

**ILLINOIS HOSPITAL ASSOCIATION
MEDICAID
JUNE 15, 2009**

The hospital community recognizes that the State faces significant fiscal challenges. The General Assembly has 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.

On behalf of our 200 member hospitals and health systems across the state of Illinois we provide comment on various strategies that have been discussed to change the Medicaid program and speak about the critical need to protect the health care delivery system. 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 jobs and revenues, and brings in substantial, additional non-State funding.

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 strategies to reduce costs and achieve greater efficiencies in the Medicaid program, we urge you to “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.

Strategies Supported by IHA

Strategies that the IHA supports conceptually to provide savings and greater efficiencies in the Medicaid program include:

- Enhancing the non-capitated primary care case management program;
- Enhancing and expanding the State's disease management program;
- Interconceptional care management strategies to significantly improve birth outcomes;
- Rebalancing long-term care by expanding community-based programs;
- Enhancing pharmacy cost containment efforts; and
- Implementation and expansion of Health Information Exchanges.

Harmful Strategies Opposed by IHA

IHA opposes the following strategies because of the great harm they would cause to the health care delivery system and to the critical financial underpinnings of the Medicaid program, including the Hospital Assessment Program:

- Hospital rate cuts;
- Expanding capitated managed care;
- Global waivers; and
- Implementing contracting programs for hospital procedures.

These strategies would not only produce negligible savings of state dollars but also could jeopardize the Hospital Assessment Program, costing the state billions in lost federal revenues, while undermining access and quality of care.

Without the additional federal dollars generated by the assessment program, Illinois has one of the most miserly Medicaid programs in the nation, with extremely low provider rates. Illinois ranks 42nd in the country on spending per Medicaid recipient.

There have been claims that some of these strategies could generate substantial savings – in the hundreds of millions or even billions of dollars. Such savings are illusory and not achievable from these strategies. To save that kind of money means eliminating children, families and the newly unemployed from the Medicaid program, reducing services to the remaining eligibles, and cutting provider rates that are already extremely low. The number of uninsured in Illinois will increase even more.

I. Hospitals Provide Critical Financing for the State’s Medicaid Program and Are Not The Cause of Spending Increases

In order to understand why we oppose hospital rate cuts and harmful strategies, such as expanded capitated managed care, it is important to understand how the hospital budget line in the Illinois Medicaid program is financed and the fundamental pressures facing the program.

Over the past five years Illinois Medicaid enrollment has increased by over 45% -- from 1.65 million beneficiaries in 2003 to 2.4 million in 2008. It should come as no surprise that Medicaid spending has also increased.

Despite covering substantially more people, hospital inpatient base rates have been frozen since 1995, and a majority of Medicaid outpatient base rates for hospitals are now lower than they were in 1998. Without the enhanced funding from the Hospital Assessment Program, on average, Medicaid covers only 75% of Illinois hospitals’ *costs* of treating Medicaid recipients.

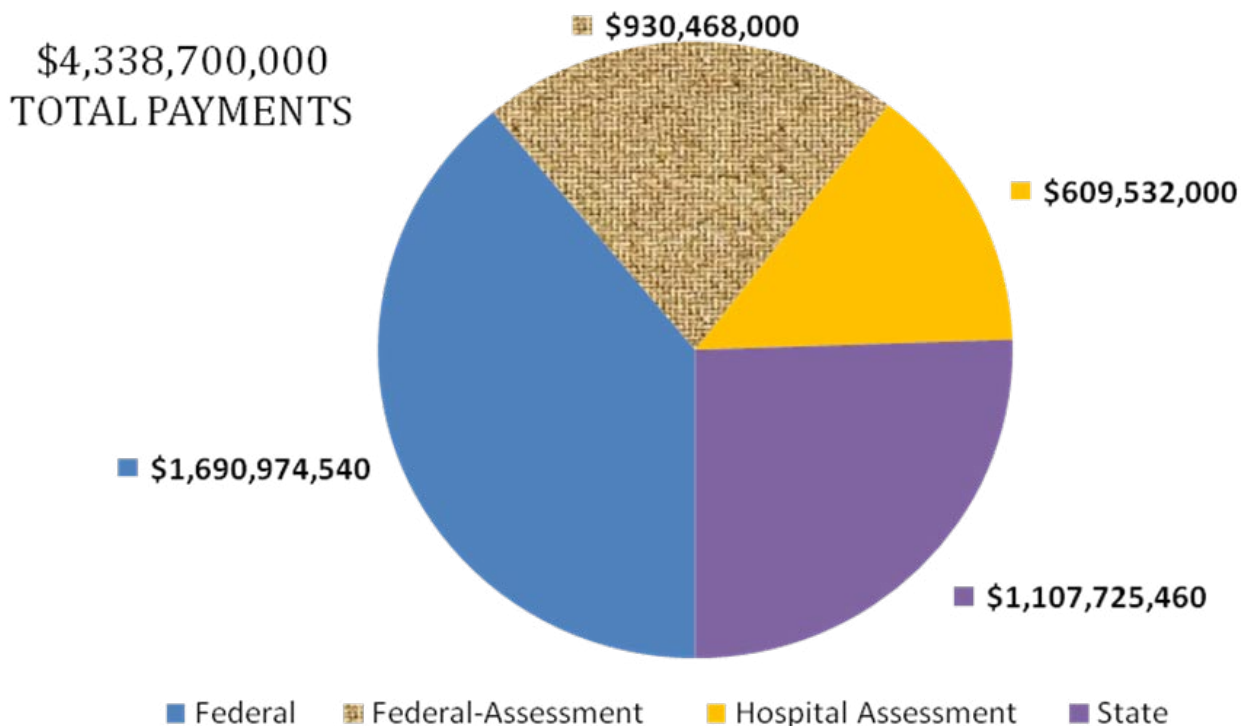
To help the State boost its inadequate Medicaid reimbursement rates, Illinois hospitals have worked with the State to develop three Hospital Assessment Programs over the past five years to provide new federal and hospital tax funds for the state’s Medicaid program. Moreover, by the end of the current 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 are 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.**

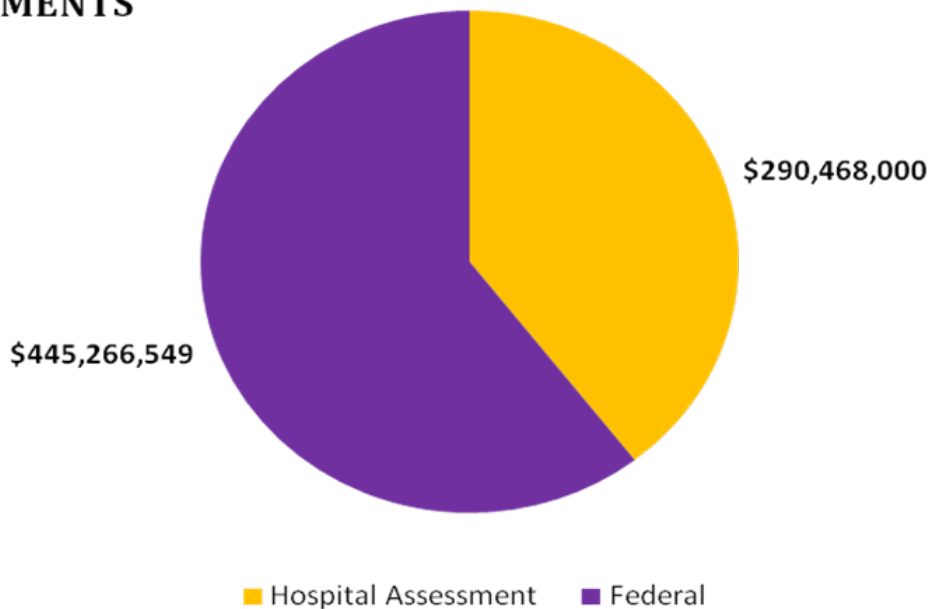
Funding of Budgeted FY2009 Hospital Payments



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.

Additional Medical Assistance Payments Funded by the Hospital Assessment

\$735,734,549
TOTAL PAYMENTS



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, when matched, will net the state \$2.5 billion over five years for other Medicaid needs.

In sum, Medicaid spending increases are being driven by factors other than hospitals – such as the 45% increase in enrollment over the last five years. The Hospital Assessment Program enables the State to leverage billions of dollars in federal funds to maintain and improve access to critical hospital and other health care services for Illinois residents. Let’s not kill the goose that lays the golden egg.

II. Workable Strategies to Achieve Savings and Greater Efficiencies in Medicaid

IHA believes there are several strategies that the State should explore in order to enhance the efficiency and effectiveness of the Medicaid program, including the following:

The State should expand primary care case management and disease management

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 results of the State’s efforts to manage the care of people eligible for public programs AND to promote preventive care and quality so far are very promising. The Illinois Department of Healthcare and Family Services (HFS) reported that it achieved \$34 million in **NET** savings in the first year (FY2007) through the implementation of its primary care case management (“Illinois Health Connect”) and disease management (“Your Healthcare Plus”) programs, and \$104 million in net savings in the second year of the disease management program in FY2008.

The state’s primary care case management and disease management programs keep people healthier and help keep costs in check by preventing inappropriate and costly emergency room visits and hospitalizations. Each client is assigned a “medical home” where they receive regular ongoing care and have access to primary care doctors who provide regular checkups and preventative care. Through extensive outreach efforts, Illinois Health Connect has more than 5,000 “medical homes,” including physicians and Federal Qualified and Rural Health Centers across the state.

The disease management program provides an even more intensive and comprehensive approach to patients with chronic disease, such as coronary artery disease, asthma or depression. The program coordination includes the use of nurses and social workers to ensure that participants obtain the help they need for their health, food and housing issues to get better control of their situations and reduce the incidence of costly medical crises.

Interconceptional care management strategies to significantly improve birth outcomes

Two-thirds of births in the Illinois Medicaid program are second babies or higher, with 17% of the subsequent births having an inter-pregnancy interval of less than eighteen months. A number of these births result in complications that have very costly consequences for the Medicaid

program. HFS should expand the beginnings of its intervention program of interconceptional care for those high-risk pregnancies. Interconceptional care is defined as a set of interventions that identify and modify biomedical, behavioral and social risks to a woman's health or pregnancy outcome through prevention and management from conception of one pregnancy to the conception of the next.

Long-term care rebalancing

The state could consider reducing the reliance on institutional care in the Medicaid long-term care system, so individuals who are aged or living with a disability or serious mental illness can remain in the communities in which they live with quality services as long as it is medically practicable and cost-effective. There are very specific strategies outlined in the Governor's Taxpayer Action Board (TAB) report on how to accomplish this goal, including: enhancing the Community Care Program for Medicaid eligible seniors; enhancing community options for people with developmental disabilities that are living in State or privately-run institutions; assessing the feasibility of outsourcing State-run psychiatric hospitals; and managing admissions to ensure a short institutionalization period and facilitate rapid reintegration to a community setting.

Enhancing pharmacy cost containment efforts

The cost of brand drugs in the Illinois Medicaid program has grown 8.8% annually over the last five years (from \$118.31 to \$180.39, according to the TAB report). Moreover, 30% of all prescriptions are still filled with brand drugs. Additionally, the cost of mental health drugs is excessively high and the prescribed drug list does not provide as a first option lower-cost alternatives. Finally, the dispensing fee that pharmacies receive from the Medicaid program is high compared to other states.

Possible strategies for cost containment include:

- Pooling all State prescription drug purchases and combining administrative resources to reduce duplication of effort and maximize savings;
- Reviewing options for lower cost drugs and aggressive management of mental health drugs to ensure effectiveness of the Medicaid Preferred Drug List (PDL);
- Reviewing dispensing fees charged by pharmacies to the Illinois Medicaid program. Currently, the state is paying pharmacies a fee of \$3.40 for brand name drugs and \$4.60 for generic drugs.

Implementation and expansion of Health Information Exchanges

To move the Medicaid program toward the goal of facilitating access to and retrieval of clinical data to provide safer, more efficient and effective patient-centered care, the state should consider implementing and expanding Health Information Exchanges (HIEs). The Dept. of Healthcare and Family Services' computer technology should be upgraded to enable the department to interface with the technology used by the provider community.

III. Oppose Flawed Medicaid Reform Strategies That Will Jeopardize Federal Medicaid Funding and Harm Access to Care for Illinoisans

With the current budget crisis, many well-intentioned officials have suggested strategies to rein in Medicaid spending. On the surface, these strategies may sound appealing, but upon closer examination it is clear that they will do more harm than good. These strategies are fatally flawed and should not be considered further.

Capitated, Risk-Based Managed Care – No Savings But Less Access, Lower Quality and Jeopardizes Critical Financial Underpinnings of the Medicaid Program

Capitated, risk-based HMO managed care for Medicaid 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 compared to the rest of the country. According to the Kaiser Commission on Medicaid and the Uninsured, in FY2006 (the most recent year in its study), Illinois ranked 42nd among states in Medicaid spending per recipient. Medicaid costs have risen primarily because more people are covered as a result of unfunded policy choices made by a former Governor and the General Assembly.

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 the current low fee for service rates.

Illinois would need to put substantial funding into current HMO capitation rates in order to attract HMOs that have left the state. There are only three capitated managed care organizations (MCOs) in the Illinois market (there were 16 HMO plans in the state in the mid-1990s). In early May, one of those 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.

The Problems with Global Waivers (Block Grants)

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 Implementing Selective Contracting Programs for Hospital Procedures

Given Illinois’ history with selective contracting for hospital services, any such exploration should be undertaken with great caution. In 1984, Illinois implemented the Illinois Competitive Access and Reimbursement Equity (ICARE) program for hospitals, a competitively bid program for hospital procedures. While the program was in place, 24 hospitals closed, including many in high Medicaid areas, diminishing access to care for beneficiaries. The ICARE program was discontinued in 1991 after litigation was filed against the state and federal governments challenging the operation of the program. It seems unlikely, given current low rates, that a competitive bidding program for hospital services would result in “lower cost and higher quality.”

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.