

Chicago Sun Times

Trim Medicaid costs, but don't harm care

February 15, 2010

Making Medicaid more efficient is, without a doubt, a part of the answer to the state's budget crisis.

But it's time to be honest about how much we can actually expect to squeeze out of the program.

Republican gubernatorial front-runner Bill Brady and others have suggested that moving all or most of the state's 2.4 million Medicaid recipients into HMO-style managed care networks could cut spending by \$1 billion or more.

We find that hard to believe, considering that Illinois already spends less per Medicaid beneficiary than most states. Not to mention that the state's existing managed care programs, while successful, haven't generated nearly that much in savings.

Still, we think a pilot program requiring 40,000 of the state's 150,000 elderly, blind and disabled Medicaid recipients to join private HMOs could lower costs modestly and improve care, if it's done the right way.

Doctors participating in the pilot program would be paid a fixed, or capitated, monthly rate per patient instead of fee-for-service compensation. Pay to these private companies would be tied to how well health-care providers coordinate care and achieve specific health outcomes for patients.

The Illinois Department of Healthcare and Family Services says this integrated care model, which would be phased in later this year, could save taxpayers about \$200 million over five years by reducing preventable hospitalizations and improving chronic disease management.

If the pilot program works, more Medicaid patients might be shifted to private plans.

We like the focus on linking pay to performance, the use of electronic medical records and the coordination of care through a "medical home" -- all key components of health-care reform.

But the private plans the state chooses for this pilot program must have strong incentives to keep costs down by providing high-quality preventive care, not by blocking access to vital services, as Illinois HMOs have done in the past.

A \$225 million settlement against Amerigroup, an HMO that avoided enrolling pregnant women and people with disabilities, is only one recent example of how these groups have put profits ahead of patients.

Before launching this program, the state must guarantee an infrastructure to identify problems early and respond to them quickly.

This is especially crucial for the elderly and disabled, the Medicaid patients with the greatest health-care needs.

Even if the program lowers costs, there's no guarantee that expanding capitated managed care to a broader patient population, as Brady and others have proposed, would produce significant savings for the state.

Illinois Health Connect, the primary care case management program that links 1.7 million Medicaid patients to primary care doctors, reduced Medicaid spending by \$100 million in its first year, according to the state. A separate disease management program, with 220,000 people on the rolls, saved an additional \$104 million in 2008.

We would hate to see the state gamble on capitated care for all, or even most, Medicaid patients at the expense of programs that already work. We also worry that moving too many Medicaid patients to private HMOs could hurt the state's hospital assessment program, which generates federal matching dollars the state cannot do without.

Looking for ways to trim Medicaid costs without compromising care is necessary.

But thinking that Medicaid cuts -- without pension reforms and new tax revenue -- are enough to balance a nearly \$13 billion budget deficit is simply delusional.