# Illinois' Massive Shift to Managed Care

*Illinois lagged behind national trends when it first tested the waters of managed care about a decade ago. But in recent years, the state took the plunge — signing on to managed care for 80% of Medicaid patients.*

In fiscal year 2010, the Illinois Department of Healthcare and Family Services (HFS) spent $251 million on managed care organizations, just over 2.58% of its entire expenditures on care for the year. In fiscal year 2019, it is estimated that this expenditure will grow to $10.8 billion, more than 70% of HFS's care expenditures. This could rise as high as $14 billion in overall state spending.

This substantial shift in spending has implications for transparency, care for some of Illinois' most vulnerable residents, and the state's overall health care system. (A legislative working group is currently considering dozens of proposals to change the way Medicaid is regulated in Illinois.)

This expansion of managed care will continue for the foreseeable future. In August 2017, HFS announced new contracts with seven managed care organizations (MCOs) to expand the percentage of Illinois Medicaid recipients under managed care from 64.5% to 80%. Geographic coverage would also expand from 30 Illinois counties to all 102.

The total value of the seven new managed care contracts was $63 billion, making this recent managed care expansion initiative—also known as HealthChoice Illinois—the largest procurement in state history.

Given the scale of this shift, it is important for residents and policymakers to understand the history of managed care in Illinois, as well as its impact on state budgets and policy in the future.

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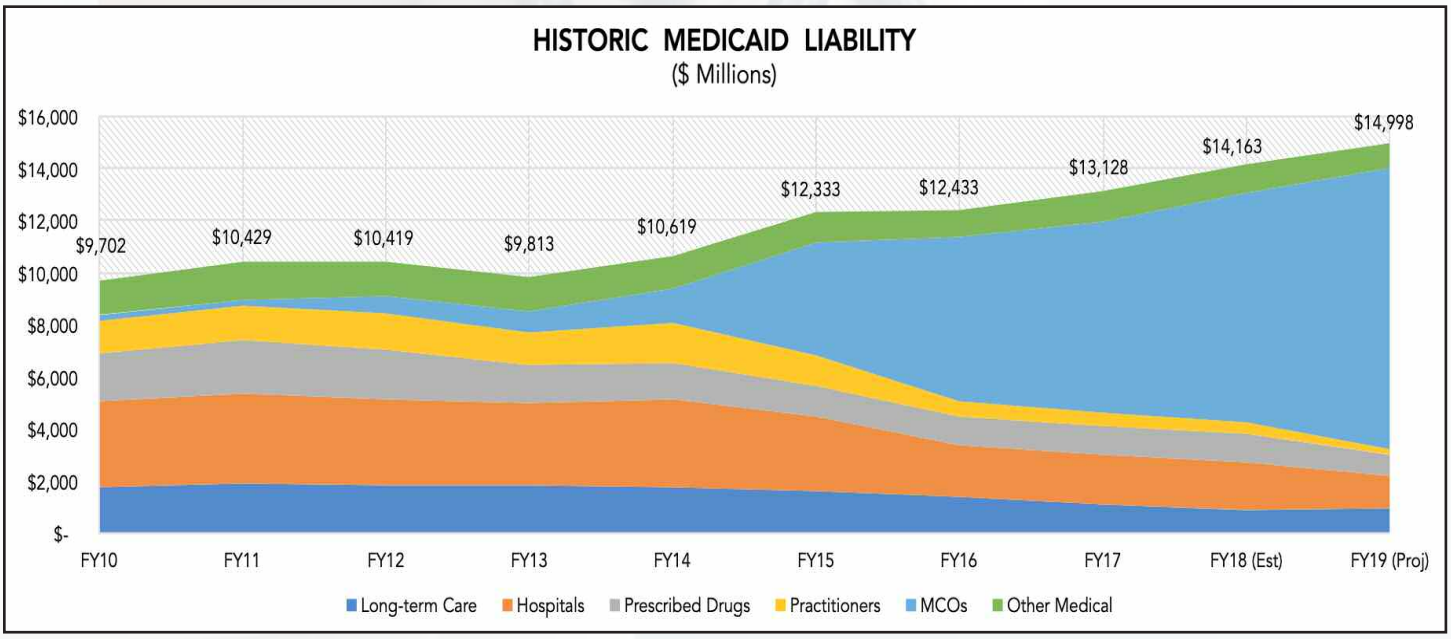
## What is Managed Care?

Managed care in the United States is rooted in the 1960s and 1970s with the expansion of government managed health insurance. As part of President Lyndon Johnson's




* HFS numbers that reflect total General Revenue and related funds liability

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"Great Society," Congress passed the Social Security Amendments of 1965, which created a national health insurance program for seniors (Medicare) and low-cost medical services for low-income Americans (Medicaid).

To pay for these services, states would pay health care providers directly, with monetary assistance coming from the federal government. This process is known as fee-for-service.

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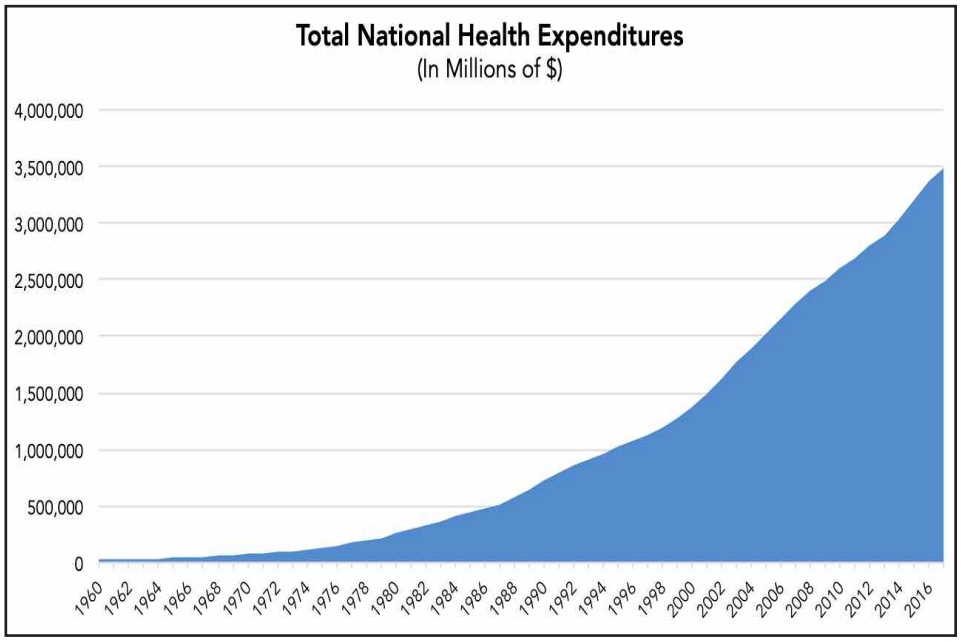
In 1973, Congress passed the Health Maintenance Organization Act, which amended the Public Health Service Act to allow for-profit entities to provide medical care services. Previously, medical care was provided by non-profit entities. The new law allowed for the proliferation of health maintenance organizations (HMOs), which established networks of providers to cover the health care needs of individuals.

Although the basic concept of HMOs existed prior to 1973, through prepaid private insurance providers like Blue Cross Blue Shield, the change in law led to the expansion of HMO usage in the 1980s as a way to curb rising medical costs.

HMOs achieved savings by pushing providers to discount their rates and linking networks of providers to make the system more efficient. However, by the 1990s, HMOs had fallen out of favor following protests that the systems were generating cost savings by denying care.

But the 2000s witnessed a resurgence of managed care at the state level. MCOs contracted with states to provide Medicaid services through a risk-based system for a pre-set premium, known as a capitation payment. This system is called "risk-based" because MCOs are at financial risk for the services outlined in their Medicaid contracts with the states, since they are responsible for contracting with providers directly. If the price contracted with the provider is greater than the annual capitation payment, then the MCO would absorb the loss.




### Who is covered by Medicaid in Illinois?

Historically, Medicaid has covered three broad groups of low-income individuals: families, individuals age 65 and older, and individuals under 65 with disabilities.

In 2010, Congress passed the Affordable Care Act (ACA), which, among other health care changes, expanded Medicaid eligibility for states willing to participate. The federal government also offered to pay 100% of the costs of Medicaid expansion for participating states from 2014 to 2016, then stepping down to 95% of costs in 2017, 94% in 2018, 93% in 2019, and 90% in all subsequent years. Illinois law requires benefits to this group to cease if Illinois' federal match falls below 90%.

Income eligibility ranges from state to state, but a minimum threshold is established by the federal government. In Illinois, Medicaid covers adults who are up to 133% of the federal poverty level (plus a 5% income disregard) and gives additional coverage to pregnant women who are up to 213% of the federal poverty level and children who are up to 147% of the federal poverty level.

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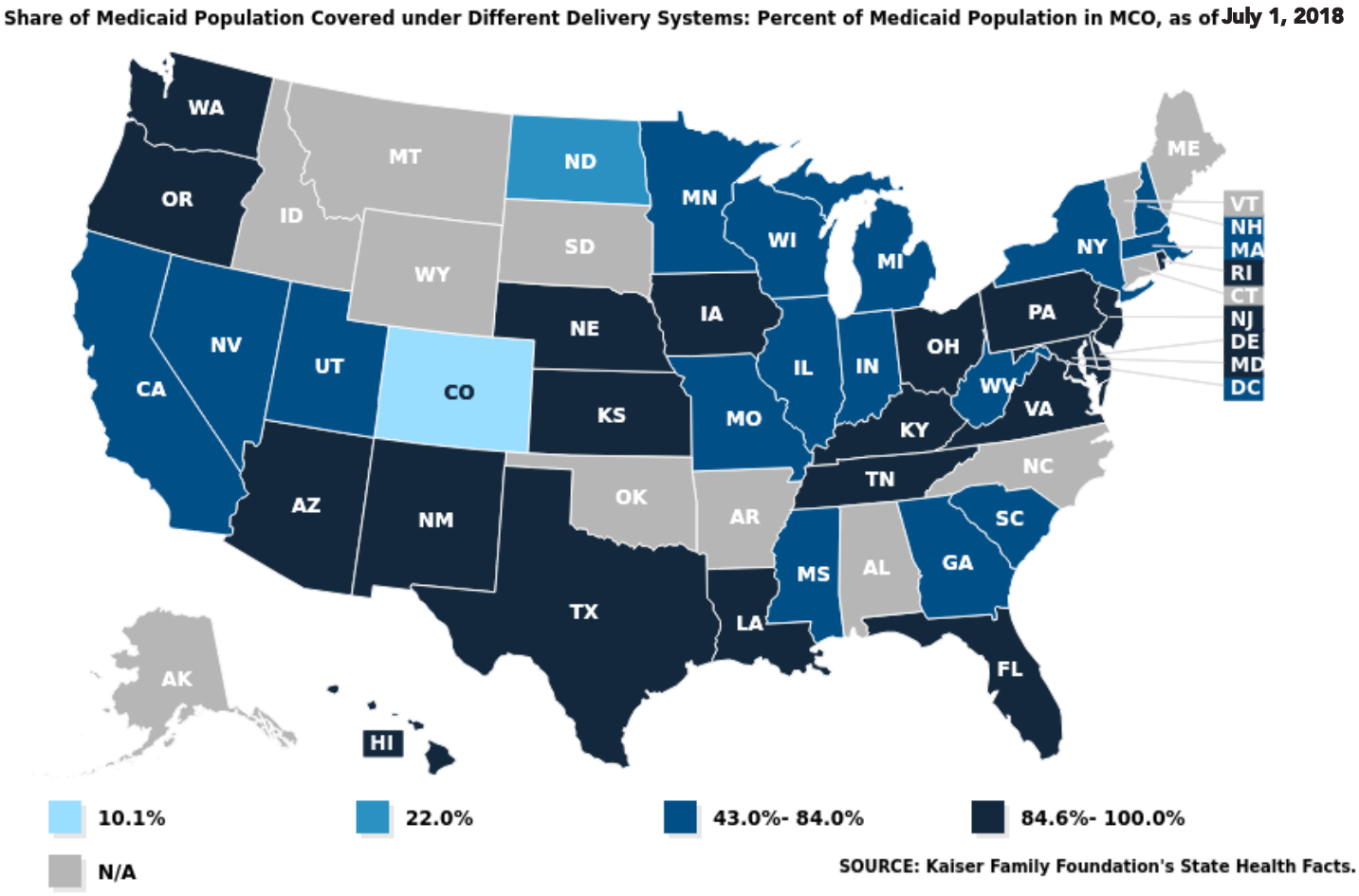


States are required to pay actuarially sound rates under this system, per federal law. MCOs must follow federal and state requirements that cover enrollment and disenrollment procedures, beneficiary grievance and appeals processes, access to care, and regular reporting requirements.

As of 2018, 39 states utilize MCOs for some part of their Medicaid programs, with 28 states (including Illinois) having at least 80% of their systems under MCOs.

## First Major Managed Care Expansion in Illinois

In comparison to other states, Illinois was relatively late expanding into managed care. However, starting in 2010, with managed care spending representing a small portion of state Medicaid spending, the General Assembly passed a series of laws that would begin to move Illinois toward becoming a majority-managed care state. At the time, managed care represented less than 3% of Medicaid spending.

The first major legislative push came in January 2011 with Public Act 96-1501, which grew out of a desire by the Legislature to show an ability to rein in state expenditures while approving an income tax increase.

A Senate Special Committee on Medicaid Reform recommended care coordination to maximize efficiency, and the majority of the Legislature agreed. Public Act 96-1501 required that by January 1, 2015, at least 50% of all Medicaid recipients eligible for full benefits would be enrolled in care coordination.

It was envisioned that MCOs would facilitate this care coordination. The state would pay based on the patient population, usage rates, medical records, and general performance related to health care outcomes.

Additionally, verification standards were tightened to cut down on waste and fraud—default termination of coverage with no response to 60-day notice of eligibility ending, no presumption of eligibility for adults except where mandated by federal law, changes to All Kids program eligibility, etc. These changes were projected to save the state $500 million over four years.

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## In Illinois, seven major groups are covered under Medicaid or Medicaid-attached programing:

**Mothers and Children:** Pregnant women and their children up to one year of age in families with monthly income at or below 213% of the federal poverty level. Children under one year of age are eligible at any income level if Medicaid covered the mother at the time of the child's birth.

**Aid to Aged, Blind, and Disabled (AABD):** Seniors, persons who are blind and persons with disabilities with monthly incomes of up to 100% of the federal poverty level and limited other resources.

**ACA Adults ("newly eligible"):** Adults ages 19-64 who are not parents raising children and who have monthly incomes of up to 138% of the federal poverty level.

**FamilyCare Assist:** Parents and caretaker relatives raising dependent minor children. To be eligible, adults must have family monthly incomes at or below 138% of the federal poverty level.

**Workers with Disabilities:** Persons with disabilities who work and have earnings up to 350% of the federal poverty level who buy in to Medicaid by paying a small monthly premium.

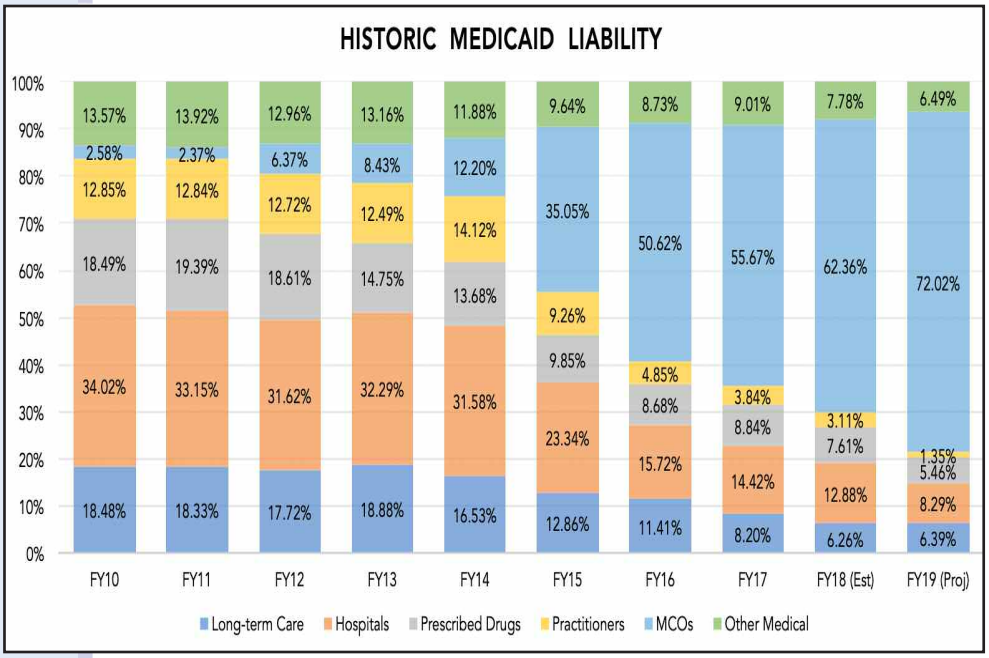
**Patients with Breast or Cervical Cancer:** Individuals under age 65 without insurance that covers cancer treatment and whose breast or cervical cancer diagnosis has been confirmed by the Department of Public Health. Medicaid covers treatment for individuals with monthly incomes up to 200% of the federal poverty level.

**Department of Children and Family Services:** Designed for children in DCFS custody, those placed in subsidized guardianship and adoption assistance arrangements and former DCFS youth in care ages 19-26 who were enrolled in Medicaid when they aged out of foster care. There are no income or resource limitations.

Comptroller Susana A. Mendoza visits nursing homes, hospitals, and health care facilities all over the state. On these visits, she hears from administrators and staff about their concerns, including delayed payments, and she talks with patients about their life circumstances and the quality of their care.

In 2012, HFS projected that medical assistance liabilities would grow by 5% every year from fiscal year 2012 to fiscal year 2017. Federal stimulus dollars that had been supplementing state medical expenditures ended in 2012, and the projected Medicaid bill backlog was pegged to increase from $1.7 billion in fiscal year 2012 to $21 billion by fiscal year 2017.

A bipartisan working group, called the Legislative Medicaid Advisory Committee, was formed to reduce the Medicaid liability by $2.7 billion. The work from this group eventually became the Save Medicaid Access and Resources Together (SMART) Act, which passed in 2012. The new law contained eligibility restrictions and cost-sharing measures. The

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SMART Act limited optional services, cut rates to nursing homes and instituted new payment benchmarks for hospitals. Some of these cost savings in the SMART Act have since been changed or repealed.

Like with the previous legislation around Medicaid reform, the SMART Act also attempted to combat fraud and waste within the system. The act created more stringent monitoring standards for vendors, allowed HFS to collect interest on overpayments and required the inspector general for HFS to conduct more system audits.

The SMART Act also included the implementation of an Integrated Eligibility System (IES), which is a benefit eligibility system that is designed to accommodate Affordable Care Act (ACA) rules. The Center for Medicaid and Medicare Services offered a 90% federal match as incentive for states to develop these systems.

Since the SMART Act passed, other major reforms to the Medicaid system have been taken up by the General Assembly, including Public Act 98-0651, which placed further regulations on MCOs to ensure each system offers adequate services, especially in relation to their hospital provider network.

## Largest Procurement in State History

In his 2016 State of the State address, then-Governor Rauner unveiled a plan to remake the state's Medicaid system by moving more Medicaid recipients to managed care. Rauner said care coordination would save the state money through increased efficiency and reductions in fraud and abuse.

As a result, HFS put out a request for proposals to expand MCO coverage of Medicaid from 30 counties in Illinois to all 102 counties, and from 64.5% of the Medicaid population to 80%.

**Transferring the management of the state's Medicaid program to a private system has meant less government insight into the system overall.**

In May 2017, the Office of the Comptroller issued a report raising concerns about the lack of transparency around the procurement process for the managed care expansion. Comptroller Susana A. Mendoza conveyed these concerns in a letter to the Rauner administration and provided testimony on the report to the House Human Services Committee.

In August 2017, HFS announced six MCOs (Blue Cross Blue Shield of Illinois, Harmony Health Plan, IlliniCare Health, Meridian Health Plan, Molina Healthcare and CountyCare Health Plan) had been awarded four-year managed care contracts. Later, a seventh MCO (NextLevel Health) would also receive a contract. The seven MCOs received four-year contracts worth a total of $63 billion, the largest procurement in state history.

Illinois Comptroller Susana A. Mendoza provided testimony to the House Human Services Committee in May 2017 about the lack of transparency around the procurement process for the state's recent managed care expansion.

The expansion of MCO coverage in Illinois, called HealthChoice Illinois, was originally intended to be divided into three distinct phases.

The first step was to transition beneficiaries who were currently enrolled in an MCO and reside in a county where managed care already exists. HFS sent transition letters in October 2017 to these enrollees. For Phase I enrollees, coverage under the new system began January 1, 2018. Beneficiaries then had a 90-day

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switch period (January 1, 2018 to March 31, 2018) to change MCOs.

Next, HFS enrolled beneficiaries who resided in counties that did not have managed care and were not currently enrolled in an MCO, as well as newly eligible Medicaid beneficiaries and some populations previously excluded from managed care. HFS mailed enrollment letters to these beneficiaries between a transition period of January 8, 2018 and February 16, 2018. All beneficiaries new to managed care had 30 days from the date of the enrollment letter to select a Primary Care Physician (PCP) and an MCO. For Phase II enrollees, coverage under the new system began April 1, 2018. Beneficiaries then had a 90-day switch period to change MCOs.

The final phase – to conduct statewide enrollment of DCFS Youth and Special Needs Children – was originally expected to occur around July 1, 2018, but has been significantly delayed.

## Managed Care Today

Over the past 10 years, managed care has moved from a health care expenditure representing less than 3% of HFS's care expenses to a $14 billion-plus annual behemoth. The goal of increasing efficiency and cutting down on waste through care coordination has been the impetus for this large managed care expansion.

However, transferring the management of the state's Medicaid system to a private management system has meant less government insight into the system overall. Two audits conducted by the Illinois Auditor General, one in January 2018 of MCOs and one in March 2018 of HFS, revealed inadequate oversight of MCOs by HFS. Findings included not tracking MCO medical loss ratios (MLRs). Lawmakers subsequently passed a law (Public Act 100-0580) to add more transparency to the MCO system.

While the new MCO expansion was progressing, issues with the state's Integrated Eligibility System were uncovered. In December 2017, 30,000 Illinoisans were unable to receive their SNAP benefits. Officials stated the issue was due to the rollout of Phase II of IES, stemming from a slowdown in determining eligibility. Additional issues were highlighted in the summer and spring of 2018, this time dealing with long-term care determinations.

On March 30, 2018, the Northern District of Illinois Federal Court ordered in *Koss v. Norwood* that the state comply with federal regulations regarding applicants for long-term care benefits. DHS and HFS were ordered to issue provisional eligibility to applicants that had been pending longer than federal guidelines allowed.

**The audit confirmed the concerns raised by the Comptroller's report, finding there had been significant errors in data collection, reporting, and monitoring.**

On June 28, 2018, the Office of the Comptroller published a report on Medicaid long-term care determinations and pending legislation that further highlighted this issue. The report pointed to a 142.9% spike in long-term care admissions pending over 90 days, from December 2017 to May 2018. As a result of this spike in long-term care determinations, the Legislature passed Public Act 100-1141, which enshrined the provisional authority ordered in *Koss v. Norwood* into law.

Another item highlighted in the Comptroller's June 2018 report was a lack of publicly available data between July 2017 and December 2017. The Office of the Comptroller formally requested this information from HFS on May 25, 2018 but received a response that the data was not available due to data entry catch-up and quality control activities.

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### How does the federal Medicaid match work?

In addition to the ACA federal coverage, the federal government pays a match rate based on a formula called the Federal Medical Assistance Percentage (FMAP). The formula uses the state per capita personal income measured against the national average.

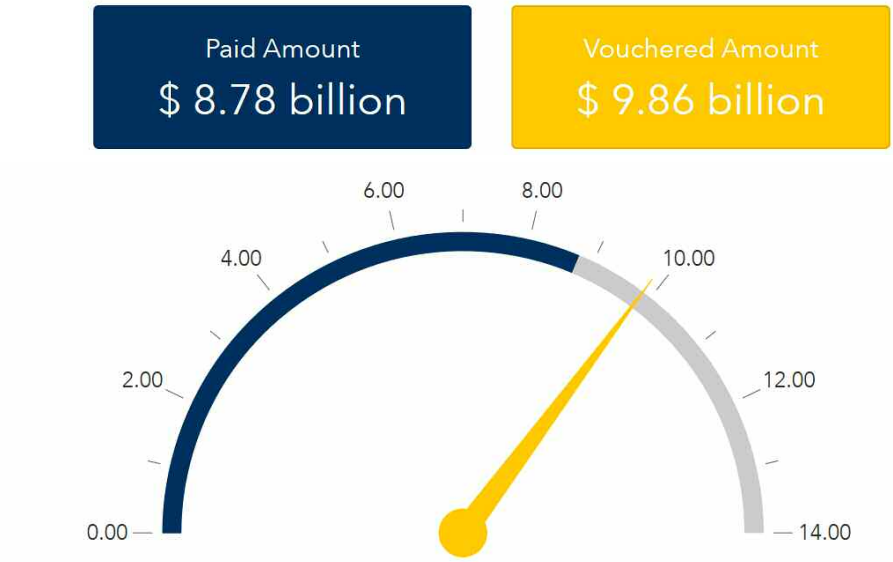
The FMAP must be greater than 0.50 and cannot be greater than 0.83.

Illinois' FMAP typically hovers around 50%. Therefore, generally, for every $1 that Illinois spends on Medicaid-eligible services, the federal government returns about $0.50.

This federal return then can be used again on Medicaid-eligible services and generate a $0.25 match, which can keep being wound down until there are no more Medicaid-eligible bills.

In the wake of these lingering issues, the legislature passed Public Act 100-0380 and Public Act 100-0665, which established performance and compliance audits for long-term care determinations and requested a review of the current program.

On March 14, 2019, the Illinois Auditor General released its report of long-term care determinations from 2015 to 2017.




The audit confirmed the concerns raised by the Comptroller's June 2018 report, finding there had been significant errors in data collection, reporting, and monitoring within the system, which had caused the system to be in violation of federal guidelines.

In addition to the issues the Office of the Comptroller highlighted about data collection and transparency, lawmakers and care providers have raised concerns about payments from MCOs.

Medical equipment providers and other health care providers have asserted that lower prices offered to them by MCOs were inhibiting their ability to continue to provide Medicaid services.

Additionally, some providers have complained that MCOs are slow to pay and/or are denying claims at a higher rate than were being denied under the fee-for-service model or in the commercial insurance setting.

In March 2019, a group of lawmakers and representatives from the state's Safety Net Hospitals held a press conference at the state Capitol, where they said MCOs are denying claims from hospitals across the state at an average of 26%.

The Office of the Comptroller does not have access to the data needed to independently confirm MCO denial rates. Furthermore, MCOs, providers, and HFS do not appear to have a universally agreed upon benchmark for what constitutes a denial.

## Outlook for Managed Care

Due to these and other issues, more than 40 legislative proposals dealing with managed care have been introduced during the General Assembly's 2019 spring session, including House Bill 2117/Senate Bill 1238, an initiative by the Office of the Comptroller to strengthen transparency within the managed care cash-flow process.

Additionally, the Governor's fiscal year 2020 budget proposal partially relies on the passage of an MCO assessment, which the administration projects will generate $390 million in revenue. The assessment is similar to other MCO assessments in California and Michigan, and is expected to be debated by the Legislature this spring.

As a result of all this discussion on managed care and Medicaid, the General Assembly has formed a working group represented by the four legislative caucuses to review the system holistically. The group is considering several topic areas, including claims denials, eligibility determinations, and payment rates.

Some of the measures before the group include proposals to streamline the process for seeking prior approval for procedures, create a standardized list of information providers must submit to support a claim, update patient rosters in a timely manner, and adopt uniform definitions on things like what constitutes a denial of a claim.

Lawmakers are also considering a proposal that would require the state to reinstate all long-term care residents whose Medicaid applications were rejected or denied, if the state failed to notify the facility where they reside, as required by state law. This proposal is meant to address some of the problems with eligibility determinations that took place under the Rauner administration.

Ultimately, the goal of the working group will be to bring more transparency and accountability to a program that provides care for millions of residents and represents an increasingly significant state expenditure. ■