ILLINOIS CHAMBER
OF COMMERCE

# Medicaid Reform – Coordinated Care Key Policy Issues
# Illinois Chamber of Commerce Comments
# July 1, 2011

The Illinois Chamber of Commerce applauds the Department of Healthcare and Family Services, the Administration, and the General Assembly for taking steps earlier this year to begin tackling programmatic inefficiencies and challenges within the state's Medicaid program. The Illinois Chamber supported P.A. 96-1501 because we believe it takes the initial steps necessary to align the Medicaid program with trends currently taking shape in the private market that demand greater efficiency, higher quality, and better outcomes. The new law also lays a strong foundation for the state to prepare the Medicaid program to meet the increased enrollment demands under the Affordable Care Act.

Given that Medicaid represents nearly a quarter of Illinois' operating budget, the Illinois Chamber believes the state must take an aggressive approach towards gaining fiscal control of the program, particularly in light of the recent tax increase. Medicaid not only represents a state budgetary behemoth, it also has a tremendous impact on the state's healthcare system as a whole. The private sector not only furnishes a significant financial investment in the program through income taxes paid to the state, it also bears the brunt of the cost-shifting that occurs when Medicaid underpays and underperforms. The current trajectory of our health system no longer supports a program that pays for quantity over quality and we hope the coordination of care provisions included in P.A. 96-1501 will indeed align the trajectory of the Medicaid program with the realities of the current market.

To that end, the Illinois Chamber appreciates the opportunity to submit the following comments in response to the Department of Healthcare and Family Services' June 2011 "Coordinated Care Program: Key Policy Issues" document. The Chamber is comprised of a diverse number of entities that have a direct interest in the Medicaid program, including managed care organizations, insurance companies that offer managed care products, and providers, among others. We anticipate that many of these entities will submit specific comments that will likely differ in their approach to certain issues raised in the paper. For that reason, we have kept our responses to many of the topics covered in the document fairly broad. We do, however, look forward to the opportunity to participate in, as well as help facilitate, future dialogue on this critical issue.

**General Comments**

While the Illinois Chamber believes the current and future challenges surrounding the state's Medicaid program demand innovation in how enrollees access and utilize their care, the path towards achieving the care coordination goals set forth in P.A. 96-1501 should begin by building on and strengthening those models already in place. There is no need for the state to "reinvent the wheel." Furthermore, the Medicaid reform debate has been an ongoing debate for a number of years, with several reports laying out detailed proposals for tackling systemic challenges that are still applicable today, including the 2005 Lewin Report and the 2009 Taxpayer Action Board report.

Illinois has already laid a strong foundation for improving the coordination of patient care through limited utilization of managed care, primary care case management (PCCM) and disease management (DM) programs, and most recently, the rollout of a pilot Integrated Care Program for the AABD Medicaid population. Each of these models, however, present opportunities for enhancements that can address programmatic inefficiencies and help move the state forward towards achieving the care coordination enrollment goals identified by P. A. 96-1501.

The Department has also already initiated this planning process by establishing a Care Coordination Subcommittee under the Medicaid Advisory Committee that will work to "expand and enhance" the Department's medical home healthcare delivery system by examining various service delivery models, incentives for providing comprehensive care, utilization of evidence-based practices, and electronic health records. We hope that the written comments received in response to the Department's Key Policy Issues will also be considered by this group, as well as the reports completed on this issue in years past.

Furthermore, many of the principles for care coordination identified by this subcommittee provide a strong base that will serve to guide the Department's efforts in constructing a coordinated delivery system. The Illinois Chamber would also note a report on the feasibility of implementing risk-based managed care in Maine prepared by that state's Department of Health and Human Services last year identifying five key factors to implementing a successful managed care program, many of which should resonate in Illinois' own efforts to build more robust care coordination:[1]

- Cultivate long-term collaborative partnerships to help respond to future developments and improve the program over time.

[1] "Feasibility of Risk-Based Contracting in the MaineCare Program." Report from the Maine Department of Health and Human Services to Maine Legislature's Joint Standing Committee on Health and Human Services, May 24, 2010. http://www.maine.gov/dhhs/reports/riskbasedcontracting.pdf

- Aggressively manage quality and collect usable and easily reportable performance data (transparency).
- Engage stakeholders in the design, development, implementation, and oversight of these programs.
- Ensure that the administrative infrastructure is in place to adapt to the difference between a managed care/coordinated care environment vs. a fee-for-service environment.
- Be responsive to local conditions, different provider environments and demographics.

**Care Coordination Models**

In order to achieve the programmatic savings targeted by the Administration, care coordination models should be comprehensive and aggressive in their efforts to effectively manage risk and provide effective management across all spectrums of care. There has been a great deal of debate over the years over expanding utilization of Medicaid managed care. Illinois' use of managed care in the Medicaid program is currently voluntary and statewide penetration of managed care has been low, with the majority of managed care being utilized in the Cook County and Metro East regions.

The Illinois Chamber recognizes the concerns, particularly those of the provider community, in expanding utilization of managed care to include mandatory enrollment for certain Medicaid populations, but full-risk managed care must be a part of the care coordination equation. Our organization, however, is sensitive to Illinois' unique financing arrangements – the Cook County Inter Governmental Transfer (IGT) and the Hospital Assessment Program – both of which bring in millions of dollars in federal funding that should not be jeopardized, but these unique financial considerations should also not preclude the state from exploring ways to strengthen the state's utilization of managed care.

The state's PCCM and DM programs have generated cost-savings to the state, but as noted by the June 2009 Report of the Taxpayer Action Board (TAB), the current PCCM and DM programs could be "significantly strengthened."[2] The state's PCCM-Illinois Health Connect- currently allows participants to change the primary care physician at least once a month, which could create a significant disruption in care for those that are frequent "doctor shoppers," and further makes it difficult for providers to act as true "coordinators" of a patient's care. The 2009 TAB report suggests that programmatic enhancements should include provider risk-sharing and greater incentives to providers who successfully encourage patients to adopt healthier lifestyles.

Utah has also recently signed off on Medicaid reforms, including transforming its current managed care model into an Accountable Care Organization (ACO) model. Under the new 2011 law, the Utah Medicaid ACO model contemplated is different

[2] http://www2.illinois.gov/budget/documents/tabreport.pdf

than the model adopted by the Medicare program in that the state is willing to consider as an ACO "any organization that can (1) manage risk and accept a capitated premium for its services, (2) distribute payments across the continuum of scope of service providers and (3) meet the quality standards required under contract."[3]

Under the Utah model, the centerpiece of the ACO model is the "medical home," with the ACO having more flexibility in how it distributes payments throughout its network of providers. The state's waiver request suggests that ACOs could "choose to distribute incentive payments through its network of providers when various cost-containment, quality, or other goals are met."[4] The key differences between the ACO model and the managed care model, as noted by the state's waiver request, is that the ACO payments would eliminate incentives for excess care and contracts would only be maintained if the ACO meets established quality and access criteria.

Like Illinois, Utah also has a hospital assessment, which the state uses to support current reimbursement levels. The state plans to "restructure its hospital assessment base and place the majority of the previous quarterly distribution payments into the new ACO capitated rates."[5]

While the Illinois Chamber is not suggesting such a model can work in Illinois, it is an option that could be explored by the Department and its Care Coordination Subcommittee as it examines ways to enhance and perhaps, transform its current PCCM.

Disease Management is also another significant piece of effective care management. The ACA, beginning on January 1, 2011, allows states to permit Medicaid enrollees with multiple chronic conditions to designate a provider as a health home. As noted by the Department in its key policy issues document, however, the state's DM program does not currently meet the coordinated care requirements set out by the law. Effective care coordination models will need to provide for the management of chronic disease and should further incentivize healthier behaviors that limit risks of developing chronic conditions based on discernible outcomes.

**Quality Measures and Data Transparency**

Care coordination must be accompanied by tools that can effectively measure quality and patient outcomes. While the Illinois Chamber does not have any specific recommendations as to what metrics should be employed to measure quality and patient outcomes, we do suggest that different models be subjected to similar quality measures in order to adequately discern the effectiveness of the various care management strategies. We also believe that all care coordination entities should be

[3] Utah Medicaid Payment and Service Delivery Reform 1115 Waiver Request: Utah Department of Health, Division of Medicaid and Health Financing, July 1, 2011

[4] Ibid.

[5] Ibid.

able to share data across all models of care in a way that can not only help streamline the delivery of care for patients, but also enhance programmatic transparency.

The Department should also not overlook partnerships with the state's academic health center research centers as an avenue to strengthening health outcomes while controlling costs within the Medicaid program. Since the ACA, the role of comparative effectiveness research in health policy has been elevated; however, comparative effectiveness research (CER) is already being utilized by a number of states in regards to their Medicaid program. As noted in a June 2011 article published in the journal *Academic Medicine*, "using CER to inform benefit-design in a systematic way would assist all Medicaid programs."[6] Eleven states, including border-states Missouri and Wisconsin, are members of the Medicaid Evidence-based Decisions project (MED), which links policymakers with academic health researchers to routinely examine coverage and benefit-design decisions, including the risks and benefits associated with certain medical procedures, treatments for substance abuse, and dental treatments.[7]

Given Illinois strong academic health center resources, the Department and policymakers should begin to collaborate and build relationships with the health research community to ensure that, regardless of the model of care, the care delivered to the Medicaid patient is the most effective and the most efficient.

Finally, program transparency cannot be emphasized enough. The Department must ensure that de-identified state Medicaid claims are available to stakeholders to ensure benefits are not only appropriate and informed, but services provided are indeed coordinated. Furthermore, de-identified claims data is also necessary to any effort to partner with academics and healthcare researchers to ensure treatments are effective.[8] Claims data is also necessary for identifying patterns of uncoordinated care, including duplication of diagnostic and therapeutic services, prescription usage and/or abuse, multiple treating providers and prescribers, and the frequency and type of emergency care utilization.

The 2005 Lewin report noted that in the case of Florida's PCCM, lack of data management tools presented a significant challenge to providing effective patient management, with a lag time of up to three months between when a service occurred and when the data became available.[9] Real-time access to data is critical, but also not without significant investments and system upgrades.

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[6] "Improving State Medicaid Policies with Comparative Effectiveness Research: A Key Role for Academic Health Centers," Judy T. Zerzan, MD, MPH, Mark Gibson, and Anne M. Libby, PhD, *Academic Medicine, Vol. 86, No.6/June 2011,* p. 697
[7] Ibid.
[8] Report of the Taxpayer Action Board, June 2009
[9] "Assessment of Medicaid Managed Care Expansion Options in Illinois," The Lewin Group Report prepared for Commission on Government Forecasting and Accountability, May 3, 2005

The Illinois Chamber believes that appropriate administrative infrastructure and robust data management tools are critical, not only for those care coordinated entities, but also for the state. We have been very supportive of efforts undertaken by the Administration to move the state towards more interoperability of patient health information systems through its Health Information Exchange initiative, and continue to support provider and other health entity efforts to engage in meaningful use of electronic health records. We also applaud the state for making additional investments in its enrollment databases through federal ACA funds received in an effort to streamline eligibility determinations as they relate to Medicaid and coverage on the new health insurance exchange that will come on-line in 2014.

In addition to the federal funding investments applied to upgrades in the Department's EVE systems, we also hope the Department will move forward in its implementation of the "Medicaid Accountability through Transparency" program that was authorized last year by P.A. 96-941. The Illinois Chamber is sensitive to the fact that the state's fragile budget situation does not readily allow for additional financial investments in this IT infrastructure, but would hope future savings achieved under these Medicaid reform provisions can be re-invested into these types of necessary programmatic improvements.

**Consumer Protections and the Exchange**

The Illinois Chamber agrees with the Department's assessment that managed care has changed significantly over the past two decades. Managed care is not what it used to be and has had to work to overcome public missteps in years past. In Illinois, the case of *Memisovski v. Maram & Adams*, was indeed a setback for managed care, but as the 2005 Lewin Report points out, the case itself helped set a new standard for Managed Care Organizations (MCOS) by pushing for timely preventive services for children.[10]

The shifting landscape of healthcare delivery and coverage through both private market forces and the influences of the federal ACA, along with "lessons learned," the managed care market has evolved and will continue to evolve. The federal health reform law itself has placed a renewed emphasis on preventive care; a focus that the private market has already embraced. Consumers, including Medicaid enrollees will also have access to a number of consumer protections under the new federal law that will serve to strengthen care coordination models, including managed care plans. As noted by the 2005 Lewin Report, managed care services have been purchased in other states for an administrative and profit cost below the amounts Illinois has been paying.[11] Although that trend has since changed, the new pressure placed on commercial health insurers under the federal health reform law should help correct this, with the ACA requiring plans to abide by an 85% Medical Loss Ratio (MLR). The Department, however, has already set a bit of a precedent for

[10] Ibid
[11] Ibid

a higher MLR standard on managed care plans by requiring new Integrated Care Program entities to abide by an 88% MLR.

Medicaid's interaction with the new health insurance exchange should also be kept at the forefront of further discussions surrounding care coordination and programmatic change. In addition to the expansions in Medicaid eligibility that will take place in 2014, the program could see a great deal of enrollment fluctuation as individuals move in and out of Medicaid and coverage on the exchange due to changes in income. The possible "market churn" presents a challenge in and all of itself that means care coordination will have to contemplate ways in which the state can manage that population effectively. The ACA authorizes states to implement a Basic Health Plan to help manage this population and two pieces of legislation were introduced during the spring legislation session that would authorize this type of plan. While more dialogue is needed on this issue, the Illinois Chamber believes this is an important issue that must be addressed sooner rather than later in order to ensure the sustainability of the exchange, as well as the effectiveness of the Medicaid reforms.

Care coordination provisions will also need to contemplate the possibility of increased enrollment over and above enrollment projections based on income eligibility. As noted by Healthscape Advisors, small group market contraction could result in higher than anticipated enrollment figures in both the exchange and Medicaid.[12] Several reports, including the Congressional Budget Office (CBO) and an earlier Mercer report, suggest that the ACA could prompt small employers, particularly those with lower average workforce salaries, to terminate their existing coverage, which would ultimately send these employees to the exchange or Medicaid, based on their income qualifications. In fact, a more recent report distributed by McKinsey suggests contraction of the small group market could be even greater than originally projected.[13]

Finally, care coordination is especially critical for those newly eligible adults. Healthscape Advisors notes in their policy paper that this population is likely to have a "pent-up demand for healthcare services" that could present challenges for entities in their attempts to effectively manage those demands.[14]

## Conclusion

The Illinois Chamber applauds the Department's efforts thus far in rethinking how the state provides healthcare under the Medicaid program. The coordinated care provisions of the state's Medicaid reform law represent a tremendous opportunity for the state to transform the delivery of care, as well as the effectiveness of that

[12] Health Reform: Medicaid and Government Subsidy Market, Healthscape Advisors, April 2010, www.healthscapeadvisors.com

[13] http://www.mckinseyquarterly.com/How_US_health_care_reform_will_affect_employee_benefits_2813

[14] Ibid

care. In closing, however, we would note that while coordinated primary care that focuses on prevention and stronger patient outcomes is indeed a central piece to any health reform effort – public or private- the shift towards a stronger coordination of care does not occur without adequate reimbursement and incentive for providers not only to deliver care to Medicaid patients, but also improve outcomes for those patients.

We realize the task ahead is daunting and will require tremendous stakeholder engagement, but we look forward to participating in the future dialogue on this critically important issue and making Illinois' Medicaid program a national model of care.