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# *the policy prescription*

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## Medicaid Reform in Illinois

### Overview of Illinois Medicaid Reform

In January, Illinois passed a far-reaching piece of legislation intended to reform Medicaid. The Medicaid reform law includes four major components. First, it advances a long-term care rebalancing initiative, which is designed to remove barriers to community-based services for people of all ages with disabilities and long-term illnesses. It offers individuals utilizing long-term care services a reasonable array of service options in the community. Second, it includes stricter verification of eligibility requirements for Medicaid and All Kids. It also limits All Kids to children who have family incomes at or below 300% of the federal poverty level. Third, pending a federal waiver, the law would allow pharmacies to refuse to fill a prescription for someone who does not pay the required co-payment. Fourth, it requires that the State enroll at least 50% of Medicaid clients in a capitated care coordinated system of care no later than January 1, 2015. (This includes All Kids clients.)

The Medicaid reform law states that coordinated care means recipients will receive their care from providers who participate under contract in integrated delivery systems that are responsible for providing or arranging the majority of care for those recipients. According to the Illinois Department of

Healthcare and Family Services, “coordinated care” includes a full range of services revolving around the needs of clients, with options other than just traditional managed care organizations. Illinois’ existing primary care case management (PCCM) is not a form of coordinated care.

### Experience of Other States in Managed Care

Since the 1990s, state Medicaid programs have increasingly relied on different forms of managed care to organize and deliver services to their Medicaid beneficiaries. In forty-six states and Washington, DC, more than half of their Medicaid recipients are enrolled in managed care. In 20 of these states, over 80% of the Medicaid population is enrolled in some form of managed care.<sup>1</sup>

Some states have implemented capitated managed care. Others have implemented primary care case management, and some states have implemented both. Capitated managed care organizations are paid a fixed monthly fee per enrollee and assume the financial risk for delivering a set of services. PCCM programs are a blend of fee-for-service and managed care. The state contracts with a provider to provide basic care and to coordinate and authorize any needed specialty care or other services. The primary care physician is paid a small case management

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<sup>1</sup>Medicaid and Managed Care: Key Data, Trends and Issues. The Kaiser Commission on Medicaid and the Uninsured, February 2010.

fee per person per month and other services are usually paid on a fee-for-service basis.

### Does Managed Care Save Money?

According to the Lewin Group, traditionally, full risk capitated models generate a greater savings compared with fee-for-service and PCCM programs. Because the Managed Care Organization (MCO) receives a monthly capitated rate per member, there is maximum incentive for the MCO to manage care and monitor utilization.<sup>2</sup> However, setting capitation rates too high can result in states having greater expenditures under their managed care program than in their fee-for-service programs. Rates set too low will make it difficult to attract or retain health plans.<sup>3</sup>

A Lewin synthesis of 24 studies suggests that the Medicaid capitated managed care model can yield cost savings, though the amount of these savings varies greatly, depending on local circumstances and implementation choices made by different states and different managed care plans. The savings achieved under these models varied widely, from a negligible half of 1% to 20%, which were based on differences between capitated managed care and fee-for-service costs, and cannot be compared to one another because of differences in state programs and study methodologies.<sup>4</sup>

“An evaluation of enhanced PCCM programs in five states (OK, NC, PA, IN, AR) indicates that they may perform as well as or better than capitated managed care organizations on measures of access, cost, and quality if sufficient resources are devoted to their design, implementation, management and funding. At the same time, lack of direct control over hospital use... was an obstacle to achieving savings.”<sup>5</sup>

Until recently, mandatory managed care in Medicaid was largely limited to children and families in Medicaid, whose costs tend to be low. The elderly and disabled, who have more complex needs and higher costs, have generally remained in the fee-for-service sector. As a result, “managed care spending as a share of total Medicaid spending on services is low (20% in 2007) compared to the roughly two-thirds of Medicaid beneficiaries who are enrolled in managed care.”<sup>6</sup>

Many states in addition to Illinois are reevaluating their Medicaid programs, with some of them exploring statewide capitated managed care programs, some exploring including all populations, and some implementing PCCM.

Experience to date shows that whichever managed care program a state selects should address core principles, including care coordination, utilization management, quality assurance, consumer education, provider choice, and access to care.

### Illinois' Experience to Date

Historically, Illinois has not had an overall positive experience with capitated managed care. Data show that Illinois managed care organizations have not done an adequate job in ensuring that children receive appropriate well-child care.<sup>7</sup> Clients have complained about access to care. There have been marketing abuses. Also, only 75% of the revenue that plans received from the State has gone to support the provision of health care services (“medical loss ratio”). Because of such patterns, the Medicaid program lost rather than saved money for the State from 2002-4.<sup>8</sup>

Illinois' experience with PCCM appears more positive. Cost savings attributed to Illinois Health Connect, Illinois' primary care case managed program, were at \$80 million in FY 2008 and \$120 million in FY 2009. Illinois Health

<sup>2</sup> *Assessment of Medicaid Managed Care Expansion Options in Illinois*. Prepared for: Commission on Government Forecasting and Accountability, May 3, 2005.

<sup>3</sup> *Medicaid Managed Care Cost Savings—A Synthesis of 24 Studies*, Prepared for: America's Health Insurance Plans, July 2004, Update March 2009.

<sup>4</sup> *Ibid.*

<sup>5</sup> *Medicaid and Managed Care: Key Data, Trends and Issues*, Kaiser Commission on Medicaid and the Uninsured, February 2010, citing Verdier, et al., *Enhanced Primary Care Case Management Programs in Medicaid: Issues and Options for States*, Enter for Health Care Strategies, September 2009.

<sup>6</sup> *Medicaid and Managed Care: Key Data, Trends and Issues*, Kaiser Commission on Medicaid and the Uninsured., February 2010.

<sup>7</sup> Health and Disability Advocates. Testimony submitted to House Special Committee on Medicaid Reform, December 8, 2010.

<sup>8</sup> *Assessment of Medicaid Managed Care Expansion Options in Illinois*. Prepared for: Commission on Government Forecasting and Accountability, May 3, 2005.

Connect also has demonstrated, high patient and provider satisfaction and improved care. (Testimony of Margaret Kirkegaard, Medical Director, Illinois Health Connect to the Illinois Health Reform Implementation Task Force)

It is not clear how much more money would be saved by a capitation-based managed care system. Your Healthcare Plus, Illinois' disease management program achieved a net savings to the state of \$104 million for the Illinois Medicaid program in the fiscal year that ended June 30, 2008. The estimated savings came estimated at \$80 million in FY 2008 and \$120 million in FY 2009. Illinois Health Connect also has demonstrated high patient and provider satisfaction and improved care.<sup>9</sup>

It is not clear how much more money in Illinois would be saved by a capitated managed care system. Your Healthcare Plus, Illinois' disease management program, achieved a net savings to the state of \$104 million for the Illinois Medicaid program in the fiscal year that ended June 30, 2008. The estimated savings came in the form of a 9% reduction in Medicaid spending for the program's mostly adult population.<sup>10</sup> Illinois already spends less per family member on Medicaid costs than many other states who have more capitated managed care.<sup>11</sup>

### Other Components

The new state reform law would allow pharmacies to refuse to fill a prescription for someone who does not pay the required co-payment if they receive a federal waiver.

Studies have shown that even minimal cost sharing leads to unmet medical need and financial stress.<sup>12</sup> A study of dual Medicaid and Medicare recipients in states found that the primary impact of a co-pay met was to reduce the likelihood that a beneficiary will fill any prescription.<sup>13</sup>

Also, according to the Illinois Retail Merchants Association, Medicaid patients do not pay the co-payment on nearly half of the prescriptions that pharmacies fill.<sup>14</sup>

If Medicaid patients are unable to pay for prescriptions, they may have increased emergency room visits and hospitalizations and worse health outcomes.

### Next Steps

The next step is to monitor the implementation of the state health reform law to ensure that Medicaid recipients receive high quality accessible care.

Illinois is developing an integrated care program to serve nearly 40,000 seniors and adults with disabilities in five counties, including suburban Cook County. This new capitated care program needs to be monitored to assure that people have access to high quality care before Illinois starts a state-wide capitated care program.

<sup>9</sup>Testimony of Margaret Kirkegaard, Medical Director, Illinois Health Connect, Testimony submitted to the Illinois Health Reform Implementation Task Force, November 30, 2010.

<sup>10</sup>Dean Olsen, *Hot line is healthy for state budget*, State Journal-Register, May 17, 2009.

<sup>11</sup>Health and Disability Advocates, Testimony submitted to House Special Committee on Medicaid Reform, December 8, 2010

<sup>12</sup>Artiga, Samantha and Molly O'Malley. *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences*, May 2005.

<sup>13</sup>Kamal-Bahl S and Stuart B, *Effect of Restrictions on Prescription Drug Use in State Medicaid Programs*. Abstract Academy for Health Services Research and Health Policy Meeting, 2001.

<sup>14</sup>Illinois Issues blog, December 14, 2010.