April 3, 2009

ILLINOIS HOSPITAL ASSOCIATION

Response to Committee on Deficit Reduction: Senate Republican Member Report

Report's Recommendations on Medicaid Would Undermine State's Health Care Delivery System and Would Not Produce Claimed Savings

The Illinois Hospital Association, on behalf of its 200 member hospitals and health systems across the state, respectfully offers its comments concerning recommendations on the Medicaid program contained in the "Committee on Deficit Reduction: Senate Republican Member Report," issued on April 1.

IHA urges the Governor, legislative leaders and the General Assembly to carefully consider the great harm that would be caused to the Medicaid program and to the state's health care delivery system by some of these recommendations if they are implemented. Many of these recommendations would not achieve the savings claimed in the report.

One of the report's key recommendations for a Medicaid global waiver is a block grant approach that would lock in the State at its currently poorly funded level while shifting ALL of the risk to the State – without the State having total control of the Medicaid program. In essence, a block grant approach would attempt to partially balance the state budget on the backs of Medicaid patients, our most vulnerable populations – the young, pregnant women, the elderly, the disabled, and the newly unemployed – and on the backs of providers who maintain our fragile and fraying health care safety net.

In addition, many of the recommendations and claimed cost savings are based on old data and do not take in account the substantial savings that have been generated in recent years by managed care approaches implemented by the State, including primary care case management, disease management and an expanded preferred prescription drug list. For example, many of the calculations in the report are based on data that uses an incorrect federal Medicaid matching rate under the economic stimulus law – citing a state share of 44%, when in fact the correct figure is, 39.58%.

Much of the work and resulting conclusions from the consultant (the Lucas Group) underlying the report's recommendations appear to be substandard and outdated, and in many cases, based on flawed assumptions.

The following summarizes IHA's concerns about the report's recommendations on the Medicaid program (the report's recommendations are listed in bold text, followed by IHA's comments in italics):

Medicaid Global Waiver: The report suggests designing a strategic plan encompassing all existing waivers and state plan under one demonstration waiver.

By pursuing a waiver from the federal government, Illinois would be the first large state in the nation to institute a pure block grant approach for Medicaid. Only Vermont and Rhode Island have been approved for this approach.

Currently, the federal government and the states share the risks and burdens of greater-than-anticipated increases in Medicaid enrollment and health care costs. If costs rise for any reason – including increased enrollment, medical/pharmaceutical inflation, or new medical technologies – these costs are shared between the states and the federal government. This uncapped federal financing of Medicaid more readily allows the program to guarantee coverage to all eligible individuals and ensure that the federal share is at least somewhat adequate.

Capping Medicaid funding through a block grant would lock in or freeze the federal cost with modest annual increases. The effect of a block grant approach is to shift the risk from one that is shared by both the State and federal government to risk that is totally taken on by the State.

Illinois already receives less than its fair share of Medicaid funds from the federal government. The state provides care to 4.1 percent of the nation's Medicaid population but receives only 3.3 percent of total Medicaid funding, and has the lowest federal matching rate, 50 percent.

Block grants do not automatically adjust for bad economic times when Medicaid enrollment increases and state revenues decline – as is occurring now in the current recession. If enrollment costs exceed what the state has budgeted and the federal grant, the state must cover those costs with additional state funds, stop enrollment, reduce eligibility, eliminate covered services or reduce provider payments.

A block grant approach could jeopardize or even eliminate Illinois' unique financing mechanisms, such as the hospital assessment program and intergovernmental transfer (IGT). Such an approach would require the State to negotiate with the federal government new terms of the assessment program and the IGT, including payments to providers. The current hospital assessment program and IGT, which bring the State billions of dollars, would be eliminated and have to be reworked. That is a risky step to take, with too many unknowns and unanswered questions, at a time when the State is facing enormous financial challenges. The State already has in place a new five-year assessment program that will bring the State more than $4.5 billion in federal Medicaid funds for hospitals and other Medicaid needs, such as developmental disability services and long-term care.

Finally, a block grant approach does not provide as much flexibility to the State as suggested in the report. Under the global waiver approach there are many aspects of the program that must meet federal regulations, including beneficiary eligibility and covered services. In fact, the most recently approved global waiver (for Rhode Island, only the second one in the nation) includes terms and conditions that the state must still notify CMS of certain changes to its Medicaid program. Under those terms and conditions, CMS has 15 calendar days to inform the state of any correction – including unilateral changes by CMS – to the State's originally proposed change, which then becomes binding on the state and is not appealable.

Medicaid Acute Care Savings: The report claims that Illinois' Medicaid program relies too heavily on costly inpatient hospital procedures and emergency room usage as primary care and indicates that Illinois is in the highest quartile of Medicaid acute care costs in the nation.

*When comparing acute care cost per enrollee, Illinois ranks **39th** in the nation. Illinois spends $2,758 per enrollee for acute care, which is below the national average of $2,989.* [1]

The report calls for a series of steps to control acute care costs, which it says "could also be realized through implementation of the Lewin Report." [The Lewin Report called for the use of **mandatory** capitated, risk-based managed care for Illinois' Medicaid program.]

The Problems with Capitated, Risk-Based HMO Managed Care in Illinois
*The State currently employs risk-based HMO managed care. The report implies that greater use of HMOs should be made by implementing **mandatory** HMO managed care. More than any other measure, taking such action would unravel the unique financial structure of the Medicaid program. It would threaten the viability of the State's successful Hospital Assessment Program (discussed elsewhere in this document) and its intergovernmental transfer programs. Because of measures that the State has already taken, mandatory HMO managed care would not deliver the promised savings suggested by the report.*

The Hospital Assessment Program and intergovernmental transfers – which are calculated on the number of fee-for-service inpatient days – net the State more than $1.5 billion annually. Under capitated, risk-based HMO managed care, Medicaid beneficiaries would be removed from the fee-for-service system and could not be counted in calculations for the upper payment limit – which would mean the loss of the revenues – billions of dollars – generated for the State by the Hospital Assessment Program. Many other states that employ capitated, risk-based HMO managed care do NOT have the special Medicaid financing mechanisms used by Illinois to leverage substantial federal matching funds.

To achieve profits for their shareholders and to cover their administrative expenses – especially in Illinois, where provider payment rates are already low – HMOs place barriers between Medicaid beneficiaries and providers in order to provide less care or pay less for the care. However, when a state employs non-capitated Medicaid managed care as Illinois does with primary care case management and other managed care techniques, the resulting cost efficiencies and health care quality improvements go to the benefit of Medicaid patients and the State.

Illinois' Medicaid program has already squeezed payments by keeping hospital inpatient base rates frozen since 1995 and is paying some of the lowest rates in the country. In addition, Illinois spends less per Medicaid enrollee in several categories compared to the rest of the country. According to the Kaiser Commission on Medicaid and the Uninsured, in FY2005 (the most recent year in its study), Illinois ranked 46th among states on Medicaid payments for children enrollees and 40th for adult enrollees.

Capitated, risk-based HMO managed care for Medicaid is not reform and would jeopardize and undermine the state's unique and complex health care financing system, which relies heavily on the Hospital Assessment Program and intergovernmental transfers.

[1] Kaiser Commission on Medicaid and the Uninsured, State Health Facts 2006.

Report's Recommended Steps to Control Costs

The following steps recommended in the report have already been implemented in Illinois and have been generating substantial savings:

- **Enhance Health Connect – a Primary Care Case Management Program**. *Illinois has already implemented primary care case management and has 1.7 million individuals enrolled with a primary care provider. In the first year of this program (when not totally implemented), the state saved $34 million. At a recent legislative hearing the Department of Healthcare and Family Services indicated that the preliminary numbers for the second year (FY2008) will be at least $100 million in savings.*
- **Emphasize outpatient over inpatient procedures**. *Illinois has review processes in place to make sure that inpatient medical procedures were medically necessary to be performed. All hospitals are required to conduct utilization review, and Illinois has a peer review organization that performs concurrent utilization review for inpatient admissions.*
- **Divert patients from the emergency room**. *One of Illinois' disease management programs is targeted for frequent emergency room users.*
- **Reduce inpatient pharmacy costs**. *Currently Illinois' inpatient payment is an all inclusive rate (DRG or per diem). Illinois does not make any additional payment for inpatient pharmacy costs.*
- **Focus on disease management**. *Illinois currently has a disease management program in place. Illinois could expand the target populations that are covered by disease management.*
- **Expand the State's selective contracting of medical procedures and durable medical equipment**. *Hospitals have not had their base inpatient Medicaid rates increased since 1995, and on average, receive only 75% of cost from the Medicaid program (without the assessment program). It is unlikely that the State could negotiate rates that are lower than the already low rates now in place.*

Medicaid Pharmacy Cost Containment: The report claims savings can be achieved through more aggressive and consolidated pharmacy benefit management, better managed drug utilization, higher co-pays to incentivize proper use, and reducing inpatient pharmacy costs.

According to the 2007 Kaiser Commission on Medicaid and the Uninsured, Illinois ranks 34th with 7% of acute care spent on drugs and is <u>below the national average</u> of 7.7%.

Currently Illinois' inpatient payment is an all inclusive rate (DRG or per diem). Illinois does not make any additional payment to hospitals for inpatient pharmacy costs.

Since 2003, Illinois has been able to increase the percentage of generic drug utilization in its programs from 60% to 73%. The Department of Healthcare and Family Services stated that its generic drug utilization is one of the highest in the nation.

Medicaid Determination of Eligibility: The report suggests a private-public partnership to hand off determination of benefits eligibility to a private partner, touting the state of Indiana's partnership with IBM as a model.

According to several published reports, the Indiana program has been the subject of numerous problems and complaints. As a result, legislation is now pending in the Indiana General Assembly to halt the privatization until the state's Select Joint Commission on Medicaid Oversight has evaluated it.

A March 9, 2009 article in the Evansville Courier and Press noted that lawmakers have been swamped with complaints that the system is too difficult to navigate, citing several problems, including:

- *A jammed call center makes it difficult to wait long enough to talk with a representative, especially for those using prepaid cell phones;*
- *Elderly and disabled Hoosiers say they need the one-on-one help they used to get at local agency locations; and*
- *IBM's system routinely fails to correctly sort documents, forcing clients to refile their paperwork.*

In addition, another published report (Fort Wayne, Indiana Journal Gazette) noted that there have been complaints about a part of the program administered by the Lucas Group:

> *"Some 3,700 Indiana families had their benefits abruptly cut off or reduced. But nobody bothered to keep track of how many of those families were actually ineligible for welfare – and nobody knows how many people were too confused, overwhelmed or intimidated to respond to the letters."*

Other Critical Issues to Consider

We also urge you to carefully consider the negative impact of the report's recommended changes on the Medicaid program, the State's economy, the financial underpinnings of the Medicaid program, and hospitals, a critical part of the health care safety net.

Hospitals: Vital to the Fiscal Health of the State's Economy

Hospitals are one of the state's largest, more stable, and important employers and are one of the state's more significant economic engines. They employ nearly 240,000 workers, at all skill levels, and pay them more than $13 billion in wages and benefits. Hospitals are one of the top three employers in nearly half of the state's counties.

In addition to employing nearly a quarter of a million Illinoisans, they purchase vast quantities of goods and services in Illinois to run their facilities, supporting a wide range of other businesses. The total impact of hospitals on the state's economy is nearly $72 billion a year.

Medicaid as a Major Stimulus to the State Economy

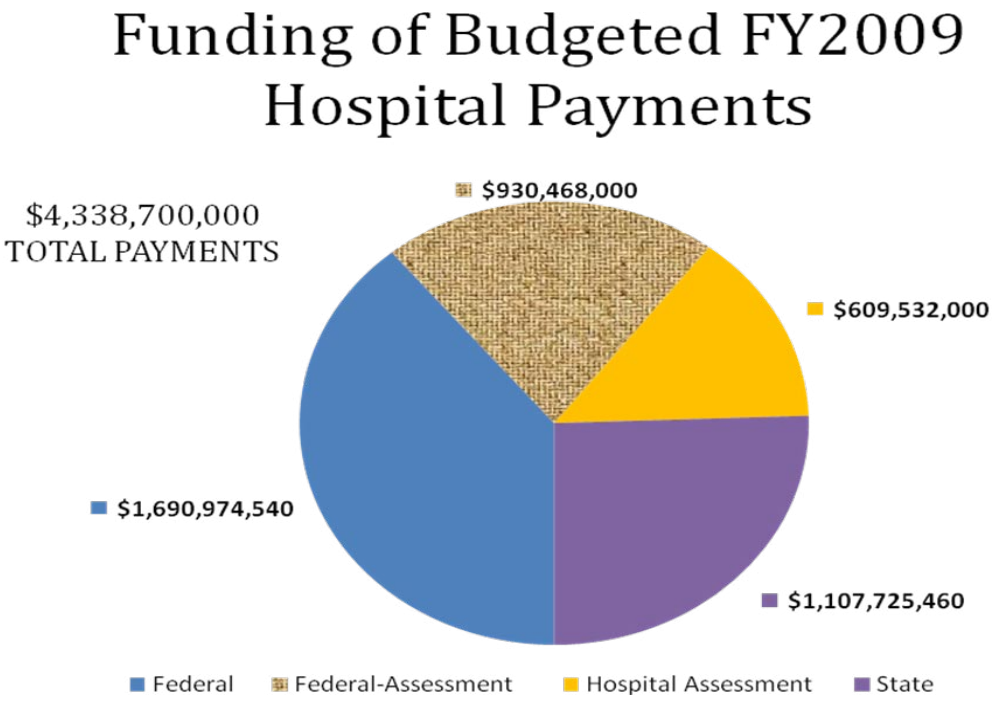
Under the federal stimulus law, which provides the State with an enhanced federal Medicaid matching rate of 60 percent (an increase of more than 10 percent), for every $1 Illinois spends on Medicaid, the federal government will contribute $1.50. Medicaid has a tremendous multiplier effect on the economy – a greater impact than state spending on other programs – because it pulls a large infusion of **new** dollars – federal dollars – into the economy from outside the state. One study indicates that each $1 of Medicaid spending generates $2.50 of economic activity in Illinois *(Families USA, analysis and economic model from the U.S. Department of Commerce, April 2008).*

When hospitals and other health care providers receive Medicaid payments from the State, those funds promote new rounds of spending – including supporting wages for employees and the purchases of pharmaceuticals, goods and services from other businesses, which in turn generate further rounds of spending through out the economy and tax revenues for the state.

Conversely, reductions in state spending for Medicaid would result in less federal funding for the State. **At the enhanced FMAP rate of 60 percent, Illinois would have to cut Medicaid spending by $2.50 to save $1 in state funding.** Cutting Medicaid during an economic downturn will actually worsen the state economy, as well as reduce access to needed health care services for the State's most vulnerable populations.

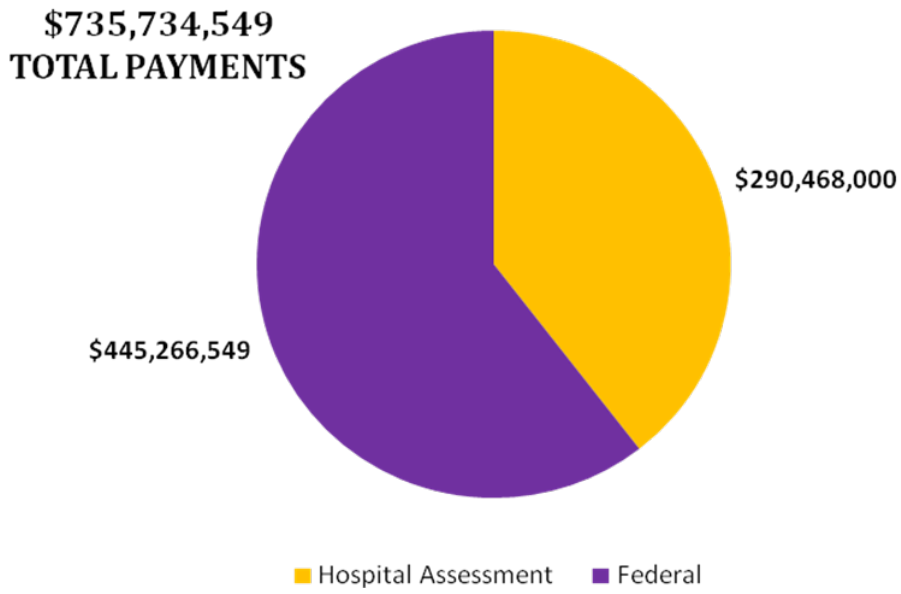
Hospitals as a Key Partner with the State on Medicaid and its Finances

Illinois hospitals recognize that the State has faced and continues to face very difficult fiscal challenges, including finding the resources to support the Medicaid program. In recognition of those challenges, Illinois hospitals welcomed the opportunity to partner with the State to develop three Hospital Assessment Programs over the past five years to provide new federal and hospital tax funds for the state's Medicaid program – to help boost inadequate hospital reimbursement base rates that have not been updated in nearly 15 years. Moreover, by the end of the current assessment program, the three assessment programs will have generated a total of $3.5 billion for other non-hospital Medicaid services, such as long-term care and developmental disability services.



In fact, when you look at the total $4.34 billion in Medicaid payments to hospitals in Illinois in fiscal year 2009, only about 25 percent or $1.1 billion is from state funding. Three-quarters of the hospital payments are from NON-state funding sources: $610 million paid by hospitals to the State for the assessment program, which triggers a federal match of $930 million, and $1.69 billion in other federal funds.

Hospital Assessment Program Provides $735 Million for Other Medicaid Needs



Under the assessment program, hospitals contribute substantial funds to the State: a total of $900 million a year – with $610 million of that contribution generating the federal match and with the remaining $290 million – when matched by federal funds – generating a total of **$735 million** for the State to use for other Medicaid needs. It is a partnership that benefits everyone.

But these substantial resources provided to the State by the Hospital Assessment Program would be seriously jeopardized or even eliminated if some of the report's recommendations are implemented.

Protecting Health Care in the State Budget

Whatever decisions are made on the state budget, it is critical that funding for Medicaid is protected. If next year's budget fails to fully fund Medicaid, more of our children, pregnant women, the elderly and the disabled will go without health care coverage and services that families depend on may have to be reduced. During the current economic crisis, it is even more vital to preserve the health care safety net, as more people become unemployed and lose their health insurance. Medicaid payments, which account for a significant share of overall hospital revenues, already fall short of paying for the care hospitals actually provide.

The economic impact of Medicaid cuts hurts far more than just hospitals – it hurts the communities in which we live and work. Jobs, businesses and the overall local economy will feel the impact in very real ways. Inadequate access to health care leads to lower worker productivity -- and that hurts business. These cuts will also result in higher employer health insurance costs -- and that hurts employers and employees. Ultimately, the cost burden will have to shift to make up for the Medicaid shortfall.

Conclusion

Illinois hospitals recognize the need for the State to have a strong Medicaid program that is cost-effective and efficient. We believe any changes to the program to reach that goal must be accomplished in ways that ensure continued access to quality health care for our most vulnerable populations. We have collaborated with the State on many cost-efficiency measures in the Medicaid program, including primary care case management and disease management, and we are strongly committed to continuing the partnership.

However, it is highly questionable as to whether the Senate Republican recommendations on Medicaid can achieve the cost savings claimed in their report. As pointed out, many of the recommended steps are already being implemented, and the most radical changes suggested in the report, a block grant approach and mandatory managed care, would undermine and jeopardize the financial stability and foundation of the state's health care delivery system. The current Hospital Assessment Program, which will provide the State with $4.5 billion in additional federal funds over the five-year life of the program, would no longer be available if some of the report's recommendations are implemented.

We welcome the opportunity to engage in serious discussions about how to best improve the state's Medicaid program.

Illinois hospitals urge the State to allocate sufficient funding for the Medicaid program to ensure adequate and timely payment to health care providers, without reducing services covered and without reducing eligibility for the Medicaid program. It is critical that the State maintain and protect the Medicaid program.