IHA Illinois Hospital Association

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MEDICAID SUBCOMMITTEE
GOVERNOR'S TAXPAYER ACTION BOARD
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I am Howard Peters, Senior Vice President, Illinois Hospital Association, here on behalf of our 200 member hospitals and health systems across the state of Illinois.

We thank the members of the Medicaid Subcommittee for the opportunity to provide comment on the draft strategies for the Medicaid program and to speak about the critical need to protect the health care delivery system – especially Medicaid. The Medicaid program not only ensures the health and well being of all the state's residents, but just as importantly, provides a substantial stimulus to Illinois' economy and to the local economies of communities across the State that helps generate revenues, and brings in substantial, additional non-State funding.

We recognize the State faces significant fiscal challenges. This subcommittee and the Governor's Taxpayer Action Board (TAB) have the difficult, but important task of identifying approaches to enable the State to be more fiscally responsible, efficient and accountable as a good steward of its resources for vital programs and services, including health care.

The Illinois Hospital Association supports a cost-effective, efficient Medicaid program that promotes timely access to quality health care. Illinois' hospitals have consistently collaborated with the State to identify pragmatic and workable mechanisms to control Medicaid costs and improve care – including developing primary care case management and disease management, reducing inappropriate prescription drug utilization, and promoting a medical home for all Medicaid patients.

In considering the draft strategies for the Medicaid program, we urge the subcommittee and the Taxpayer Action Board to make sure that these strategies "first, do no harm" to patients and the health care delivery system. Implementing untested or flawed strategies or strategies based on faulty assumptions could have far-reaching negative consequences in the immediate future and in the years to come.

TAB Subcommittee's Proposed Strategies for the Medicaid Program

We urge caution and suggest that the subcommittee and the Taxpayer Action Board refrain from recommending strategies that are harmful or strategies that lack details and are not fully understood in terms of their implications for patients and the Medicaid program.

Strategies that we could support on a conceptual basis, although not enough details have been provided to enable us to take a definitive position, include:

- Expansion and potential changes to non-capitated Primary Care Case Management;
- Enhanced and expanded Disease Management;
- Expansion of quality community-based programs; and
- Implementation and expansion of Health Information Exchanges.

Strategies that we oppose because of the harm they would cause to the health care delivery system and to the critical financial underpinnings of the Medicaid program include:

- Expansion of or mandatory implementation of capitated managed care;
- Global waivers (block grants)/Medicaid benefit redesign; and
- Punitive types of pay for performance, rather than incentives.

Examples of strategies that lack details so that they cannot be evaluated include:

- "Selective contracting pilot program to ensure high quality and competitive price" *[What is this for? Who is to be contracted with? What will be contracted for? Etc.]*
- "Payment methodology reform that focuses on performance" *[What is the methodology reform? Who does this affect? How is this to be implemented? What performance measures will this be based on? Etc.]*

Hospitals Are Critical to Funding Support for the State's Medicaid Program

I want to take a few moments to explain why we urge the subcommittee to remove the proposed strategies concerning a global waiver (block grant) and capitated, risk-based managed care from the Taxpayer Action Board's report to the Governor.

But first, it is important to understand how the hospital budget line in the Illinois Medicaid program is financed.

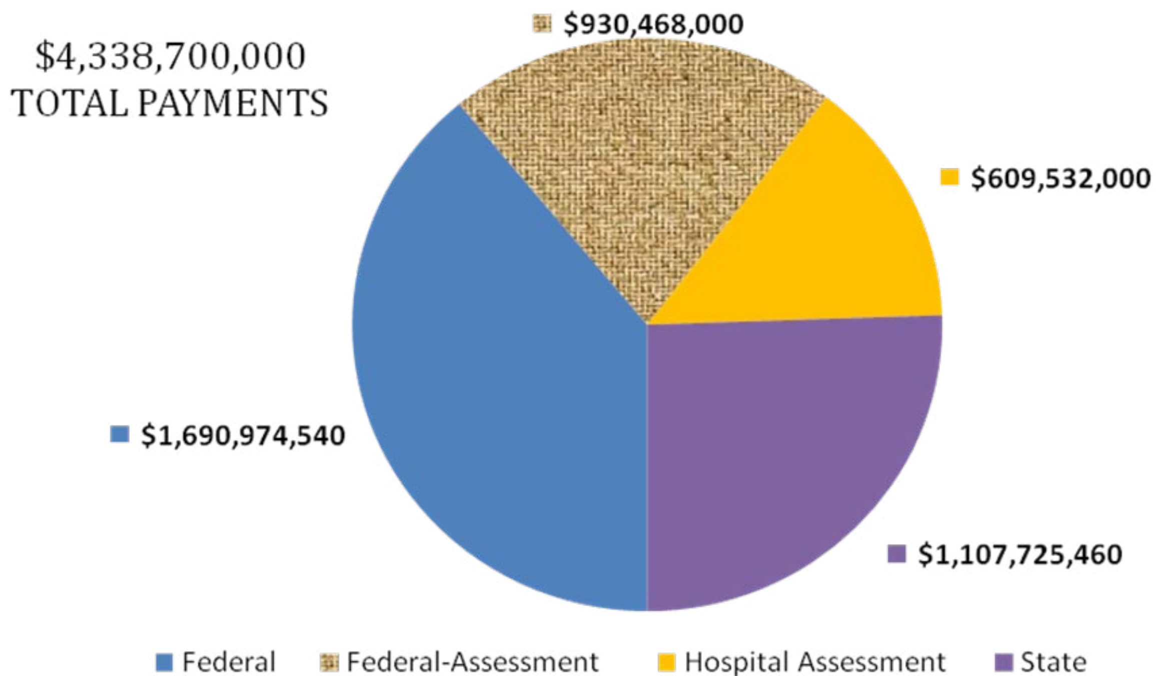
Medicaid inpatient base rates for hospitals in Illinois have been frozen since 1995, and the Medicaid program covers, on average, only 75% of hospital costs (without payments from the Hospital Assessment Program). A majority of Medicaid outpatient base rates for hospitals is now lower than they were in 1998.

To help the State boost its inadequate reimbursement rates, Illinois hospitals have worked with the State to develop three Hospital Assessment Programs over the past five years to provide new federal and hospital tax funds for the state's Medicaid program. Moreover, by the end of the current assessment program, the three assessment programs will have generated a total of $3.5 billion for other Medicaid services, such as long-term care and developmental disability services.

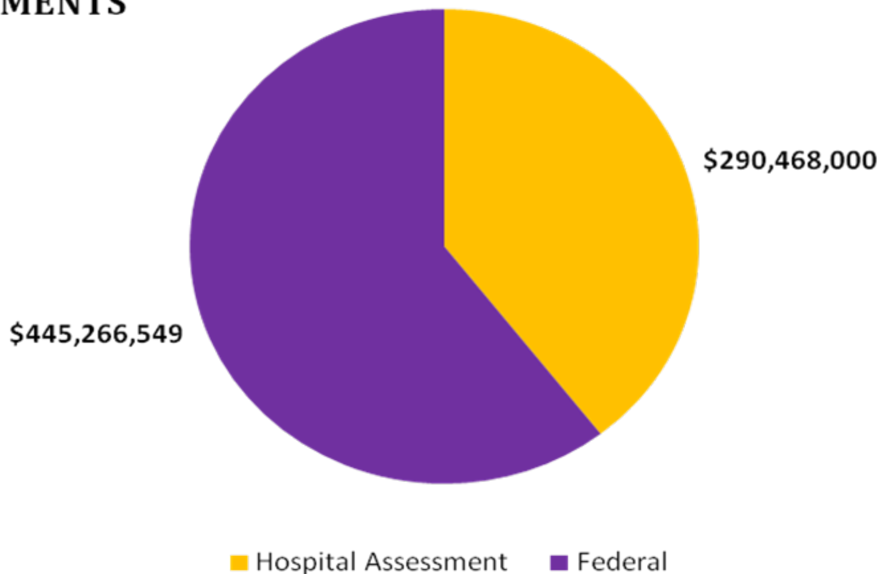
In fact, when you look at the total $4.34 billion in Medicaid payments to hospitals in Illinois in fiscal year 2009, the vast majority of funds used to make these payments is from NON-State sources:

- **Three-quarters of Medicaid payments to hospitals in FY2009 are from NON-State funding sources**: $610 million paid by hospitals to the State for the assessment program, which triggers a federal match of $930 million, and $1.69 billion in other federal funds;

- **Only about 25 percent** or $1.1 billion **is from state funding**.



Just as importantly for the State, the Hospital Assessment Program is generating additional NON-State funds of approximately **$735 million** for other Medicaid needs in the current fiscal year.



Under the assessment program, in the current fiscal year, hospitals contribute substantial funds to the State: a total of $900 million a year, with $610 million of that contribution generating the federal match to pay hospitals.

The remaining $290 million of hospitals' contributions go to the State to use for other Medicaid needs. Under the State's enhanced FMAP rate, that $290 million generates another $445 million in federal matching funds, for a total of $735 million.

Over the five years of the current assessment program (state fiscal years 2009 – 2013), the program will bring the state $3.85 billion in federal Medicaid funds for hospitals, as well as provide the state another $650 million for other Medicaid needs, such as long-term care and developmental disability services. With the State receiving temporarily increased federal matching funds under the economic stimulus law, the $650 million, if matched, will net the state $2.5 billion over five years for other Medicaid needs.

Flawed Strategies That Would Harm Patients and the Medicaid Program

Global Waiver (Block Grant): Would Jeopardize Illinois' Medicaid Financing Mechanisms
Over the years, some have suggested that the state's Medicaid program – all its existing waivers and state plan – be put under one demonstration waiver or a block grant approach. But given Illinois' unique financing mechanisms that are the foundation of the Medicaid program, such an approach would have enormous, negative consequences that would actually jeopardize, if not eliminate, key funding sources for the State.

A block grant approach for Medicaid would lock the State in at its currently poorly funded level while shifting ALL of the risk to the State – without the State having total control of the Medicaid program. In essence, a block grant approach would attempt to partially balance the state budget on the backs of Medicaid patients, our most vulnerable populations – the young, the elderly, pregnant women, the disabled and the newly unemployed – and on the backs of providers who maintain our fragile and fraying health care safety net.

By pursuing a waiver from the federal government, Illinois would be the first large state in the nation to institute a pure block grant approach for Medicaid. Only Vermont and Rhode Island have been approved for this approach.

Currently, the federal government and the states share the risks and burdens of greater-than-anticipated increases in Medicaid enrollment and health care costs. If costs rise for any reason – including increased enrollment, medical/pharmaceutical inflation, or new medical technologies – these costs are shared between the states and the federal government. This uncapped federal financing of Medicaid more readily allows the program to guarantee coverage to all eligible individuals and ensure that the federal share is at least somewhat adequate.

Capping Medicaid funding through a block grant would lock in or freeze the federal cost with modest annual increases. The effect of a block grant approach is to shift the risk from one that is shared by both the State and federal government to risk that is totally taken on by the State. Illinois already receives less than its fair share of Medicaid funds from the federal government. The state provides care to 4.1 percent of the nation's Medicaid population but receives only 3.3 percent of total Medicaid funding, and has the lowest federal matching rate, 50 percent.

Block grants do not automatically adjust for bad economic times when Medicaid enrollment increases and state revenues decline – as is occurring now in the current recession. If enrollment costs exceed what the state has budgeted and the federal grant, the state must cover those costs with additional state funds, stop enrollment, reduce eligibility, eliminate covered services or reduce provider payments.

A block grant approach could jeopardize or even eliminate Illinois' unique financing mechanisms, such as the hospital assessment program and intergovernmental transfer (IGT). Such an approach would require the State to negotiate with the federal government new terms of the assessment program and the IGT, including payments to providers. The current hospital assessment program and IGT, which bring the State billions of dollars, would be eliminated and have to be reworked. That is a risky step to take, with too many unknowns and unanswered

questions, at a time when the State is facing enormous financial challenges. The State already has in place a new five-year assessment program that will bring the State more than $4.5 billion in federal Medicaid funds for hospitals and other Medicaid needs, such as developmental disability services and long-term care.

Finally, a block grant approach does not provide unlimited flexibility for the State. Under the global waiver approach there are many aspects of the program that must meet federal regulations, including beneficiary eligibility and covered services. In fact, the most recently approved global waiver (for Rhode Island, only the second one in the nation) includes terms and conditions that the state must still notify CMS of certain changes to its Medicaid program. Under those terms and conditions, CMS has 15 calendar days to inform the state of any correction – including unilateral changes by CMS – to the State's originally proposed change, which then becomes binding on the state and is not appealable.

The Problems with Capitated, Risk-Based Managed Care

The Illinois Medicaid program already relies heavily on managed care to help control costs, provide greater efficiencies, and improve the quality of care. Of the 2.4 million Illinoisans served by Medicaid, 1.7 million people or nearly 71 percent are in managed care, well above the national average of 64 percent (which includes all types of managed care, such as primary care case management, disease management, capitated, risk-based HMOs and other managed care approaches). The Illinois Medicaid program employs a wide range of managed care techniques, including:

- Primary care case management
- Disease management
- Concurrent reviews
- Prior approval
- Medical homes

The results of the State's efforts to promote regular check ups, preventive care and quality through primary care case management and disease management so far are very promising. In the first year of this program (FY2007, when it was not fully implemented), the State saved $34 million. At a legislative hearing earlier this spring, the Department of Healthcare and Family Services indicated that the preliminary numbers for the second year (FY2008) will be at least $100 million in savings. These strategies, which have a track record of generating savings, should be given time to work.

However, **capitated, risk-based HMO managed care** for Medicaid is not the answer and is not real reform. It will only take hundreds of millions of dollars out of the health care delivery system each year in the form of profits and administrative expenses.

To achieve profits for their shareholders and to cover their administrative expenses – especially in Illinois, where provider payment rates are already low – HMOs place barriers between Medicaid beneficiaries and providers in order to provide less care or pay less in expenses. However, when a state employs non-capitated Medicaid managed care techniques as Illinois

does, the resulting cost efficiencies and health care quality improvements go to the benefit of Medicaid patients and the state.

Just as important, Illinois has unique Medicaid financing mechanisms that make the use of capitated, risk-based HMO managed care very problematic for the State's health care finances. Intergovernmental transfers and the hospital assessment program – which are dependent on the number of fee-for-service inpatient days – net the State more than $1.5 billion annually.

Under capitated, risk-based HMO managed care, Medicaid beneficiaries would be removed from the fee-for-service system and could not be counted in calculating the maximum amount that could be paid to hospitals, commonly referred to as the upper payment limit. The bottom line is that reducing the upper payment limit will force a restructuring of the current Hospital Assessment Program, resulting in substantially reduced federal funds to the State. Many other states that employ capitated, risk-based HMO managed care do NOT have the special Medicaid financing mechanisms used by Illinois to leverage substantial federal matching funds.

While some states have implemented cost containment strategies over the years, including reducing provider payments, Illinois' Medicaid program has already squeezed payments by keeping hospital inpatient base rates frozen since 1995 and is paying some of the lowest rates in the country. In addition, Illinois spends less per Medicaid enrollee in several categories compared to the rest of the country. According to the Kaiser Commission on Medicaid and the Uninsured, in FY2005 (the most recent year in its study), Illinois ranked 46th among states on Medicaid payments for children enrollees and 40th for adult enrollees.

Another negative consequence of low Medicaid provider payments – which capitated, risk-based HMOs would need to squeeze even lower to achieve profits and cover administrative expenses – is low participation by physicians and hospitals. HMOs will not be able to attract physicians to serve their patients because their reimbursement rates will likely be even lower than their current low rates.

Illinois would need to put substantial funding into current HMO capitation rates in order to attract HMOs that have left the state. It is important to note that there are only two capitated managed care organizations (MCOs) remaining in the Illinois market. Earlier this week, one of those two remaining MCOs agreed to pay $80 million in restitution under a deferred prosecution agreement related to a federal charge that it engaged in an elaborate scheme to defraud Florida's Medicaid and Healthy Kids programs.

The FBI Special Agent in Charge who helped investigate the case said in a May 5 U.S. Department of Justice press release: "In this case, corporate greed was responsible for the theft of funds from critical government programs. These programs were designed to facilitate health care services to adult citizens and children who otherwise would not be able to afford needed treatments. The company executives and employees allegedly responsible for defrauding Medicaid and other health care programs in Florida had a choice, to help or steal, and they chose the latter."

Last year, a different Illinois HMO settled charges that it avoided enrolling pregnant women and sick members in Illinois – for $225 million. The HMO had allegedly excluded those groups when running a Medicaid managed care plan in Illinois because such patients would have been more expensive to treat. The settlement stemmed from the largest jury verdict in history ever awarded under the False Claims Act and the Illinois Whistleblower Reward and Protection Act.

The capitated, risk-based HMO managed care model has not lived up to its claims in Illinois, with a number of large Medicaid HMO insolvencies, providers still owed tens of millions of dollars, and a dismal record of less and lower quality care provided to Medicaid beneficiaries.

In 2004, in a landmark federal court case (*Memisovski v. IDPA*), the court found that Medicaid beneficiaries (children in Cook County) received less and poorer quality care in HMOs than in the fee-for-service system.

Access to needed specialty care and continuity of care – especially for those who are chronically ill and need to be in a plan with a strong referral network – also is undermined in capitated, risk-based HMO managed care. Inadequate Medicaid payment rates have caused physicians to close panels or drop out of Medicaid entirely. Many hospitals are similarly reluctant to join Medicaid HMO networks for the same reasons.

Capitated, risk-based HMO managed care will NOT save the State money but will only unravel the State's current health care financing system and divert scarce resources away from the actual delivery of care to HMO profits and administrative expenses.

Conclusion

Finally, to ensure that the State can adequately support the Medicaid program (and reduce its need for state funds), we strongly urge the Governor, General Assembly and Illinois Congressional Delegation to push for a permanent increase in the State's federal Medicaid matching rate. Illinois' temporary rate increase under the federal stimulus law is in place only through the end of 2010. Without the temporary increase, Illinois is at the lowest federal matching rate (50 percent).

The Illinois Hospital Association and the hospital community are strongly committed to its partnership with the State to preserve and protect the health care delivery system for all Illinoisans – especially our most vulnerable populations – by working with the State for a cost effective, efficient and quality Medicaid program and by continuing to collaborate on ways to develop and maintain reliable, sustainable and predictable funding sources.

Thank you for the opportunity to comment. We urge this subcommittee to continue to ask questions about all the proposed strategies for the Medicaid program, remove the harmful ones from consideration, and put some "meat on the bone" before recommending that the Taxpayer Action Board forward any of these strategies to the Governor.