



# **THE ILLINOIS MEDICAID PROGRAM**

**An Issue Brief**

**Prepared by**

**The Institute for Illinois' Fiscal Sustainability**

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## EXECUTIVE SUMMARY

This report is an overview of the Illinois Medicaid program, a joint federal-state program to support health care services for certain portions of the low-income population. The program costs roughly \$13 billion a year, or about a quarter of the state's annual operating appropriations. About half of each dollar spent by the state has typically been reimbursed by the federal government. Approximately 2.5 million Illinois residents receive some Medicaid services and it is the primary source of medical coverage for more than 1 out of 6 residents.

Illinois' Medicaid expenses have grown from \$11.8 billion in FY2005 to \$12.4 billion in FY2008. FY2009 expenses are likely to exceed \$13 billion, particularly with the additional federal stimulus money from the **American Recovery and Reinvestment Act** of 2009 (ARRA). ARRA has temporarily raised the rate of Illinois' federal match to 60.48% from 50.32%, which is expected to generate an additional \$2.9 billion in federal Medicaid funds between October 1, 2008, and December 31, 2010.

As in other states, the Medicaid program in Illinois is attracting increased scrutiny because of its size and rapid growth. Earlier in the decade, Medicaid enrollment and expenditures grew faster in Illinois than in most other states, but growth seems to have stabilized in the last several years. At the same time, Illinois ranks near the bottom nationwide in Medicaid payments per enrollee. Overall, the Illinois program appears to be somewhat broader in the number of services and the percentage of residents who receive some coverage while being slightly more restrictive on reimbursement to providers.

Generalizations about the Illinois Medicaid program are difficult because of its scope, the complexities of its financing and administration and the numerous factors that influence its growth. Correspondingly, proposals for major short-term savings are not likely to be realized without significant cuts, and the most promising changes are likely to come from careful coordination among various services. Without a comprehensive review of the program, it is difficult to draw conclusions about its current operations and possible opportunities for improvement. Nevertheless, it is clear that several areas in particular deserve closer attention, including the following:

- **Institutional and long term care:** Illinois lags behind other states in developing alternatives to institutional care for the elderly and disabled. Of particular concern are the hundreds of millions of dollars that Illinois spends annually on institutional care that is not eligible for federal reimbursement.
- **Physician and hospital outpatient care:** Illinois' reimbursement rates for specialty physicians and hospital outpatient care have been low, which might lead to higher treatment costs in inpatient settings.
- **Managed care:** Illinois enrolls a smaller percentage of Medicaid recipients in managed care than other states. As an alternative to requiring enrollment in health maintenance organizations (HMOs), the state recently started a program to connect patients to primary care physicians who are supposed to monitor and manage their care. This is a promising

option, but the state has not yet provided enough evidence to assess the program's success. Greater HMO enrollment is also worth considering, particularly for the aged and disabled.

- **Medicaid eligibility expansion:** Illinois has expanded eligibility without sufficient provisions in the budget to fund the expansion.
- **Prescription drug costs:** Core Medicaid pharmaceutical expenses are similar to other states, but there may be additional savings and attention should be paid to the Illinois Cares Rx program, which is not matched by federal funds.
- **Payment delays:** The Medicaid payment cycle bears the brunt of the state's cash flow problems and provider payments are historically in arrears, although this problem will be solved in the short term by the use of federal stimulus funds.

The Medicaid program in Illinois, as in other states, provides essential health care coverage to significant and vulnerable segments of the population in the context of an overall American healthcare system that is marked by considerable decentralization and lack of coordination. Because the Medicaid program is a very large portion of the Illinois state budget, it needs constant scrutiny and review to ensure that the expenditures are appropriate, are targeted at the highest priorities and do not exceed the state's resources.

### **Civic Federation Recommendations**

The Civic Federation calls on the General Assembly to establish a joint legislative and gubernatorial commission to launch a review of the future financing of the state's Medicaid program. Included in the review must be a plan to compensate for the expiration of the federal stimulus program on December 31, 2010. With the additional federal match scheduled to end in 19 months, the state should prepare now for the \$1.3 billion budget gap that will be created in 2011.

The Civic Federation recommends that the state appoint a joint legislative and gubernatorial commission to take a detailed look at the entire Medicaid program. We also recommend that Governor Pat Quinn establish an executive-level Medicaid management group to address program issues that cut across specific agencies and budgetary categories. In addition, we recommend the issuance of a comprehensive annual report on Illinois Medicaid in a prescribed format that would provide essential data and evaluate the program's operations and effectiveness.

## BACKGROUND

Medicaid, Title XIX of the Social Security Act, is a joint federal-state program to support health care services for certain portions of the low-income population under rules promulgated by the federal government. This report is an overview of the Illinois Medicaid program, which consists of approximately \$13 billion of programs, or about a quarter of the state's operating budget. Roughly half of the total budget has typically been underwritten by the federal government, so net funds provided by state sources are less than \$7 billion. Almost 2.5 million Illinois residents, nearly 20% of the population, receive some Medicaid services, and it provides the primary medical coverage for more than 1 out of 6 of the state's residents.<sup>1</sup>

Medicaid is state-administered with federal financial participation. The federal government matches state expenditures with a reimbursement rate ranging from 50% to 83%, depending on a state's wealth. Medicaid is an outgrowth of federal programs started after World War II to support and encourage health care for the indigent. In 1965 congressional supporters of expanding these programs took advantage of the creation of Medicare, the health insurance program for the elderly, to also create the Medicaid program. Largely an afterthought, Medicaid came into existence without benefit of a single explicit congressional hearing. States, however, quickly took advantage of the program. In all states Medicaid now constitutes a major portion of the state budget and therefore is typically a major source of contention.

Eligibility for Medicaid is determined by both federal and state law. The federal government determines which groups of people must be eligible and which services must be covered, but states are given flexibility to extend coverage to additional groups and to cover additional benefits. Because Medicaid programs are state-run, they vary widely in their eligibility standards, range of services, reimbursement methodologies, and overall generosity to both recipients and providers.

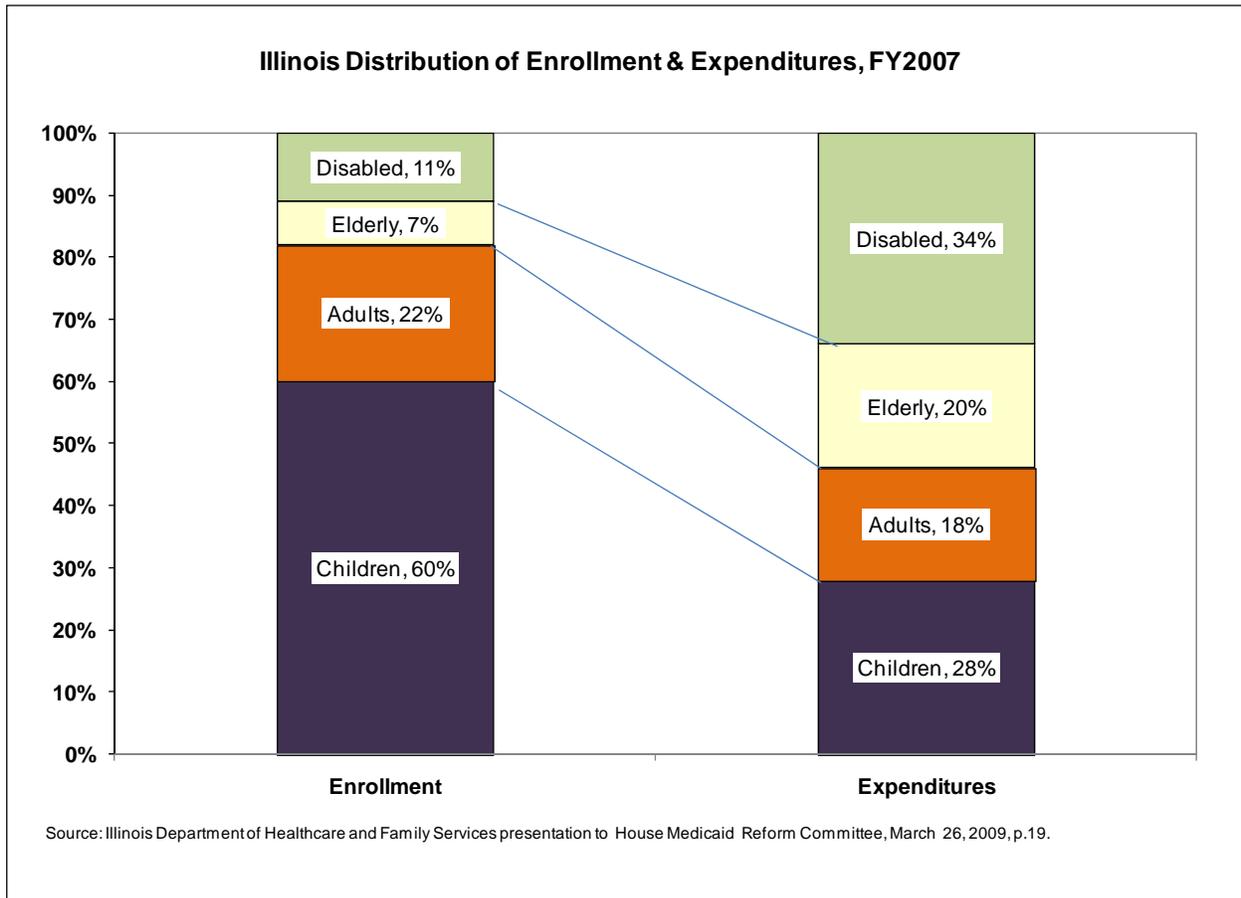
Medicaid expenses have grown steeply over time in all states, and total Medicaid spending (state and federal) is now greater than Medicare spending. Increases in Medicaid spending largely reflect rising costs throughout the United States' health care system. Medicaid costs also rise as more people qualify for coverage due to economic downturns, loss of employer-sponsored health insurance and demographic shifts such as the aging population. In addition, states can make their programs more generous by expanding eligibility and benefits. On the whole, Medicaid expenditures per recipient have not grown faster than overall health care costs.<sup>2</sup>

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<sup>1</sup> For some people, typically those who are also covered by Medicare, Medicaid covers only part of their health care.

<sup>2</sup> R. Kronick and D. Rousseau, "Is Medicaid Sustainable? Spending Projects for the Program's Second Forty Years," *Health Affairs On-Line*, Posted February 23, 2007. (doi:10:1377/hlthaff.26.2.w271)

Medicaid has typically been thought of as a program to support health care for mothers and children on welfare. However, even though children, parents and pregnant women make up most of the Medicaid population, the bulk of Medicaid spending is used to aid the elderly and disabled. Illinois is typical in this regard. In Illinois, about 82% of Medicaid recipients in FY2007 were children, parents and pregnant women. Yet the elderly and disabled accounted for 54% of expenditures.<sup>3</sup>



### MEDICAID EXPENDITURES IN ILLINOIS

The Medicaid program in Illinois is administered primarily by the Department of Healthcare and Family Services (HFS)<sup>4</sup> and “Medicaid” is often considered to be equivalent to the medical programs operated by HFS. While there is significant overlap, 1 out of 5 Medicaid dollars is actually expended by some other Illinois agency—including the Department of Human Services (DHS) and the Department on Aging—and about 10% of HFS’ medical program expenses are outside of the Medicaid program. The FY2010 proposed appropriation for HFS’ Medical Assistance Program is \$14.2 billion, or 26.8% of the entire proposed operating budget for the

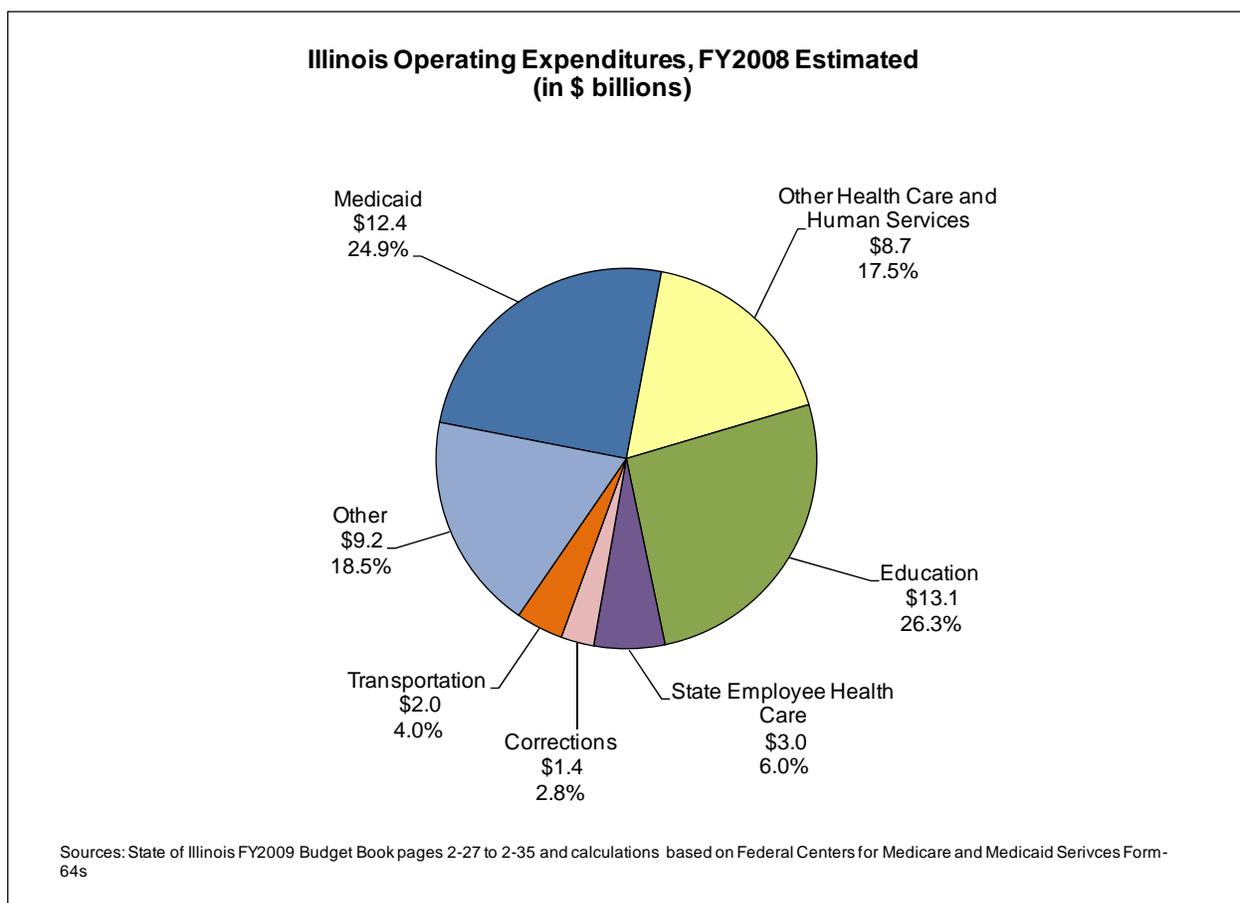
<sup>3</sup> Illinois Department of Healthcare and Family Services presentation to House Medicaid Reform Committee, March 26, 2009, p. 19.

<sup>4</sup> HFS was previously known as the Illinois Department of Public Aid and many people still refer to IDPA rather than HFS.

state. If Medicaid expenditures from all agencies are included, Medicaid's share of proposed appropriations is slightly higher.

Unless otherwise indicated, this report focuses specifically on Medicaid expenses rather than the Medical Assistance budget which is limited to HFS. Likewise, unless noted, all expenditures include expenditures from the State Children's Health Insurance Program. The State Children's Health Insurance Program (SCHIP) is technically separate from the Medicaid program but, as a practical matter, usually functions as an adjunct to Medicaid and expenditures are often grouped with Medicaid expenditures.<sup>5</sup> Unless otherwise noted, all data on Illinois' Medicaid program cited in this report were obtained from U.S. Centers for Medicare & Medicaid Services Form-64s, which reflect information that states are required to report quarterly to the federal government.<sup>6</sup>

As shown in the following graph, Medicaid expenditures constituted one-quarter of the state's operating budget in FY2008.



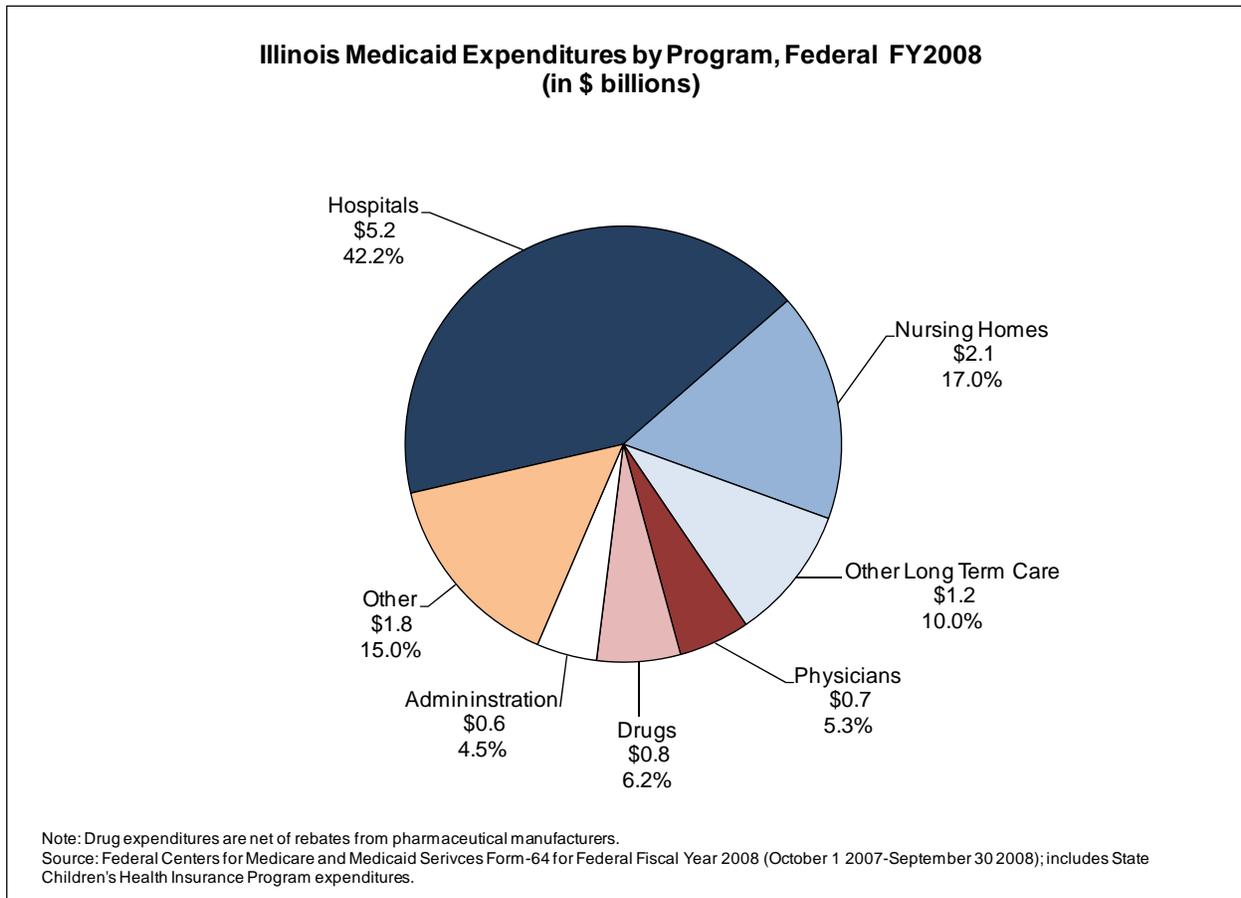
Although by convention all Medicaid expenses are shown in the Illinois budget, roughly one-half of the Medicaid expenditures reflected in the budget are funded by the federal government on a

<sup>5</sup> SCHIP is now known simply as the Children's Health Insurance Program (CHIP). To avoid confusion with the Illinois Comprehensive Health Insurance Plan, a separate state program that offers health insurance to those unable to obtain private health coverage, this paper continues to refer to the federal-state program as SCHIP.

<sup>6</sup> The latest available data from the federal government were from federal FY2008, ending September 30.

matching basis. Thus, each dollar in the budget only reflects 50 cents of state funds. Taking into account the federal match, the share of state funds used by the Medicaid program would be materially less than shown above. The share would be even lower if the use of provider assessments were taken into account.<sup>7</sup> Calculating the exact share of traditional state funds employed by the Medicaid program would be exceedingly complex, but given the federal match and provider assessment the share of total state operating funds devoted to Medicaid is estimated at approximately 15%.<sup>8</sup>

As shown in the following graph, more than 40% of total expenditures within the Medicaid program are to hospitals, but that number is complicated by use of the provider assessment mechanism for increasing reimbursement without using state funds. Nursing homes account for another 17% of all Medicaid expenditures, while other long term care (LTC) accounts for 10%. Other LTC includes Medicaid-eligible expenses for mental health facilities. No other program accounts for more than 10% of total expenditures.



<sup>7</sup> As discussed below, provider assessments use payments by health care providers to draw federal matching funds without actually using state funds.

<sup>8</sup> The situation is complicated by the fact that the state must reimburse the entire amount of a payment before the federal government returns its half. This has two important consequences: (1) the appropriation is for the entire amount of the expenditure, not just the portion that will eventually be paid by the state; (2) the state must have sufficient cash flow to pay the entire reimbursement, which contributes to delays in the payment cycle.

## RECENT TRENDS IN ILLINOIS' MEDICAID PROGRAMS

Illinois' Medicaid expenses grew 12.7% to \$12.4 billion in FY2008 from \$11 billion in FY2006. FY2009 expenses are likely to exceed \$13 billion, particularly with the additional federal stimulus money from the **American Recovery and Reinvestment Act** of 2009 (ARRA).

ARRA has temporarily raised the rate of Illinois' federal match to 60.48% from 50.32%, which is expected to generate an additional \$2.9 billion in federal Medicaid funds between October 1, 2008, and December 31, 2010. It is difficult to calculate the actual growth in the Medicaid program for any specific period as the erratic payment cycle makes it hard to determine what changes are due to real growth and what are due to payment cycle issues. Illinois law allows the state to defer payments for Medicaid claims to the next fiscal year, and the state has repeatedly carried over substantial Medicaid liabilities in order to balance its budget at times of fiscal difficulty.<sup>9</sup> Because of these complications, a more stable way of measuring changes in the Medicaid program over time is to look directly at the liabilities, which are the amount of valid bills the state has on hand regardless of when they get paid. Although the state does not routinely publish the total liabilities, a recent presentation by HFS shows liabilities grew 74.2% between FY2000 and FY2009 to \$11.2 billion from \$6.4 billion.<sup>10</sup>

Making comparisons among states' Medicaid programs is fraught with difficulties because of the payment timing issues discussed above and the wide differences in benefit provisions and enrollment levels across the country. Despite these complexities, it is useful to try to compare Illinois' program with those of other states in order to get a broad idea of the strengths and weaknesses in Illinois Medicaid.

Illinois ranked 7<sup>th</sup> among states in total Medicaid spending in FY2007 and 5<sup>th</sup> in overall Medicaid enrollment in FY2006.<sup>11</sup> Only eight other states saw more rapid growth in Medicaid spending between FY2003 and FY2007, when Illinois expenditures rose 34%. More recently, however, there have been no major program changes or major changes in eligibility in Illinois.

Illinois' Medicaid enrollment rose rapidly during the first part of the current decade. Between 2002 and 2006, enrollment jumped 26.2%, the 6<sup>th</sup> biggest increase of any state. On the other hand, Illinois ranked 42<sup>nd</sup> in Medicaid payments per enrollee in 2006. Overall, the state's Medicaid program appears to be typical or perhaps slightly broader in the number of services and the percentage of residents who receive some coverage while being slightly more restrictive on reimbursement to providers.

State officials maintain that most of the growth in Medicaid enrollment in the past ten years—from 1.5 million recipients to 2.5 million—has stemmed from increased enrollment in existing

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<sup>9</sup> 30 ILCS 105/25 (2007); Office of the Illinois State Comptroller, *Fiscal Focus*, July 8, 2008, p.7.

<sup>10</sup> Illinois Department of Healthcare and Family Services presentation to the Taxpayer Action Board's Medicaid subcommittee, May 13, 2009. The number for FY2009 is an estimate. These numbers do not include all hospital assessment funds and do not include funds cycled through the Cook County and the University of Illinois trust funds, discussed in footnote 50.

<sup>11</sup> The Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org). Data for federal fiscal years ending September 30. Note that the latest expenditure data are for 2007, while the latest enrollment data are for 2006. These data, used here for comparison purposes, do not include SCHIP expenditures or administrative costs.

programs.<sup>12</sup> However, certain recent state-mandated changes in program eligibility are worth noting. For example, the decision to raise the income threshold for the aged, blind and disabled population had a significant impact on both enrollment and costs.<sup>13</sup> Beginning in July 2000, the state expanded the eligibility standard for the aged, blind and disabled from about 36% of the Federal Poverty Level<sup>14</sup> to 100%, resulting in the addition of 136,000 recipients, many of whose expenses were considerably higher than average because they were disabled.

The State Children's Health Insurance Program, authorized by the federal government in 1997 through a separate title of the Social Security Act, was designed to expand coverage for uninsured children by offering an enhanced federal match for such expansions. The current Illinois SCHIP program is called **AllKids** and is an amalgamation and expansion of several previous programs. AllKids offers four types of coverage:

- Children from families with countable income at or below 133% of the Federal Poverty Level (FPL) receive Medicaid coverage with no additional charges.
- Children from families with incomes between 133% and 150% FPL pay no premium, but have small co-payments, consistent with regulations for all Medicaid programs.
- Children with families whose income is over 150% FPL who are not otherwise insured—and have not been so for the previous 12 months—may buy into the Medicaid program at premium and co-pay levels determined by a sliding scale.
- If a family has income between 133% and 200% FPL and has other health insurance for their children, they may receive a grant equal to the cost of the insurance up to \$75 per month.

The net effect of AllKids was to add 410,000 children to Illinois Medicaid between 2003 and 2008.<sup>15</sup> However, HFS has stated that few of those additional children were in families with income over 200% of the FPL.<sup>16</sup> The evidence nationwide shows that expansion of children's insurance has been a cost-effective approach to improving children's health.<sup>17</sup> The preliminary AllKids report issued by HFS in 2008 was not required to document whether the program has improved the health status of participants, but a full report due to the General Assembly on July 1, 2010 will measure the health benefits of utilizing AllKids and other outcomes.

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<sup>12</sup> Illinois Department of Healthcare and Family Services response to Taxpayer Action Board's Medicaid subcommittee, May 5, 2009, p.4.

<sup>13</sup> Illinois Department of Healthcare and Family Services response to Taxpayer Action Board's Medicaid subcommittee, May 5, 2009, pp.4-5.

<sup>14</sup> The 2008 Federal Poverty Guideline was \$10,400 for a family of one and \$17,600 for a family of three; <http://aspe.hhs.gov/poverty/08Poverty.shtml>

<sup>15</sup> Illinois Department of Healthcare and Family Services, "AllKids Preliminary Report" (July 2008), p. 1.

<sup>16</sup> Illinois Department of Healthcare and Family Services response to Taxpayer Action Board's Medicaid subcommittee, May 5, 2009, p.4.

<sup>17</sup> A. Dick et al., "SCHIP in Three States: How Do the Most Vulnerable Children Fare?" *Health Affairs* (2004, Vol. 23, No. 5), pp. 63-75; G. Kenny & J. Yee, "SCHIP at the Crossroads: Experiences to Date and Challenges Ahead," *Health Affairs* (2007, Vol. 26, No. 2), pp. 356-369.

Another Medicaid expansion provided for an increased income threshold for parents of low-income children already eligible for coverage. In Illinois adults up to 185% of the FPL were covered under a program known as **FamilyCare**.<sup>18</sup> In November 2007, the Centers for Medicare & Medicaid Services of the federal Department of Health & Human Services effectively denied federal matching funds for any adults with income exceeding 133% of the FPL. Governor Rod Blagojevich, against the explicit wishes of the General Assembly, not only continued coverage for the affected populations but also sought to expand coverage to those with incomes up to 400% of the FPL who had children receiving state aid. Legal and political ramifications notwithstanding, state officials contend that the fiscal impact of these expansions was not particularly large in terms of the overall Medicaid program. Initially, fewer than 4,000 adults were enrolled with incomes over 185% of the FPL at a cost of \$6 million through December 2008.<sup>19</sup> Since then, the state has stopped enrollment in the expanded FamilyCare program.

Illinois also created **Illinois Cares Rx**, a prescription program for seniors and the disabled with incomes up to 200% of the FPL. The program was started prior to the inception of prescription drug coverage under Medicare Part D, but the state opted to continue extra benefits for Part D-covered enrollees and to continue benefits to enrollees who were not eligible for Part D. The cost of this program is approximately \$130 million, which is entirely funded by the state and does not receive a federal match.

## **ISSUES OF CONCERN**

Generalizations about the Illinois Medicaid program are difficult because of its scope, the complexities of its financing and administration and the numerous factors that influence its growth. Correspondingly, proposals for major short-term savings are not likely to be realized without significant cuts, and the most promising changes are likely to come from careful coordination among various services. Without a comprehensive review of the program, it is difficult to draw conclusions about its current operations and possible opportunities for improvement. Nevertheless, it is clear that the following areas in particular deserve closer attention.

### **Institutional and Long Term Care**

Predictably, most nursing home care is for the elderly. However, as shown in the table below based on data compiled by the Illinois Department of Public Health, almost a third of such care is provided to people below the age of 65. Most, but not all, of these are patients suffering from mental illness or developmental disabilities.

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<sup>18</sup> Family Care allows an adult in a family where children are eligible for SCHIP to be Medicaid eligible if **income** is sufficiently low. The program in Illinois was started during the administration of Governor George Ryan at a very low percentage of the FPL. The eligibility threshold was gradually increased, culminating in the attempts under Governor Rod Blagojevich's administration to move it as high as 400% FPL. When Governor Blagojevich was removed from office in January 2009, one of the impeachment counts alleged that he violated the state constitution by broadening the eligibility of the program without first gaining legislative approval.

<sup>19</sup> Memo from Department of Healthcare and Family Services to the Special Investigative Committee of the Illinois House of Representatives, December 22, 2008.

### Nursing Home Residents by Age, 2007

	<i>Nursing Care*</i>	<i>Developmentally Disabled</i>	<i>Total</i>	<i>Percent</i>
Under 18	292	4	296	0.3%
18 to 64	20,327	7,660	27,987	30.6%
65 to 74	10,260	368	10,628	11.6%
75+	52,446	220	52,666	57.5%
Total	83,325	8,252	91,577	100%

*Source: Illinois Department of Public Health Annual Survey, 2007*

*Note: "Nursing Care" includes all patients who are not developmentally disabled, including persons with mental illness.*

Overall, Medicaid pays for about 60% of all nursing home care, and an even larger share of the under-65 nursing home utilization is paid for by Medicaid or otherwise by the state. It is also important to note that more than a quarter of long term care (LTC) expenditures, both for the elderly and the mentally ill/disabled, is spent for services other than nursing homes, such as home health care and adult day care.<sup>20</sup> These additional services reach a much larger number of individuals, although the expenditures per person are typically lower.

Medicaid payments for nursing homes are determined partially by formula and partially by legislative intervention. The core reimbursement system was frozen in 1994 and has been subject to a series of ad hoc adjustments. More recently, HFS has begun to phase in its own version of a system developed by the federal government based on an assessment of each patient that is converted to reimbursement through a series of standardized cost elements. However, since 1994 and as the new system is being worked out, nursing homes have continued to receive fairly regular cost-of-living increases. The legislation that created the 1994 "freeze" on nursing home rates specified that the "freeze" required specific re-enactment each year. As a consequence, there is an automatic vehicle for discussions and negotiations in the General Assembly. Nursing home rates have increased at a steadier rate than those of other providers. On the other hand, there is some data that seem to suggest that Illinois nursing home rates are low in comparison to other states. But it is hard to evaluate aggregate figures without some way of adjusting for differences in the severity of the underlying cases.<sup>21</sup>

There is widespread agreement among both advocates and state officials who oversee Illinois Medicaid that too many elderly and disabled people reside in nursing homes and that the state could save money and improve the quality of people's lives by moving more of them into community care settings. This issue drew the most support from officials who testified in April and May 2009 before the Medicaid subcommittee of Governor Pat Quinn's Taxpayer Action Board (TAB), which is charged with making recommendations for immediate savings on Medicaid and other areas of state government.

<sup>20</sup> U.S. Centers for Medicare & Medicaid Services Form-64s. [http://www.cms.hhs.gov/medicaidbudgetexpendsystem/02\\_cms64.asp](http://www.cms.hhs.gov/medicaidbudgetexpendsystem/02_cms64.asp). For the purposes of this paper, it was necessary to obtain data for federal FY2007 and FY2008 directly from CMS.

<sup>21</sup> Rates for Illinois Medicaid nursing home care vary by a factor of more than three. Given these differences, it is easy to see how case mix differences can substantially impact the overall average rate.

The state has recently added several programs to move patients to community settings. According to HFS data, 84% of all new spending on long term care between FY2004 and FY2007 was in non-nursing home settings.<sup>22</sup> Still, it is unclear whether these initiatives have had a significant impact. In FY2007, only 14 states and the District of Columbia devoted a smaller share of their long term care dollars to home and personal care services.<sup>23</sup> Illinois ranks last in the number of adults with developmental disabilities per capita served in settings of six persons or less, and 41 states have fewer developmentally disabled residents in state-operated institutions with 16 or more people.<sup>24</sup> Part of the problem, especially in programs for the elderly, is that Illinois programs do not provide a wide array of services and are not particularly flexible.

The impetus to move people out of institutions has a legal dimension. The state is facing three federal class-action lawsuits filed by advocates for the mentally ill and the physically and developmentally disabled.<sup>25</sup> The suits allege that the state has failed to comply with a 1999 Supreme Court opinion that held that unnecessary institutionalization of people with disabilities is discrimination under the Americans with Disabilities Act.<sup>26</sup>

Alternative-setting options to avoid nursing home care do not necessarily produce cost savings. Particularly in elderly populations, many of the people who take advantage of alternative settings would never end up in a nursing home anyway and, consequently, the programs do not generate net savings. However, there are definitely well-targeted programs that have created net savings.<sup>27</sup> Even if savings are modest, programs that improve the quality of Illinois citizens' lives may be a good investment.

Experts do not agree on how many people could reasonably be expected to be moved out of institutions, the pace at which they could be moved or how much additional money would be required to provide necessary supportive services in the community, such as affordable housing for the mentally ill. The DHS division of rehabilitation services told the TAB Medicaid subcommittee that about 14,000 people under the age of 60 who live in nursing homes and cost the state more than \$500 million a year could be moved to less restrictive settings, for a savings of more than \$250 million.<sup>28</sup> The division's home services program, designed to allow the physically disabled to live in their homes as independently as possible, costs roughly \$17,000 per person a year, compared with an average annual cost of \$36,000 for nursing home care.

The experts do, however, agree that the screening procedures used to determine whether the elderly and physically and mentally disabled require nursing home care cause too many people to

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<sup>22</sup> Illinois Department of Healthcare and Family Services Division of Medical Programs presentation to House Medicaid Reform Committee, March 26, 2009, p.43.

<sup>23</sup> The Kaiser Family Foundation, [statehealthfacts.org](http://statehealthfacts.org). It should be noted that there are some programs funded entirely with state funds and are therefore not included in this ranking.

<sup>24</sup> Illinois Department of Human Services presentation to TAB Medicaid subcommittee, April 17, 2009, p.17.

<sup>25</sup> *Williams v. Blagojevich*, No. 05-4673 (N.D. Ill. filed August 15, 2005); *Colbert v. Blagojevich*, No. 07-4737 (N.D. Ill. filed August 22, 2007); *Ligas v. Maram*, No. 05-4331 (N.D. Ill. filed July 28, 2005).

<sup>26</sup> *Olmstead v. L.C.*, 527 U.S. 581 (1999).

<sup>27</sup> H.S. Kaye et al, "Do Noninstitutional Long-Term Care Services Reduce Medicaid Spending," *Health Affairs* (2009, Vol. 28, No. 1), pp. 262-272.

<sup>28</sup> Illinois Department of Human Services presentation to Taxpayer Action Board's Medicaid subcommittee, April 17, 2009.

be placed unnecessarily in nursing facilities. Once people are placed in nursing homes, there do not appear to be consistent or rigorous so-called “post-screening” procedures to assess their ability to leave. Several state officials suggested that the testing criteria should be changed so patients with relatively little need for institutional care would not be eligible for state support in nursing homes.<sup>29</sup> However, such low-need Medicaid recipients are the most lucrative nursing home patients precisely because they require relatively little care. Officials from several state agencies told the Taxpayer Action Board that the strong political influence of the nursing home industry is regarded as an obstacle to such changes. Indeed, some state officials even suggested that, despite the fiscal implications, it might be necessary to provide aid to nursing homes, perhaps by buying out beds, in order to neutralize the potential opposition of the nursing home industry.<sup>30</sup>

Of particular concern in Illinois’ institutional care practices are state expenditures for patients in institutions that do not qualify for Medicaid funds. In Illinois, for-profit nursing homes known as **Institutions for Mental Diseases** (IMDs) provide care for about 4,300 mentally ill people. Federal rules preclude use of Medicaid funds for people between 22 and 64 years of age in institutions in which more than half of the patients have mental illnesses.<sup>31</sup> One of the federal class-action lawsuits against the state alleges that people are being illegally confined to IMDs and that the state should develop suitable community-living alternatives for them.<sup>32</sup> Similarly, the federal government does not provide Medicaid reimbursement for the 1,400 or so people living in state-run psychiatric hospitals, some of whom would be eligible for Medicaid if they could be moved to other settings.

The Illinois Department of Public Health annual survey suggests that in 2007 there might have been as much as \$400 million in state payments for mental patients who are not eligible for the federal Medicaid match. Because these patients are in non-Medicaid eligible facilities, other medical costs that would probably be Medicaid matchable, such as physician and drug costs, are not eligible. Expenditures for these other services are estimated to be about 75% of the cost of the institutional services, so the total unmatched state cost could approach \$700 million.

An aggressive program of developing alternative long term care settings that would be eligible for federal matching funds would allow Illinois to provide better treatment options for the same or less state money. However, development of alternative settings would surely be time-consuming and possibly expensive in the short run. One solution that Illinois, and other states, have used to some extent is place mentally ill patients in nursing homes that have a sufficiently high percentage of elderly that the mentally ill patients are able to be covered by Medicaid. The outcome of these steps has been decidedly mixed, resulting in some fiscal relief but often a decrease in the quality of care for elderly patients and sometimes even danger to the elderly patients.<sup>33</sup> HFS argues that the solution is for the federal government to allow Medicaid match

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<sup>29</sup> Testimony to Taxpayer Action Board’s Medicaid subcommittee, April 22, 2009.

<sup>30</sup> Testimony to Taxpayer Action Board’s Human Services’ subcommittee, April 22, 2009.

<sup>31</sup> These rules apparently result from the federal government’s desire to promote more community services and from their long-standing reluctance to assume the funding of state institutions that had historically been supported by the states.

<sup>32</sup> *Williams v. Blagojevich*, No.05-4673 (N.D. Ill. filed August 15, 2005).

<sup>33</sup> Carla Johnson, “Mentally Ill a Threat in Nursing Homes,” AP Wire, March 22, 2009.

for current facilities. Given, however, that the federal government has shown no sign of relenting and the state is facing legal action, it might be time to consider other alternatives.

Another pressing concern is the **Howe Developmental Center**, a state-run facility for the developmentally disabled in Tinley Park. The facility was decertified by federal authorities in 2007 after reports of substandard care and health and safety violations and no longer receives federal funding. Since decertification, the state has lost \$40 million in federal dollars and continues to lose \$2.2 million each month.<sup>34</sup> The facility is also under investigation by the federal Department of Justice for alleged violations of the civil rights of institutionalized persons.<sup>35</sup> DHS has recommended closing the facility and moving the 289 people now living there to community-based settings or other state operated developmental centers. It costs an average of \$186,573 a year to treat a patient at Howe, compared with \$142,533 in other state facilities, \$57,428 in privately-run intermediate-care facilities, \$53,291 in community-integrated living arrangements and \$19,852 for home-based services.<sup>36</sup>

The state's Commission on Government Forecasting and Accountability voted on April 28, 2009, to support DHS' recommendation to close Howe. However, the proposed action has triggered strong opposition from unions that represent Howe employees and from some families of disabled adults.<sup>37</sup> Governor Quinn had asked commission members to delay their vote while a consultant conducts an independent review of the facility. The governor has since indicated that he does not plan to make a decision on whether to support the commission's recommendation until the consultant's review is completed.<sup>38</sup>

### **Physician and Outpatient Care**

The cornerstone of any health care program is physician care. Although not typically the most expensive portion of the program, physician actions or lack of action drive very large portions of the actual costs. Whether or not, for instance, physicians provide appropriate preventive care has a great impact on whether more expensive interventions can be avoided. Despite some significant advances in recent years, the Illinois Medicaid program continues to face challenges in this area.

In 2007, HFS attempted to address the issue through the creation of **Primary Care Case Management** or "**primary care medical homes**" as a way of improving overall system efficiency in order to pay for the AllKids expansion. The idea of "medical homes" is that each beneficiary would have a specific medical provider that took substantial responsibility and received a small fee not simply for providing care as patients showed up but also for exercising

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<sup>34</sup> Illinois Department of Human Services Division of Developmental Disabilities response to the Commission on Government Forecasting and Accountability, January 9, 2009, p.2.

<sup>35</sup> Illinois Department of Human Services Division of Developmental Disabilities response to the Commission on Government Forecasting and Accountability, January 9, 2009, p. 19.

<sup>36</sup> Illinois Department of Human Services presentation to Taxpayer Action Board Medicaid subcommittee, April 17, 2009, p.26.

<sup>37</sup> Commission on Government Forecasting and Accountability website, Facility Closures, Howe Developmental Center, Public Comments as of April 27, 2009, <http://www.ilga.gov/commission/cgfa2006/upload/Public%20Comment%20Howe.pdf>.

<sup>38</sup> Governor's Office, State of Illinois, "Governor Quinn Names Expert to Examine Howe Center," News Release, May 4, 2009.

some consistent medical management. Theoretically, inefficient utilization, such as unnecessary emergency room visits or hospitalizations due to lack of preventative care, would be avoided by proper primary care management. The principle is **health maintenance organization**-type management but with more flexibility than a full-fledged HMO, which uses a fixed per patient payment for all services to put providers at full risk for services.<sup>39</sup> While the concept of primary care case management in a medical home as an alternative to HMOs is receiving considerable national enthusiasm, reliable evidence of wide-spread efficacy has not yet emerged.

Also in late-2007 HFS contracted with an outside firm, McKesson Health Solutions, to develop a **disease management program** focused on managing the costs of beneficiaries with expensive chronic diseases. Initiatives like this are particularly important since health care expenditures are distributed very unevenly, with a small percentage of Medicaid recipients accounting for a very large percentage of the spending. Nationwide, across all populations, the sickest 5% of patients account for 50% of all expenditures.<sup>40</sup> Illinois Medicaid expenditures are distributed similarly.

HFS reports that it has saved \$34 million by using the case management program, but it is not clear from its July 2008 “All Kids Preliminary Report” how those savings estimates were developed.<sup>41</sup> Nor is there yet evidence of significant reduction in the number of emergency room visits or hospitalizations for reasons that could have been avoided with good ambulatory care that the PCCM program was expected to produce. Moreover, anecdotal evidence from Chicago suggests that the approach of assigning Medicaid recipients to primary care providers, despite a few heartening success stories, has been largely a paper exercise, with little real involvement of recipients in many cases. If nothing else, however, the program suggests that there is sufficient primary care capacity for the expanded Medicaid program since each beneficiary is assigned to a primary care site.

Although PCCM took aim at one part of this issue, it did not address what happens to beneficiaries for whom medical issues are identified. Attempts to recruit specialists willing to see Medicaid recipients have not generated the same kind of response from specialist providers as the primary care medical homes, presumably because of low fees. Fees for primary care were raised substantially at the beginning of 2006 as part of a consent decree resulting from the Medicaid program’s failure to meet certain federal standards for primary care services.<sup>42</sup> Payments to **Federally Qualified Health Centers** (FQHCs), which provide primary care for a substantial portion of the Chicago Medicaid population, are reasonable in the context of other Medicaid fees.<sup>43</sup> But fees paid to non-primary care physicians remain substantially below the

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<sup>39</sup> While putting providers at full risk has some attractive qualities, providers usually require a premium to take this risk, often resulting in higher payments. Moreover, there is residual concern that when providers are at full risk, they have incentives to skimp on quality.

<sup>40</sup> This general distribution of health care costs has been well documented for at least the last 40 years. For a recent example, see: S. Zuvekas and J. Cohen, “Prescription Drugs and the Changing Concentration of Health Care Expenditures,” *Health Affairs* (2007, Vol. 26, No. 1), pp. 249-257.

<sup>41</sup> Department of Healthcare and Family Services, “All Kids Preliminary Report” (July, 2008), p. 16.

<sup>42</sup> This case is instructive in how difficult it can be to change the Medicaid program. The case was originally filed in 1992 but did not go to trial until 2004 as *Memisovski v Maram, 2004 U.S. Dist. Lexis 16772 (2004)*. The court found in favor of the plaintiffs, but it took virtually another year to hammer out the consent decree.

<sup>43</sup> FQHCs are neighborhood health centers that meet certain federal requirements in governance structure and the provision of care. Most receive federal grant money in addition to their ongoing rates, which in Illinois are set at a much higher percentage of costs than for most providers. While still not a large portion of the total Illinois program,

market. All services under AllKids—except where a family has its own insurance—are reimbursed at existing Medicaid rates. Thus, to a provider, AllKids and Medicaid are indistinguishable. For physician services, both pay poorly. A 2003 survey showed Illinois Medicaid ranked 42<sup>nd</sup> in physician payment.<sup>44</sup> Since that time, there have been no general rate increases in Illinois for non-primary care physicians, suggesting the possibility that the relative ranking has drifted even lower. Moreover, Illinois Medicaid reimbursement for hospital outpatient care, which is the appropriate setting for a large amount of specialty diagnosis and treatment, is reimbursed particularly poorly.<sup>45</sup> Although it is impossible to generate more specific data without a detailed analysis, it seems almost certain that the lack of resources in ambulatory care leads to increased hospitalization and other more expensive interventions.

## Managed Care

The most striking difference in how Illinois uses its Medicaid funds in comparison to other states is in the area of managed care. Across the nation, a significant portion of Medicaid funds are controlled by **Managed Care Organizations** (MCOs), typically some form of HMO.<sup>46</sup> While the specific arrangements differ widely from state to state, MCOs typically receive some fixed dollar amount per client from which they have to cover all expenses within defined categories of medical care. Evidence on performance of MCOs in other states is on balance modestly positive, although performance appears to remain very much a function of what other decisions the states make. The key to making Medicaid MCOs effective is to ensure that all—or at least a very large share of—beneficiaries are enrolled. Otherwise, managed care could cost the state more than it would to provide the same services through traditional approaches. This occurs because managed care reimbursement is typically a flat rate with no regard for the services actually offered to individual recipients. The rate is based on an average of the costs for all recipients, sick and not so sick. When MCOs cover only a small share of the population, they can focus on signing up only the healthiest patients, who have relatively lower costs. The flat paid rate by the state then overstates their costs because the MCO's population has a lower proportion of sick people than the state average on which the rate was calculated. This is the problem that has been encountered at the national level by the Medicare Advantage programs. Hence, absent a greater political will to make managed care enrollment mandatory in Illinois, the costs of managed care may be more than the state would have paid if those same beneficiaries had been reimbursed under fee for service.

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in urban areas there has been very considerable growth of FQHC provided primary care. See Kevin Sack, "Expansion of Clinics Shapes Bush Legacy," *The New York Times*, December 26, 2008.

<sup>44</sup>Ranking was 42 out of 51 (50 states and District of Columbia). S. Zuckerman et al, "Change in Medicaid Physician Fees, 1998 – 2003: Implications for Physician Participation," *Health Affairs On-Line*, posted June 23, 2004. (doi.10.1377/hlthaffW4.374)

<sup>45</sup> The importance of outpatient care only continues to grow. Recent analysis notes that chronic care, typically the patients on whose behalf the greatest expenditures are made, is moving to outpatient settings. (S. Decker et al., "Use of Medical Care for Chronic Conditions," *Health Affairs* (2009, Vol. 28, No. 1), pp. 26-35.) There is a possibility of incurring higher costs in other settings if reimbursement structures are obstacles to encouraging this trend for Illinois Medicaid recipients. There have been some selected increases for non-primary care physicians, but they are not widespread enough to really change this landscape.

<sup>46</sup> In FY2008, the national average of funds expended through MCOs was almost 20% as opposed to 2% in Illinois. (U.S. Centers for Medicare & Medicaid Services (CMS), Form-64s). Information on Form 64 can be found at [http://www.cms.hhs.gov/medicaidbudgetexpendsystem/02\\_cms64.asp](http://www.cms.hhs.gov/medicaidbudgetexpendsystem/02_cms64.asp). For the purposes of this paper, it was necessary to obtain more recent data directly from CMS.

In this area as in others, it is difficult to make comparisons among states' Medicaid programs. For instance, Illinois appears to spend a larger share of its total costs on hospitals than other states.<sup>47</sup> However, it is not clear how hospital costs are reported in other states since in many states a significant portion of these costs are channeled through managed care arrangements and may be categorized there. A more relevant measure would be overall expenditure per enrollee by category of recipient since that focuses on the total overall expenditure and partially adjusts for differences in patient population. When payments per enrollee are categorized by recipient, Illinois ranks low for most categories in comparison to other states.

**Total Payments Per Enrollee, Illinois Rank  
Federal FY2006<sup>48</sup>**

Payments per Child	46th
Payments per Non-Disabled Adult	45th
Payments per Elderly	49th
Payments per Disabled Adult	23th

These numbers raise questions about the extent of the savings available in moving to managed care, since Illinois is already paying at relatively low levels.<sup>49</sup> Regardless of the level of savings, managed care options might improve the coordination of care for the aged and particularly for the disabled, which is where Illinois' relative costs are highest.

### **Hospitals**

In Illinois, there are two important aspects of hospital spending. First, it appears that hospital expenditure increases are being driven almost exclusively by changes in the **provider assessment program**, which do not require additional state funds. The picture, however, is complicated because massive shifts in payments from one fiscal year into the next to deal with cash flow issues confound other potential changes. Second, the underlying mechanisms of Illinois Medicaid hospital reimbursement are extremely dated and the system is held together by a series of ad hoc adjustments that lack a coherent policy structure.

Provider assessment systems are mechanisms to exploit the nature of the federal match. Providers, including both hospitals and nursing homes, agree to "tax" themselves. That tax is effectively matched by the federal government, and the net accrues to the providers without requiring additional state money. Not surprisingly, the federal government subjects such programs to periodic review. Illinois' hospital assessment program was most recently reviewed in 2008 with an increase and an extension through FY2013. In total, of the original 2009

<sup>47</sup> The Kaiser Family Foundation, *statehealthfacts.org*, data for federal FY2007.

<sup>48</sup> The Kaiser Family Foundation, *statehealthfacts.org*, data for federal FY2006.

<sup>49</sup> While these numbers probably give a more accurate picture of the overall relevant Illinois reimbursement, they do not take into account the distribution of illness within each category. If, for instance, the relevant eligibility requirements are steeper in other states, it might mean Illinois has fewer really sick people in these categories, which would depress the relative ranking. But without a comprehensive study, it is hard to understand accurately the differences among states.

hospital appropriation of \$4.3 billion<sup>50</sup>, \$1.6 billion was the provider assessment program with about \$900 million of that amount paid by providers—rather than coming from state funds—and the balance from the federal match.

Of total reimbursement actually received by the hospitals, 20% is the net from the assessment system and 80% is from the previously existing system, also described as the “base” system to which proceeds from the provider assessment scheme are added.<sup>51</sup> This 80% has two main components, a “base” system and various “add-on” payments. The inpatient base system was adopted in the early 1990’s, was promptly frozen, and has not been updated since. The outpatient base system was adopted later in the 1990’s but was also frozen shortly after adoption. Reimbursement for hospital outpatient care—the most rapidly growing part of hospital care—is particularly outdated and inadequate. Rather than addressing the core system, HFS has created successive layers of stop-gap adjustments designed to narrowly address specific problems. Material provided by the Illinois Hospital Association shows that there are currently 16 “add-ons” in place. The strength of these adjustments is that they direct funds to particular needs. There are, however, several problems: Some of the “needs” are very narrowly targeted, most of the adjustments are based on utilization data that are many years old and the bulk of the adjustments are not at all volume sensitive. That is, the hospital gets the adjustment even if it is decreasing the services in that category or gets no additional funds if it is increasing those services.

In sum, the overall framework of hospital reimbursement lacks a coherent policy structure. It is subject to political pressure and cumulative ad hoc changes in response to targeted lobbying efforts, is administratively very difficult for both hospitals and HFS and creates insufficient incentives to accept more Medicaid patients. There is no evidence that hospitals are overpaid; Medicaid reimbursement across the state averages less than hospitals’ actual costs for providing care. On the other hand, at least in regard to inpatient care, hospitals are more likely to recoup a higher percentage of their actual costs than most other providers. The outpatient area, however, needs attention, in large part because, as described earlier, low rates there may result in avoidable inpatient care, which increases net costs.

## **Prescription Drugs**

It is difficult to determine the most useful numbers to use in analyzing prescription drug costs. The state budget reports “gross” costs, which are before very significant rebates from manufactures.<sup>52</sup> Under the rebate program, Medicaid programs are entitled to special low rates that have been negotiated using the leverage created by the size of Medicaid purchases. Illinois’

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<sup>50</sup> This amount does not include funds cycled through Cook County and the University of Illinois trust funds, which are appropriated separately. Medicaid services provided at Cook County do not use state funds but rather use the state as a conduit to receive the federal match for county funds. Note, also, that supplemental appropriations to comply with ARRA terms have increased the total amount of appropriation, but not changed the provider assessment amounts.

<sup>51</sup> Hospitals actually receive a larger amount from the provider assessment, but they also pay into the assessment fund. The above is focused on the “net” reimbursement—the amount that the hospitals actually net as a result of the federal match on the provider assessments.

<sup>52</sup> They are reported this way because HFS has to pay out the gross amount (for which it requires budget authority) and only gets the rebates subsequently. Reporting from the federal government, however, is after the rebates have been applied.

rebate, one of largest in the nation, equals almost half of the total costs. When after-rebate costs are compared with other states as reported by the federal government, Illinois Medicaid costs appear slightly higher than average, but not remarkably so.<sup>53</sup> Moreover, it is hard to discern how much of that difference is due to the way expenditures are recorded.

Although drug costs in the Illinois Medicaid program, like most states, have increased quite rapidly over the last dozen years, steps are being taken to control costs. As discussed above, Medicaid programs have exceptional bargaining leverage on drug costs and it is widely acknowledged that Medicaid has used this leverage to obtain the lowest across-the-board costs in the market. In addition, HFS has undertaken some of the same initiatives as other states that have resulted in managing utilization and moving more prescriptions to generics. Periodically this presents some clinical problems, but by and large this is a sensible response to drug costs. Meanwhile, pharmaceutical firms have slowed their introduction of new drugs. For society this is a mixed blessing, but it clearly reduces pressure on government sponsored programs.

The evidence is fairly strong that, on balance, effectively run prescription programs prevent hospitalization and other more expensive services. Likewise there is also evidence that more aggressive approaches to drug savings (e.g. capping number of prescriptions, or substantially increasing co-payments) can cause harm and do not save money long run.<sup>54</sup>

If Illinois costs are higher than other states, one area to look at may be the dispensing fee which is reported to be one of the highest in the nation.<sup>55</sup> The dispensing fee is the flat fee paid to pharmacies for dispensing a drug. Typically, this is a relatively small part of the total expenditure (about 10% of the after-rebate costs) but the size of the Medicaid programs makes it important to look this issue.

Another issue of concern related to prescription drugs is that the **Illinois Cares Rx**, the state's prescription program for seniors and the disabled with incomes up to 200% of the FPL, costs roughly \$130 million a year and is entirely funded by the state. The program was started prior to the inception of prescription drug coverage under Medicare Part D but the state opted to continue extra benefits for Part D-covered enrollees and to continue benefits to enrollees who were not eligible for Part D. The federal government does not match this expenditure.

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<sup>53</sup> CMS Form 64, federal fiscal year 2008.

<sup>54</sup> P. Cunningham, "Medicaid Cost Containment and Access to Prescription Drugs," *Health Affairs* (2005, Vol. 24, No. 3), pp. 780-789; D. Goldman et al., "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," *Journal of the American Medical Association* (2007 Vol. 298, No. 1), pp. 61-69; P. Neumann et al., "Are Pharmaceuticals Cost-Effective?" *Health Affairs* (200, Vol. 19, No. 2), pp. 92-109; S. Soumerai, "Benefits and Risks of Increasing Restrictions on Access to Costly Drugs in Medicaid", *Health Affairs* (2004, Vol. 23, No. 1), pp. 135-146. These articles are not arguments against all kinds of controls on prescription expenditures and they show some are quite effective. Rather, they raise concerns about overly aggressive approaches being counterproductive.

<sup>55</sup> Jay Lucas and John Stephen, Testimony Before the Illinois Senate Deficit Reduction Committee on Health Care, (March 10, 2009). Industry representatives agree that the dispensing fees are relatively high, but counter that it is particularly difficult to collect the copayment Illinois assesses on Medicaid recipients, which effectively reduces the dispensing fee.

## Cash Flow Issues

Delays in payments for Illinois Medicaid providers are a perennial problem. For FY2005 to FY2007, the deferred liabilities, or amount of expenditures in one fiscal year made from the following year's appropriation, averaged about \$1.8 billion.<sup>56</sup> Earlier in the current fiscal year, it appeared that the problem was going to be particularly acute in FY2009 due to the lack of budget agreement between the governor and the legislature. However, federal stimulus money became available under the ARRA and the payment cycle is declining. Illinois had little choice in how to use those dollars, because one of the conditions of the additional funds from the stimulus package is that the payment cycle to practitioners be reduced to 30 days by June 30, 2009. HFS estimates it will be possible to reach and maintain this goal, at least as long as there is ARRA money, which is between \$700 and \$800 million each year.<sup>57</sup>

It is difficult to assess the fundamental impact of these delays on providers. The state has been able to make enough special payment arrangements for large institutional providers to avoid a major collapse over cash flow issues. There are also payment exception rules for some smaller providers with high Medicaid volumes that help ameliorate the problem. But it is inevitable that these kinds of payment delays and erratic cycles have the impact of reducing real reimbursement levels and serve as a disincentive to participate in the program.<sup>58</sup>

## Federal Match Rate

The rate at which the federal government matches state Medicaid expenditures is based on a formula estimating state wealth. Illinois's match rate of 50%, the lowest possible, has been debated almost since the beginning of the program. In 2008, Illinois accounted for only 3.0% of federal expenditures on Medicaid although the state has 4.2% of the country's population and 4.0% of the people below poverty level. Most of the large industrial states have the same match rate and feel similarly aggrieved.

Given the size of the program, however, there has been reluctance in Washington to make changes in such a fundamental piece of architecture. Periodically, however, the match rate has been temporarily boosted as an economic stimulus. This happened around 2003 due to an economic downturn and is now a key part of the ARRA. This is a temporary increase from 50.32% to 60.48%, extending only from October 2008 until the end of 2010.

## CONCLUSION

The Medicaid program in Illinois, as in other states, provides essential health care coverage to significant and vulnerable segments of the population in the context of an overall American healthcare system that is marked by considerable decentralization and lack of coordination. Because the Medicaid program is a very large portion of the Illinois state budget, it needs

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<sup>56</sup> Office of the Illinois State Comptroller, *Fiscal Focus*, July 2008, p.7.

<sup>57</sup> The ARRA increases the Illinois match to 60.48% from 50.32% in aggregate. This increase has two components, flat 6.2% additional match from October 2008 through the end of 2010 that is uniform across all states and a formulaic adjustment related to the state's unemployment. A condition of receiving the increased match is that the state may not decrease Medicaid eligibility.

<sup>58</sup> See, for instance, Cunningham and O'Malley, "Do Reimbursement Delays Discourage Medicaid Participation by Physicians," *Health Affairs On-Line*, Posted November 18, 2008. (doi:10.1377/hlthaff.28.1.w17)

constant scrutiny and review to ensure that the expenditures are appropriate, are targeted at the highest priorities and do not exceed the state's resources.

Based on an initial review of the program, the following areas deserve particular attention:

- **Institutional and long term care:** Illinois lags behind other states in developing alternatives to institutional care for the elderly and disabled. Providing care in community settings offers not only opportunities for substantial savings but also the possibility to improve the quality life for many people. Of particular concern are the hundreds of millions of dollars that Illinois spends annually on institutional care for the mentally ill that is not eligible for federal reimbursement. Similarly, the state is losing millions of dollars a year in federal matching funds for the Howe Developmental Center, a state-run facility for the developmentally disabled that has been decertified by federal authorities. Given the amount of money at stake, it should be a high priority to review the total set of Illinois expenditures for nursing home and long-term care, with a particular emphasis on addressing non-Medicaid expenditures and alternative setting options.
- **Physician and hospital outpatient care:** Illinois' reimbursement rates for specialty physicians and hospital outpatient care have been low, a fact that is particularly troubling given that the trend in treatment of chronic ailments is moving to outpatient care. Because reimbursement rates for specialty physicians remain substantially below the market, Medicaid patients have trouble getting access to specialists such as psychiatrists, thus fostering the need for more expensive acute care. The overall efficacy of the medical home concept is undercut if there are insufficient resources to refer patients as problems are identified. A high priority for further consideration of the Medicaid program would be to better understand how the **Primary Care Case Management** and **Disease Management** programs are actually working and how the access to specialist physicians is affected by the existing rate structure.
- **Managed care:** Illinois enrolls a smaller percentage of Medicaid recipients in managed care than other states. Currently, as an alternative to health maintenance organizations, the state has focused on its **Primary Care Case Management** program, which connects each beneficiary with a primary care "medical home." This is a promising option and could be the cornerstone for broad-scale changes in the Medicaid program, but the state has not yet provided enough evidence to assess the program's success. Greater HMO enrollment is also worth considering, particularly for the aged and disabled.
- **Medicaid eligibility expansion:** Illinois has expanded eligibility without sufficient provisions in the budget to fund the expansion. The increase in the allowable income levels for aged, blind and disabled people had a significant effect on both program enrollment and costs. The fundamental issue for Illinois in regard to eligibility is how much expansion it can afford in relation to other needs. On the one hand, there is no question that lack of insurance is a real hardship for residents. On the other hand, the costs of expanding eligibility—particularly when there is no federal match—suggest that such proposals should be scrutinized carefully. Achieving a stable and consistent approach to eligibility in Illinois should be a high priority for future action.

- **Prescription drug costs:** Core Medicaid pharmaceutical expenses are similar to other states, but additional savings may be available. There is evidence that the state pays relatively high fees to pharmacies to dispense prescription drugs to Medicaid recipients. In addition, the state spends \$130 million on the Illinois Cares Rx program, which is not matched by federal funds. Covering these expenses is obviously a good thing for the recipients because prescription co-payments, even under Medicare, can become quite expensive. The question is whether this is the most effective use of the available funds.
- **Payment delays:** The Medicaid payment cycle bears the brunt of the state's cash flow problems and provider payments are historically in arrears. This problem will be solved in the short term by the use of federal stimulus funds made available by the American Recovery and Reinvestment Act of 2009, but Illinois needs to take steps to make a stable payment cycle a sustaining part of the program. No one disputes that long payment cycles are an indicator of an insufficiently funded program. The solution is straightforward: appropriate more money. The question, of course, is what should be traded-off to reduce pay cycle issues. However, once Illinois reaches the revenue cycle mandated by ARRA, it should commit to maintaining that cycle rather than using the payment cycle as a way to float otherwise unbudgeted expense increases.

## **CIVIC FEDERATION RECOMMENDATIONS**

The Civic Federation calls on the General Assembly to establish a joint legislative commission to launch a review of the future financing of the state's Medicaid program. Included in the review must be a plan to compensate for the expiration of the federal stimulus program on December 31, 2010. With the additional federal match scheduled to end in 19 months, the state should prepare now for the \$1.3 billion budget gap that will be created in 2011.

### **Comprehensive Review of the Program**

The Civic Federation recommends that the state appoint a joint legislative and gubernatorial commission to take a detailed look at the entire program. The governor's Taxpayer Action Board is raising many of the same issues, but it faces a short times frame to develop recommendations and is charged with evaluating a range of other topics in addition to Medicaid.

The commission should focus on ensuring that upon the expiration of the federal stimulus program on December 31, 2010:

- Illinois has structured expenditures to maximize Medicaid reimbursement;
- Expenditures are targeted where they can do the most good; and
- Programs are viewed in the context of providing overall health care to recipients as opposed to simply controlling spending within individual programs. For instance, greater expenditures on alternative-setting long term care or on outpatient care management

might yield greater benefits at the same or lower expenditures than spending on nursing homes and inpatient hospitalization.<sup>59</sup>

### **Medicaid Management Group**

The Civic Federation recommends that Governor Quinn establish an executive-level management group to help state agencies pursue a coordinated strategy on Medicaid. Medicaid issues cut across budgetary categories. Therefore, it is essential to make sure that actions that would improve the quality of care for patients and create a net reduction in costs across the budget are not blocked because they might increase another category of expenditures.

### **More Transparent Program Reporting**

The Civic Federation recommends implementing greater transparency mechanisms for the state's Medicaid reporting. The budget is difficult to understand as it pertains to Medicaid since it confounds changes in payment cycles, eligibility standards and inflation-related adjustments built into existing programs. The fact that legislators, taxpayers and other interested parties now lack comprehensive information on the Medicaid program tends to give too much power to provider groups, who understand the issues much better than the General Assembly.

HFS is required to produce an annual report for the General Assembly. This report typically contains much useful information but leaves many of the critical questions unanswered. One alternative is to require HFS to make this annual report more comprehensive and more rigorous than the current document and to file the report no later than March 1 of each year. Certain data elements need to be specifically prescribed in order to develop meaningful and consistent information. At a minimum, this report should include program expenditures, liabilities and enrollment and comparisons to other states in similar formats for each program. It should provide both current data and data that show trends over time. It should also provide a consistent listing of policy changes, an explanation of expenditure changes and an explanation of how various funding sources interact to yield net state expenditures. The opportunity for a neutral group of experts to review and respond to the report annually would also be beneficial.

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<sup>59</sup> A recent article on managing the costs of chronic care in the British National Health Service makes the following point: "...the evidence indicates that it is the cumulative effect of different elements in the Chronic Care Model that is likely to have the greatest impact, rather than the individual elements." C Ham, "Chronic Care in the English National Health Service: Progress and Challenges," *Health Affairs* (2009, Vol. 28, No. 1), pp. 198.