materials over the past few months, we have come to a number of conclusions.

- 1) The costs for the Medicaid program have not been expanding at a rate that is inconsistent with the history of the program nor greater than other states.
- 2) Children in the Medicaid program and especially in HMOs already do not use enough services and they are not receiving their screening exams that could prevent costly problems later.
- 3) The Medicaid program pays more to have a child in an HMO than to have one in fee for service.
- 4) Adults and children who receive Medicaid through TANF or KidCare or FamilyCare are generally a healthy population and do not use costly medical services

Therefore, we recommend the following:

- 1) Require HMOs to correctly record the services received by children in their program so we can compare their usage rates
- 2) Create a more even playing field by giving Medicaid clients the opportunity to choose an HMO on their KidCare application or at the DHS office. However, if a client does not choose an HMO, the client would be placed in fee for service.
- 3) Distribute a brochure explaining HMOs to the Medicaid enrollees.
- 4) Use disease management to assist Medicaid enrollees with chronic diseases
- 5) Increase linkages with the schools to coordinate services, provide health education, and education about proper usage of the medical system and a medical home.

The model identified by the Illinois Association of Health Plans is a complicated plan that would be costly to implement and run. The results promised are not based on any evidence that was presented over the past few months and are actually in contradiction to the lawsuit recently lost by the Department of Public Aid.

We think a more modest approach as suggested above is reasonable. It will not cost the state large amounts of money and will give clients the opportunity to choose their type of health care coverage.

Thank you again for the opportunity to present our recommendations.