



# STATE OF ILLINOIS COMPTROLLER

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Staff report on the Medicaid Managed Care Organization RFP (2018-24-001) – May 2, 2017

Since 2011, Illinois has sought to migrate its Medicaid beneficiaries into a risk-based, managed care organization (MCO) system. This integration has not always progressed smoothly, with doctors, patients, and healthcare providers publicly expressing confusion and concern over the shift in policy. Now, with nearly two-thirds of the state's Medicaid beneficiaries under MCO care, the Illinois Department of Healthcare and Family Services (HFS) has called for proposals that would significantly reorient this system by expanding MCOs' responsibilities while limiting the number of MCOs within the state's framework.

HFS is requesting a four-year contractual term within this procurement, for services estimated to cost \$9 billion in 2018 alone (currently it is estimated the state spends \$6 billion on managed care annually<sup>1</sup>). In spite of an ongoing state budget impasse, now in its 23<sup>rd</sup> month, Illinois is compelled to continue managed care payments per consent decree.<sup>2</sup>

Given the size and scope of this procurement, the Office of the Illinois Comptroller has worked to compile the following report enumerating the concerns the Office of the Comptroller has in moving forward with this procurement. The Office of the Comptroller will demonstrate that the systematic change being recommended by HFS's request for proposals (RFP) will put more pressure on the state's managed care system while potentially driving up health

care costs as a result of decreased competition. Adding to the concern is that this RFP comes at a time of extreme financial stress and uncertainty as a result of the state's ongoing budget impasse.

Gov. Rauner said in a recent public interview, *"I believe in competition and opening up markets as much as possible. Competition can increase quality and drive down cost. So making sure that people have choices, and they're not locked into a monopoly or one limited market, I think is generally a good philosophy in every aspect of life, including healthcare."*<sup>3</sup>

The Office of the Comptroller hopes the governor recognizes the long-term importance of this policy change and works with the General Assembly to review Illinois' Medicaid managed care organization system to make the best decisions possible for some of Illinois' most vulnerable residents: Medicaid beneficiaries.

## Introduction

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On February 27, 2017, HFS released an RFP on the restructuring of the state's Medicaid managed care organization system.<sup>4</sup> Presently, Illinois has a series of contracts with different MCOs that assist in covering the state's Integrated Care Program, Family Health/ACA Adults Enrollment plans, Managed Long-Term Services and Supports, and Medicare Medicaid Alignment Initiative. This new procurement by HFS will supplant the existing MCO contracts, which have

<sup>1</sup> Schorsch, Kristen. ["Rauner on a Quest for More Medicaid Savings."](#) Crain's Chicago Business, 2/27/2017.

<sup>2</sup> Memisovski, et al. v. Maram, and Beeks, et al. v. Bradley, Case 1:92-cv-04204

<sup>3</sup> [The Steve Cochran Show, WGN Radio 4/11/17.](#)

<sup>4</sup> ["The State of Illinois Medicaid Managed Care Organization Request for Proposals,"](#) (2018-24-001), Illinois Department of Healthcare and Family Services, 2/27/2017.

various termination dates. It is not clear if the state will incur any termination penalties as a result of the changes stemming from this RFP.

Currently, about 2 million of Illinois' 3.1 million Medicaid enrollees are integrated into the state's managed care system, representing roughly 64.5 percent of the total state Medicaid population. The stated goal of HFS's RFP is to expand the reach of Illinois' managed care system, both geographically and by enrollee-type, to cover all 102 Illinois counties - from the 30 counties currently covered - and 80 percent of the state's Medicaid-eligible population. Currently, 12 MCOs within the Illinois managed care system provide healthcare services to state residents.<sup>5</sup> However, this RFP has placed a limit on the contracts the state is seeking to award at between four and seven recipients. Three to five of these contracts will cover an expanded reach of service packages within the state system and offer coverage to all 102 counties. One to two contracts will cover services in Cook County only, and shall be either a government-owned or a minority-owned organization.

HFS again has claimed applicability of the "Purchase of Care" exemption to effectively remove the procurement from the independent review afforded by the Chief Procurement Officer. This action in claiming exemption from independent oversight is concerning and highlights the need for transparency, unbiased procurement process, and adequate scrutiny of conflicts of interest.

The reorientation of Illinois' managed health care system is stated within the RFP as being part of Gov. Rauner's "Health and Human Services Transformation Process," which was first outlined in the governor's 2016 State of the State Address,

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<sup>5</sup> Aetna Better Health, BlueCross Blue Shield, Cigna-Healthspring, Community Care Alliance, CountyCare, Humana, IlliniCare Health, Meridian, Molina Healthcare of Illinois, NextLevel Health, Family Health Network, and Harmony Health Plan.

during which he said, "*Our Transformation puts a strong new focus on prevention and public health; pays for value and outcomes rather than volume and services; makes evidence-based and data driven decisions; and moves individuals from institutions to community care, to keep them more closely connected with their families and communities.*"<sup>6</sup>

From the overview section of the Medicaid Managed Care Organization RFP and the emphasis on Gov. Rauner's HHS Transformation initiative, supporters of the MCO RFP believe Illinois' managed care system can be streamlined through a reduction of providers, while at the same time expanding coverage to more Illinois residents. And furthermore, that HFS believes the reduction in providers, plus the reorientation of the services geographically, will decrease confusion in the system, leading to better and potentially less expensive health care options for Illinoisans in the Medicaid system.

This shift in policy comes at a time when the state is under increasing fiscal pressures. Illinois has not had a comprehensive budget for 22 months. Since December 2014, Illinois' bill backlog has doubled - from \$6.5 billion at the end of 2014 to just over \$13 billion in April 2017.<sup>7</sup> At the same time, the state has been under a consent decree to continue making Medicaid payments. This means the costs resulting from a change in managed care might continue to be paid by the state without legislative appropriation and oversight.

Even supporters of a policy shift have expressed concern over the state's financial state. One health care provider executive who favors changes to the state's MCO system said, "*But the budget remains the real crisis. The state is behind paying the MCOs, and then the*

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<sup>6</sup> Rauner, Bruce. "[Illinois 2016 State of the State Address.](#)" 1/27/2016.

<sup>7</sup> "[Bill Backlog.](#)" Illinois State Comptroller Website, 4/17/2017.

MCOs get behind in paying the providers. Until they're paying on time, there's a fundamental flaw in the system. It's going to continue to be a disaster until they get a new budget."<sup>8</sup>

Considering the large structural changes to Illinois' health care system that will result from the Medicaid Managed Care Organization RFP, and that this procurement represents one of the largest purchases in Illinois state government history – estimated by HFS at \$9 billion in 2018 alone<sup>9</sup> – further, unbiased review into the long-term effects of such a change is clearly warranted, as well as an evaluation into whether such a change will accomplish the two main goals the RFP has outlined.

## Illinois Managed Care

Managed care is a health care delivery system designed to provide Medicaid program services to beneficiaries through state contracted private offerors called managed care organizations, or MCOs. According to the federal government, the purpose of these managed care systems is to reduce program costs for states and to improve efficiency within their Medicaid system through private market incentivization.<sup>10</sup>

The idea of managed health care is not a new concept, having its origins in the 1930s as a result of growing health costs during the Great Depression.<sup>11</sup> At that time, private physicians and hospitals partnered to provide regional services to beneficiaries for a fixed monthly fee. Recognizing the value that managed care provided by controlling the

costs and quality of health care, a majority of American workers were enrolled in a managed care system by the 1990s.

Initially solely a private-market solution, states began to migrate selected program recipients into mostly non-profit managed health maintenance organizations (HMOs). This concept of promoting managed care, and the benefits the system afforded recipients through stronger private oversight and buying power, was championed by the federal government with the passage of the Health Maintenance Organization Act of 1973.<sup>12</sup> Popularity of moving into managed care, especially HMOs, in terms of public health care peaked during the 1990s, although HMOs themselves experienced a backlash in popularity due to what some experts believed was a lack of public trust in for-profit entities managing public health care benefits.<sup>13</sup>

Following the passage of the Affordable Care Act in 2010, states have moved back toward managed care, through a risk-based managed care system that utilizes MCOs. Under this risk-based system, MCOs contract with states to provide services to selected Medicaid beneficiaries for a pre-set premium, known as a capitation payment.<sup>14</sup> This system is considered “risk-based” since MCOs are at financial risk for the services outlined in their Medicaid contracts with the states. States are required to pay actuarially sound rates under this system, per federal law. MCOs, alternatively, must follow federal and state requirements that cover enrollment and disenrollment procedures, beneficiary grievance and appeals processes, access to care, and regular

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<sup>8</sup> Conn, Justin. [“As Decatur loses managed Medicaid options, Rauner announces overhaul,”](#) Decatur Herald and Review 2/28/2017.

<sup>9</sup> Schorsch, Kristen. [“Rauner scraps Medicaid managed care, outlines new plan,”](#) Crain's Chicago Business 2/27/2017.

<sup>10</sup> [“Managed Care,”](#) Medicaid.gov, Centers for Medicare & Medicaid Services.

<sup>11</sup> [“An Overview of Medicaid Managed Care,”](#) The National Council on Disability, 2013.

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<sup>12</sup> [The Health Maintenance Organization Act of 1973](#) (Pub. L. 93-222 codified as 42 U.S.C. §300e)

<sup>13</sup> Yglesias, Matthew. [“What Was Wrong with HMOs?”](#) The Atlantic 7/31/2008.

<sup>14</sup> [“Medicaid Managed Care: Key Data, Trends, and Issues,”](#) Kaiser Commission on Medicaid and the Uninsured, February 2012.

reporting requirements.<sup>15</sup> Although there are obvious financial risks to MCOs by participating in this system, there are also permitted carve-outs for services that are riskier to privately managed organizations – such as behavioral health services – made at the discretion of states when creating managed care system contracts.

In 2011, the General Assembly passed a law mandating a change to this risk-based managed care system, with 50 percent of the state’s Medicaid population needing to be enrolled in managed care by 2015.<sup>16</sup> By January 2015, there was growing concern that this shift in services had led to unintended confusion about the reassigning of care.

In a February 2015 *Chicago Tribune* article, HFS stated it believed the confusion was due primarily to the speed of the change and not any underlying failure in the system.<sup>17</sup> In spite of this, physicians at the time expressed their concerns, with some health policy experts stating that they were worried that “the program's rocky start might create lasting mistrust that could hinder managed care's success.” At the time, the rollout was reported to have created delays in care for patients, slowed pay from insurers, new administrative burdens on doctors, and was executed with little explanation beforehand to doctors and patients.

Today, roughly 2 million out of 3.1 million Illinois Medicaid members are enrolled in an MCO. The managed care RFP lists a goal of 80 percent coverage as the target for the new “streamlined” structure, which means that while there is a shift in MCOs, there will simultaneously be an expansion in coverage, which will mean an

<sup>15</sup> [“Medicaid Delivery System and Payment Reform: A Guide to Key Terms and Concepts.”](#) Kaiser Family Foundation 6/22/2015.

<sup>16</sup> [\(305 ILCS 5/5-30\)](#) P.A. 96-1501, eff. 1/25/2011.

<sup>17</sup> Venteicher, Wes [“Confusion mounts as Medicaid patients shift to managed care.”](#) *Chicago Tribune* 2/8/2015.

additional shift in doctors and service providers.

MCO Health Plans <sup>18</sup>	March 2017 Enrollment
Aetna Better Health	229,058
Blue Cross/Blue Shield	350,926
Cigna-Healthspring	9,878
Community Care Alliance	8,229
CountyCare	141,908
Family Health Network	225,087
Harmony Health Plan	155,591
Humana Health Plan	11,037
IlliniCare Health Plan	213,185
Meridian Health Plan	387,725
Molina Health Plan	193,624
Next Level Health	57,379
<b>Total</b>	<b>1,983,627</b>

Furthermore, for rural Illinois Medicaid beneficiaries who will be integrated into the new managed care system or will have their existing providers change as a result of this procurement, basic access to services like pharmacies may become more difficult. In the model contract for this procurement, HFS states the contractor shall ensure rural enrollees have access to at least one pharmacy within a 60-mile radius of, or a 60-minute drive, from their residence.<sup>19</sup> Under this procurement, rural areas represent 83 counties in Illinois.<sup>20</sup> For

<sup>18</sup> [“Total Care Coordination Enrollment for All Programs.”](#) DHFS Database, 3/1/2017.

<sup>19</sup> [Appendix I: Model Contract – Section 5.8.1.1.7.](#) The State of Illinois Medicaid Managed Care Organization Request for Proposals, (2018-24-001), 2/27/2017.

<sup>20</sup> Rural areas are defined as: Adams, Alexander, Bond, Boone, Brown, Bureau, Calhoun, Carroll, Cass, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Grundy, Hamilton, Hancock, Hardin, Henderson, Henry, Iroquois, Jackson, Jasper, Jefferson, Jersey, Jo Daviess, Johnson, Kendall, Knox, LaSalle, Lawrence, Lee, Livingston, Logan, Macoupin, Marion, Marshall, Mason, Massac, McDonough, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Saline, Schuyler, Scott, Shelby, Stark, Stephenson, Union, Wabash,

Illinoisans who cannot drive or do not have readily available access to public transportation, having nearest pharmacy access 60 miles away may force them to go without important medication.

Considering the difficulties reported with the 2011 shift to managed care, it is plausible to assume that a double-shift to a larger coverage map with fewer providers could pose additional challenges and confusion among health care providers and Medicaid beneficiaries within Illinois.

## Warning Signs in Other States

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From recent legal action and news coverage, one can observe that risk-based managed care has not progressed without some difficulty in neighboring states to Illinois. In 2016, Iowa restructured its managed care system limiting it to three private insurers, in what Gov. Terry Branstad termed the Iowa Medicaid Modernization Initiative.<sup>21,22</sup> The transition to the new system was slated to be executed on April 1, 2016, and ran into almost immediate issues.<sup>23</sup> Early in the implementation process MCOs issued a complaint that the state had drastically underfunded the system as a whole, and that without adjustment the entire system would be in jeopardy. Iowa's Medicaid system covers 640,000 individuals, and in 2016, at the time of the transition, was valued at \$5 billion.

Following the transition, the CEO of one of the Iowa MCOs sent a letter to the

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Warren, Washington, Wayne, White, Whiteside, Williamson, Woodford counties.

<sup>21</sup> ["DHS Announces Winning Bidders for Medicaid Modernization Initiative."](#) Iowa Department of Human Services 8/17/2015.

<sup>22</sup> Four MCOs originally were awarded contracts, however [WellCare of Iowa was terminated](#) on 12/18/2015 following an appeals process.

<sup>23</sup> Leys, Tony. ["Iowa Medicaid payment shortages are 'catastrophic,' private managers tell state."](#) The Des Moines Register 12/21/2016.

Iowa Medicaid director, stating there were material flaws in the state's payment projections.<sup>24</sup> In fact, as was reported in 2017 by the *Cedar Rapids Gazette*, the three Iowa MCOs projected an end-of-year cumulative loss of around \$450 million.<sup>25</sup>

In a survey conducted just after the transition to the new system, which had a universe of 423 Iowa doctors, hospitals, clinics, and not-for-profit agencies, 46 percent of providers said they had to reduce services as a result of the change.<sup>26</sup> Ninety percent of respondents said their administrative costs increased, roughly two-thirds said they had received lower reimbursement rates, and 28 percent said they were forced to take out loans to cover their expenses while waiting for payments.

Iowa State Sen. Joe Bolkcom said, *"The reality of managed care was even worse than we predicted. It was implemented too quickly with too many Iowans with really complicated health care needs that the MCOs apparently did not plan for."*

In Nebraska, a change in the state's Medicaid system led to one MCO suing the state after it argued the procurement process violated competitive bidding laws.<sup>27</sup> The suing provider was one of three MCOs that did not receive contracts to manage the \$1.2 billion health care program, which would cover roughly 233,000 Nebraskans. The MCO eventually withdrew its suit, ending the fight over whether streamlining the Nebraska managed care system had been procured legally.<sup>28</sup>

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<sup>24</sup> Foltz, Kimberly. ["Program Performance Letter to Iowa Medicaid Director."](#) UnitedHealthcare Community Plan 11/18/2016.

<sup>25</sup> Keenan, Chelsea. ["Iowa's private Medicaid insurers to lose \\$450 million in first year."](#) Cedar Rapids Gazette 2/22/2017.

<sup>26</sup> Keenan, Chelsea. ["Survey: Iowa Medicaid providers not getting paid on time, running into billing issues."](#) Cedar Rapids Gazette 7/25/2016.

<sup>27</sup> Duggan, Joe. ["Judge weighs lawsuit brought by two health care companies over Medicaid provider bidding process."](#) Omaha World-Herald 8/12/2016.

<sup>28</sup> Johnson, Riley. ["Aetna ends court fight with state over Medicaid plan."](#) Lincoln Journal-Star 8/26/2016.

The cases of Iowa and Nebraska show what pitfalls can exist in reorienting a state's Medicaid program too rapidly.

## Consequences for Limiting Competition

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In 2013, the *New York Times* reported a trend in the health care provider market, with hospital mergers and acquisitions more than doubling since 2005.<sup>29</sup> Three years later, a similar trend in market consolidation among health care insurers forced the U.S. Department of Justice to file a suit against two large company acquisitions.<sup>30,31</sup> Both mergers were effectively blocked in court and eventually these deals dissolved completely. However, if these acquisitions had managed to occur, the consolidation would leave U.S. markets with just seven publicly traded health care insurers, whereas in 2011 there had been 14.

During the legal battle over these mergers, the CEO of one of the insurers that was listed in the lawsuit sent a letter to the U.S. Department of Justice, stating that if the acquisition was blocked from proceeding it would be forced to leave five state markets as a result of the financial margins within the industry.<sup>32</sup> Following the failure of the merger, this provider cut its coverage from 15 states to four. As pointed out by Michael Hiltzik of the *Los Angeles Times*, the move by this insurer to leave so many markets made little sense from a business perspective, as at least one market that was abandoned – Pennsylvania – was on track for record profits.<sup>33</sup>

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<sup>29</sup> ["A Wave of Hospital Mergers,"](#) New York Times 8/12/2013.

<sup>30</sup> [Case 1:16-cv-01493, DOJ vs Anthem/Cigna.](#)

<sup>31</sup> [Case 1:16-cv-01494, DOJ vs Aetna/Humana.](#)

<sup>32</sup> Betolini, Mark. ["Letter to the DOJ,"](#) Aetna Inc. 7/5/2016.

<sup>33</sup> Hiltzik, Michael. ["Smoking Gun? Aetna Threatened to Quit Obamacare if the Government Blocked its Humana Merger,"](#) Los Angeles Times 8/17/2017.

The importance of an upward trend in hospital mergers and these two failed mega-mergers in the health insurance industry is intent. The health care market for the past five to 10 years has been on a trajectory toward less choice, under the auspices of restraints assigned to the industry by the passage of the Affordable Care Act, even though the hospital mergers had been occurring for some time before 2010 and state markets were still profitable for the publicly traded health insurers.

The question becomes whether this move toward consolidation is purposeful among the market makers as a way to turn health care into an irreproachable commodity, or is occurring through some standard market settling pattern.

In 1997, the communications industry went through a similar merger and acquisition period, which resulted in a consolidated cable market existing of only a handful of providers.<sup>34</sup> Then Tele-Com President Leo Hindery coined this time period as "The Summer of Love" due to the friendly nature in which the remaining providers divided the U.S. market equally to avoid direct competition. The resulting U.S. cable market meant higher prices and lower internet speeds for American users – some of the lowest speeds and highest prices in the developed world.<sup>35</sup>

Considering the actions by providers over the past few years, there is concern this may also happen in the American health care industry.

Provider CEOs have stated that a consolidation of health care providers would actually result in lower costs for everyday Americans, due to cost savings being passed along to patients through synergies created in

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<sup>34</sup> Crawford, Susan. ["The Communications Crisis in America."](#) Susan Crawford, Harvard Law and Policy Review. 5 (2011).

<sup>35</sup> Russo, Nick, Danielle Kehl, Robert Morgus and Sarah Morris. ["The Cost of Connectivity 2014,"](#) New America Foundation, 2014.

these mergers.<sup>36</sup> This is a common argument in markets consolidating into monopolies or duopolies. However, the research into thinning industries usually shows the opposite of cost savings, such as in the case with the U.S. communications industry.

In terms of health care, Leemore Dafny, Mark Duggan, and Subramaniam Ramanathan, in the American Economic Review, took a look at the effect of health insurance mergers in the late 1990s.<sup>37</sup> The resulting paper found that insurance premiums rose dramatically since the mergers, and were statistically significant enough to draw a correlation to the actions of a now less competitive market. Furthermore, it has been reported that MCOs, as a result of the incentives within managed care systems, are denying care or overruling physician decisions, resulting in financial difficulty for hospitals and access-to-care issues for patients.<sup>38, 39</sup>

Returning to Illinois – and taking a more holistic view of HFS’s managed care procurement – health care and health care support services represent the third largest labor sector in the state, comprising roughly 8.6 percent of the labor market in 2016, according to the U.S. Bureau of Labor Statistics.<sup>40</sup> In smaller metropolitan areas, this market share is greater. Health care represents roughly 12.4 percent of the labor force in Carbondale, about 12.3 percent in Springfield, 10.4 percent in Decatur, and 10.1 percent in Peoria. By purposefully decreasing the number of managed care

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<sup>36</sup>Mathews, Anna Wilde and Brent Kendall. [“Health Insurers Aetna, Anthem Defend Deals, Say Markets Will Stay Competitive.”](#) Wall Street Journal 9/22/2015.

<sup>37</sup>Dafny et al. [“Paying a Premium on your Premium: Consolidation in the US Health Insurance Industry.”](#) American Economic Review 2012, 102(2): 1161-1185.

<sup>38</sup> Franzman, Dave. [“Family struggles with Managed Care Organization to get hospital bill paid.”](#) KCRG TV9 2/16/2017.

<sup>39</sup> Miller, Vanessa. [“University of Iowa hospitals raise alarm over Medicaid managed care denials.”](#) The Cedar Rapids Gazette 4/19/2017.

<sup>40</sup> [“2016 Illinois Occupational Employment Statistics.”](#) US Bureau of Labor Statistics.

providers, HFS’s procurement will likely have large downstream impacts to the Illinois economy and to marginalized regions of the state.

## Additional Considerations

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At least one current MCO, which presently provides coverage to 225,000 Illinoisans, fears it will dissolve as a result of the structure of this RFP.<sup>41</sup> The MCO in question is concentrated mostly in minority areas in the Chicagoland area, covering Cook and four surrounding counties. It was founded 22 years ago as a non-profit, supported by a partnership between five safety-net hospitals. In April, the MCO’s board chairman stated publically that the Medicaid Managed Care RFP would most likely result in their closure because they would be unable to expand to cover all 102 counties in Illinois and did not fall under the special considerations for Cook County providers. The dissolution this MCO would likely have wider consequences on Illinois than just the loss of the roughly 500 jobs the provider supports directly, as the closure would also impact the supporting safety-net hospitals that manage the MCO.

Additionally, since HFS is looking to issue between four and seven awards, and the current state system has 12 MCOs, this procurement would eliminate as much as two-thirds of the MCO market in Illinois. However the breakdown of the losing bidders ends up, the MCOs that are unsuccessful under this procurement will represent hundreds of millions of dollars in unpaid receipts to health care providers as a result of the state’s current backlog of bills and its nearly two-year budget impasse. This is critical to Illinois doctors, hospitals, and other health care providers holding past-due

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<sup>41</sup> Schorsch, Kristen. [“Why one of the biggest Medicaid insurers in Illinois is on life support.”](#) Crain’s Chicago Business 4/6/2017.

receipts because each MCO currently has a clause in its current state contract that protects an MCO from having to promptly pay providers if the state is more than two months delinquent in payments.<sup>42</sup>

This clause puts providers owed by MCOs that are not successful under this proposed procurement in a state of limbo, since it is unclear when these failed MCOs will be pressured to pay providers – if ever. Such a stoppage of payment would likely have a reverberating impact downstream in the Illinois health care market, with some providers potentially never receiving owed funds.

Furthermore, the model contract provided by HFS includes a “Right of Conscience” provision, which allows for the new system to eliminate certain services that are objected to by a contracting MCO.<sup>43</sup> This could include reproductive services. On March 9, 2017, the Illinois ACLU sent a formal protest letter to HFS stating that the “Right of Conscience” clause within the model contract did not properly incorporate the Illinois Health Care Right of Conscience Act.<sup>44, 45</sup> Furthermore, the letter referenced General Assembly findings that became effective on January 1, 2017, which read that it is “the public policy of the State of Illinois to ensure that patients receive timely access to information and medically appropriate

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<sup>42</sup> 5.25 Timely Payments to Providers - “Contractor will not be considered to be in breach of this Section 5.25, and the Department will not impose a monetary sanction pursuant to Section 7.16.14 for Contractor’s failure to meet the requirements of this Section 5.25, if such purported breach or failure occurs at a time when the Department has not paid any of the required Capitation to Contractor for two (2) consecutive months.”

<sup>43</sup> [5.6 RIGHT OF CONSCIENCE](#) - 5.6.1 “The Parties acknowledge that, pursuant to 745 ILCS 70/1 et seq., Contractor may choose to exercise a right of conscience by refusing to pay or arrange for the payment of certain Covered Services.”

<sup>44</sup> [745 ILCS 70/1 et seq., the Illinois Health Care Right of Conscience Act.](#)

<sup>45</sup> Meek, Amy. “Re: State of Illinois Medicaid Managed Care Organization Request for Proposals 2018-24-001,” Letter from the Women’s & Reproductive Rights Project Roger Baldwin Foundation of the ACLU of Illinois to the Illinois Department of Healthcare and Family Services 3/9/2017.

care.”<sup>46</sup> The ACLU has not indicated if it has received any response from HFS at this time.

## Timeline

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Proposals are due for the Medicaid Managed Care Organization RFP on May 15, 2017. Following a review by HFS, winning bids will be announced on June 30, 2017, which will have an effective date for all new contracts of January 1, 2018. All MCOs, even those that are not successful in garnering a new contract, will be responsible for continued services until the January 1 start date.

Considering the number of concerns listed in this report – especially in terms of economic impact on the state, market development, long-term rate changes, and potential limits to services – the Office of the Comptroller requests that the procurement process for the Medicaid Managed Care Organization RFP (2018-24-001) be put on hold pending a stringent, third-party review by the General Assembly and the state’s Commission on Government Forecasting and Accountability to determine the actual value this procurement gives to the state and its residents at this time.

Because procurement would limit competition within the Illinois health care market, and due to the fiscal constraints the state is currently under, this report recommends the state reevaluate this RFP before implementation to determine if it should continue as presently constructed.

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<sup>46</sup> [\(745 ILCS 70/2\) From Ch. 111 ½, par. 5302 – Findings and Policy.](#)