Assessment of Medicaid Managed Care Expansion Options In Illinois

Prepared for:

Commission on Government Forecasting and Accountability

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APPENDICES

EXECUTIVE SUMMARY

Illinois stands in stark contrast to virtually all other large states in the modest degree to which its Medicaid program has adopted managed care techniques. Throughout the country states have adopted successful managed care models, achieving their goals of decreased medical costs, better access to services and increased quality of care. For states considering implementing or expanding managed care models, this may be the best time to move forward. The national experience suggests an unprecedented "seller's market" clearly exists in Medicaid today.

All models of Medicaid managed care have potential shortcomings that must be carefully addressed throughout the program design, implementation, and oversight stages. The "seller's market" translates into a prime opportunity for states to design program rules and contract specifications to address any concerns with a model and still find a strong array of experienced Medicaid managed care vendors competing aggressively for contracts. Also, by moving forward after so many other states, Illinois has the opportunity to adopt key design features and oversight functions based on others' experience.

Through our analysis, Lewin has designed a series of recommendations for expanding capitated (HMO-only model) managed care in some areas of the state and managed fee-for-service (FFS), including Primary Care Case Management (PCCM), disease management and complex care coordination, in other areas.[1] Collectively, we anticipate that this approach will yield large-scale, efficiency-driven savings and will improve access and health outcomes for the beneficiary population. Savings of nearly $200 million (see Table ES-1) are projected for the first year of full implementation, and these savings increase substantially in each subsequent year as the program matures.[2] The savings can be of great importance in helping State policymakers preserve Medicaid eligibility, benefits, and provider payment rates during "lean years," and can help finance coverage expansions should the overall fiscal climate improve.

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[1] The Executive Summary provides an overview of recommendations. For more detailed information on each recommendation, see Section VII.

[2] Sufficient resources will need to be allocated to DPA to administer the procurement, and to conduct ongoing program oversight. The costs of ongoing oversight are factored into the above savings estimates. The "development costs" of conducting the procurements and modifying MIS systems to accommodate the new programs are not included in Table ES-1. These costs are estimated to be less than $5 million.

Table ES-1. Savings Associated With Implementing Recommended Model In Each Area*

	Collar County Area: HMO Model (11 Counties)	Selected Zip Codes in Cook County: HMO Model**	Remainder of Cook County: (FFS Yrs 1-2, HMO Yrs 3-5)**	East St. Louis Area: HMO Model (8 Counties)	Remaining 82 Counties (Managed FFS)	Total Savings
Year 1	$49,476,232	$19,426,345	$73,120,559	$13,721,981	$36,977,406	$192,722,523
Year 2	$61,382,542	$25,065,503	$91,261,447	$17,966,146	$46,202,486	$241,878,124
Year 3	$75,301,316	$31,669,322	$110,082,622	$22,977,462	$57,118,050	$297,148,773
Year 4	$91,585,510	$39,404,835	$142,037,850	$28,896,864	$70,039,224	$371,964,284
Year 5	$110,655,987	$48,470,613	$179,459,494	$35,893,326	$85,343,431	$459,822,852

* Figures represent savings from both Federal and State contributions to Medicaid; state share of these savings would be 50 percent of each amount shown above.

** Figures assume Cook County Bureau of Health Services will be "held harmless" from savings.

Recommendation 1. Immediate development of a mandatory enrollment capitated program in the "extended Collar County" and "extended East St. Louis" areas (collectively encompassing 19 counties) is recommended[3], in which all non-Medicare and non-spend-down Medicaid recipients would be enrolled. This would involve a competitive procurement for contracts, with no more than three health plans being selected to serve the Collar County area and no more than two health plans selected to serve the East St. Louis area. The State's RFP would define in detail the desired program features and requirements. Such features should include (but would by no means be limited to):

- Extensive prohibitions on marketing activities (complete elimination of individual marketing is recommended), relying instead on an independent enrollment broker contractor to facilitate beneficiary choice among selected health plans.
- Clear delineation of the outreach and education activities that are required to promote EPSDT and other preventive services, as well as to facilitate understanding of the HMO's delivery system and promote access to all needed services.
- Detailed rules about provider network composition and payment terms, to ensure that the program is designed to truly "manage care" and becomes a vehicle to help prop up, rather than drive down, Medicaid payment rates to physicians, hospitals and clinics.
- Inclusion, if desired, of a premium tax mechanism to replace and restore safety net funds that could be lost by reducing the days that are "countable" for the existing provider assessment program.

Note that conversion to capitation creates immediate accrued savings but imposes a short-term cash flow cost. We recommend that enrollment of the capitated program be

[3] The extended Collar County area includes the following 11 counties: Winnebago, Boone, McHenry, Lake, DeKalb, Kane DuPage, Kendall, Grundy, Will and Kankakee. The extended East St. Louis area includes 8 counties: Madison, St. Clair, Monroe, Randolph, Perry, Franklin, Jackson and Williamson.

phased-in gradually across at least a 12 month period, and that other mechanisms be deployed as needed to address the cash flow situation. It would be extraordinarily "penny wise and pound foolish" for the State to avoid implementing the capitated model due to the short-term cash flow issue.

Recommendation 2. We do not see adequate value in continuing the existing voluntary capitation program in Cook County. We recommend that this program be phased out of existence in conjunction with the immediate creation of a similar-sized (e.g., approximately 150,000 enrollees) mandatory capitation program in selected zip codes within Cook County. These zip codes should be chosen in a manner that minimizes IGT impacts, i.e., where relatively low usage of the Cook County Bureau of Health Services facilities is occurring.[4] Existing health plan contractors would have in-state experience that might provide them an edge in securing contracts under the mandatory enrollment program, but we recommend that competitive procurement of these contracts be open to all willing bidders such that no organization is ensured an award.

Recommendation 3. In the remainder of Cook County, we recommend immediate exploration of options for implementing a mandatory capitated model in Cook County, focusing on modifying the existing IGT arrangement in ways that are acceptable to CMS and that would permit the most cost-effective model of Medicaid coverage (mandatory capitation) to be used in Cook County while preserving the "safety net" role of the Cook County Bureau of Health Services. There are many possible paths to overcoming the IGT barrier, including obtaining a waiver that explicitly channels the Federal funding that is occurring to the Cook County Bureau of Health Services (while allowing a capitated program to occur), carving out inpatient care at the Bureau's facilities from the capitated initiatives (but requiring/encouraging channeling of patient volume to the Bureau), and other options. However, the certainty of any given path being workable cannot be determined without developing the detailed options and engaging in dialogue with CMS.

Recommendation 4. In all other areas of the State (82 counties), we recommend immediate development of a managed FFS program which combines primary care case management and complex care coordination program for the Family Health, SCHIP, and DCFS ward populations. In these same areas for the non-Medicare disabled population, we recommend this same model, but with the addition of disease management.[5] These fee-for-service based models would be administered through a contract with one or more qualified vendors through a carefully designed procurement (again stipulating all the State's desired features regarding access, cost savings, risk-sharing, payment terms, etc.). We further recommend that a strong performance-based payment model be incorporated in the PCCM, disease management, and complex care coordination programs to promote and reward the financial, clinical, and access outcomes the State is seeking to achieve.

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[4] Lewin did not conduct zip code level analyses and thus cannot provide detailed guidance on which zip codes meet these criteria. Several portions of Cook County appear promising in terms of not being near the Bureau's facilities.

[5] The timing of IGT solutions in Cook County should dictate whether managed FFS models are implemented in the portions of Cook County that are not part of the mandatory zip codes. If the State believes there is a clear path to resolving IGT issues within two years, for instance, the managed FFS option should probably not be implemented. If, however, the timeframes are extended, it may be worthwhile to implement managed FFS on an interim basis to maximize managed care savings in the near term.

Recommendation 5. While this opportunity has not been analyzed in detail or factored into the cost projections, once the PCCM/DM/CCC model is successfully implemented, we encourage the State to pursue a demonstration initiative with CMS to apply this model to the dual eligible population. While our study has predominantly excluded dual eligibles from our assessment, this subgroup's Medicare PMPM costs are enormously high and we believe the managed FFS model is very well-suited to addressing the needs of non-institutionalized dually eligible seniors and disabled persons. An arrangement could perhaps be implemented whereby the State would share 50/50 with CMS in the total (Medicare plus Medicaid) net savings the dual eligible program creates.

We believe an exceptional opportunity exists for Illinois to both improve the coverage its Medicaid beneficiaries receive and to achieve large-scale savings through implementing the recommendations in this study. When done well, Medicaid managed care programs represent "Medicaid at its best" – delivering an array of access enhancement, outreach and education services, providing all recipients with a medical home, achieving financial savings, and creating a meaningful and accountable system of coverage where multiple aspects of the program's performance can be tracked.

I. INTRODUCTION

The Commission on Government Forecasting and Accountability (Commission) retained The Lewin Group (Lewin) to perform an actuarial assessment of the cost-effectiveness and feasibility of various approaches to expanding the use of managed care in the State's Medicaid program.[6]

As in many other states, Illinois is facing serious budget shortfalls at a time when medical costs and enrollment in the State's Medicaid program are increasing rapidly. Illinois' average Medicaid covered population increased 9.7 percent from 2003-2004 including the SCHIP program (in which enrollment more than tripled), and enrollment still increased by 6.0 percent if SCHIP is excluded.

Our project does not involve purely a financial assessment or perspective. It is readily within the State's power to achieve budget savings to the Medicaid program through cuts in provider payment rates, benefits, and/or eligibility. All of these approaches significantly worsen the program for the beneficiary population, however. Our objective is to explore and identify Medicaid managed care approaches that will both save money (staving off the need to impose cuts on the program) and strengthen the quality of the coverage beneficiaries are receiving.

[6] Note that the Commission has undergone a name change in early 2005; previously it was named the Illinois Economic and Fiscal Commission (IEFC).

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II. SUMMARY OF EXISTING MEDICAID PROGRAM CONFIGURATION IN ILLINOIS

A. Eligibility Categories Assessed

For purposes of our analyses, the Medicaid population has been divided into four major eligibility groupings:

- Aged, Blind and Disabled
- Department of Families and Children Wards
- Family Health Plans
- SCHIP

The average size of each of these population groups during fiscal year 2004 (which extends from July 2003 through June 2004) is presented in ***Table 1***. Because there are significant challenges in coordinating care for Medicaid beneficiaries who also have Medicare coverage (the "dual eligible" population), the vast majority of our analyses predominantly excludes this subgroup. Similarly, persons who obtain Medicaid eligibility through the program's spend-down provisions have been excluded, as a large portion of these persons' costs are covered through retrospective eligibility and their coverage duration going forward is often too short to be effectively influenced by a managed care program. Our study therefore focuses on the approximately 1.5 million beneficiaries who are neither dually eligible for Medicare nor in the "spend-down" category. Because the vast majority of aged persons in the Aged/Blind/Disabled category are dual eligibles, the subgroup within this population (42 percent) that is being analyzed in terms of managed care interventions is hereafter referred to as the "disabled" or the "Medicaid-only disabled" population.

Table 1. Medicaid Beneficiary Population Distribution by Major Eligibility Category, FY2004

Eligibility Group	Aged, Blind, Disabled	Wards of DCFS	Family Health	SCHIP	Total
Medicare (Duals)	218,459	42	4,043	1,439	223,982
Spend-Down Eligibles	31,608	31	29,763	6,051	67,452
Spend-Down & Medicare	26,867	3	422	189	27,481
Neither Spend-Down Nor Medicare	158,859	68,055	1,196,001	81,539	1,504,454
Total	**382,059**	**68,124**	**1,229,385**	**88,840**	**1,768,408**
Percent Neither Spend-Down Nor Medicare	42%	100%	97%	92%	85%

Figures represent average number of persons enrolled in Medicaid during FY2004 (as opposed to total number of persons covered at any point during the year).

B. Spending Levels that can be Influenced by Managed Care

The non-Medicare, non-spend-down population comprised 85 percent of Illinois' Medicaid beneficiaries during 2004, and accounted for 59 percent of Medicaid claims expenditures.

Figure 1. Distribution of Population and Costs, FY2004

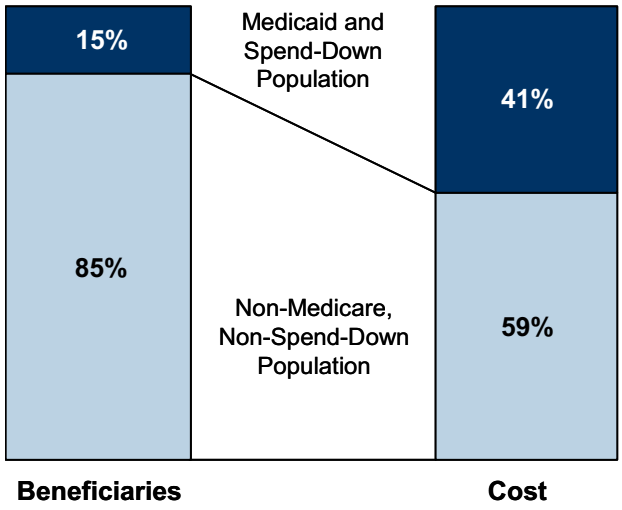


Table 2 summarizes total FY2004 claims costs in a variety of medical services categories, separating all Medicaid beneficiaries and those who did not have Medicare coverage or spend-down status. Note that all figures presented in this report, unless otherwise stated, represent total Medicaid funds—the Federal and State shares combined.

Table 2. FY2004 Claims Costs by Medical Service Category

Population Group	Inpatient	Nursing Home	Other Inst.	Pharmacy	Capitation	Waiver	All Other	Total
Non-Medicare, Non-Spend-down	$1,757,866,911	$287,990,284	$262,015,316	$781,475,139	$202,096,921	$212,384,185	$1,557,687,927	$5,058,496,741
All Medicaid	$2,003,360,112	$1,513,550,755	$726,911,037	$1,556,049,135	$207,812,028	$655,693,152	$1,861,597,995	$8,517,542,616

Note: Pharmacy claims costs shown are prior to collection of rebates.

In ***Table 3,*** the "Adjusted Total" column excludes nursing home, other institutional, and waiver services claims. The Medicaid managed care models being assessed in this study are not expected to significantly influence costs in these categories.[7] These reductions lower the amount of annual claims costs that can be impacted by the managed care models in this evaluation to approximately $4.3 billion.

[7] Note that some Medicaid managed care organizations (e.g., EverCare, a subsidiary of United Health Care) target the long-term care population and seek to lower costs and cost escalation rates for these subgroups. Evaluating Medicaid Managed long-term care options was not included in the scope of this engagement.

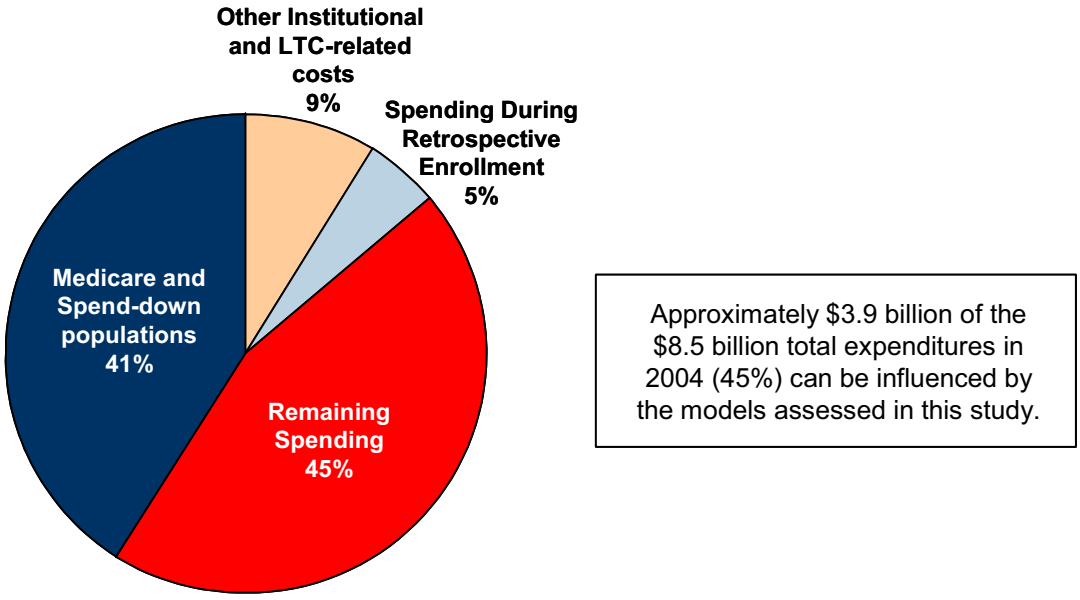
Table 3. Claims Costs Net of Long-Term Care and Other Institutional Costs

Population Group	Total	Adjusted Total
Non-Medicare, Non-Spend-down	$5,058,496,741	$4,296,106,955
All Medicaid	$8,517,542,616	$5,621,387,672

Note: Inpatient costs at acute care hospitals are included in both columns. Both columns include pharmacy expenditures prior to collection of rebates.

The claims costs that can be influenced are further reduced by factors such as retrospective eligibility (whereby, for example, an uninsured woman delivers her baby and is retrospectively enrolled in Medicaid such that the costs already incurred are covered). We estimate that approximately five percent of Medicaid costs are related to retrospective coverage periods. Thus, less than half (about 45 percent) of the State's overall Medicaid claims costs (which totaled approximately $8.5 billion during FY 2004) are amenable to being influenced by the models Lewin is evaluating. This distribution is presented in ***Figure 2.***

Figure 2. Distribution of FY2004 Medicaid Expenditures



C. Geographic Areas Assessed

This evaluation encompasses every region of the state. For many of the analyses, the State has been divided into the five regions commonly used by DPA and other entities in conducting Medicaid analyses. These regions are shown in the map below (***Exhibit A***). A crosswalk of the counties included in each region is presented in ***Appendix 1***, which also indicates the average size of the non-Medicare, non-spend-down population at the county level during FY2004 in each major category of assistance.

Exhibit A. Map of Five Regions

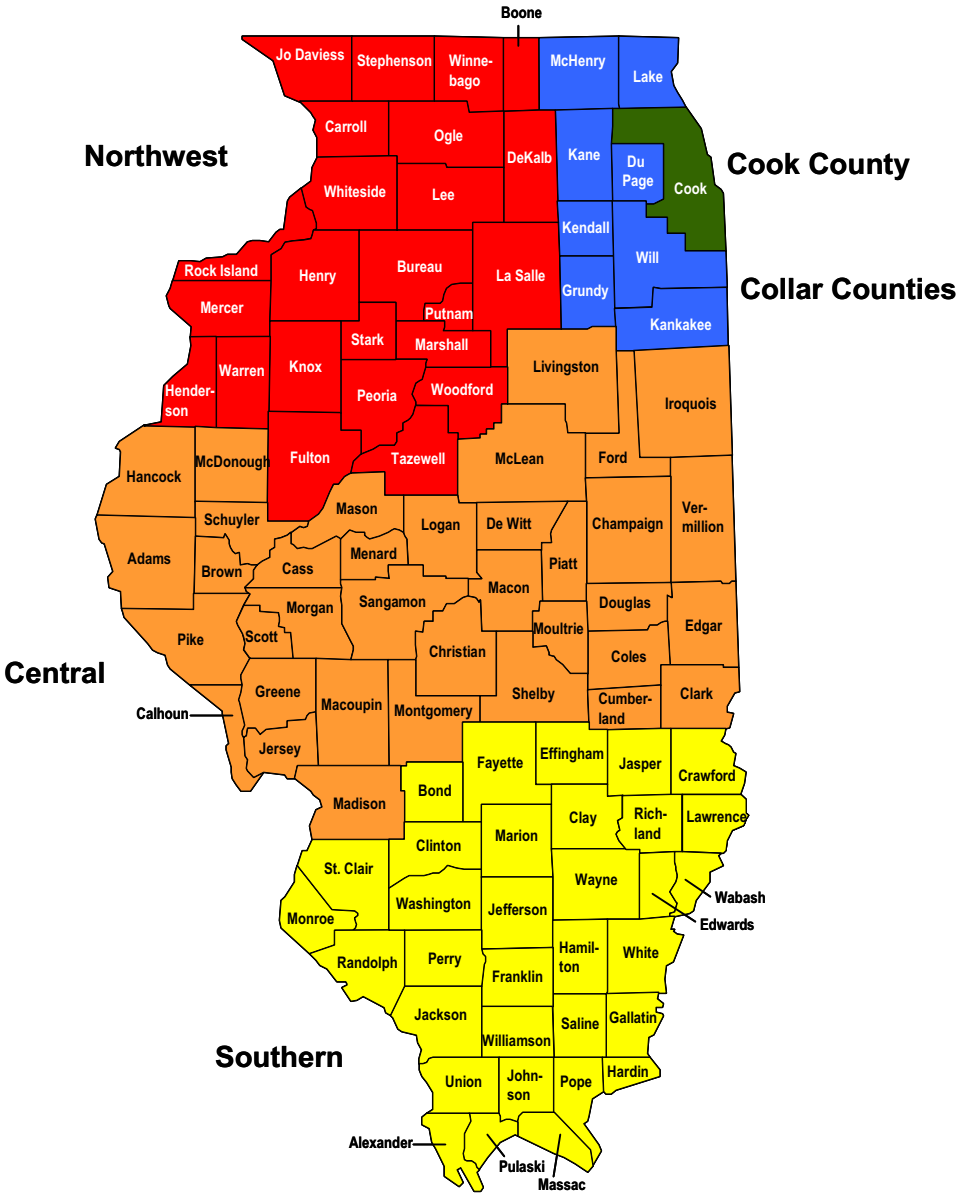


Table 4 presents the distribution of this population by region and category of assistance in both 2003 and 2004.

Table 4. Distribution of Illinois Medicaid Population by Region and Major Category of Assistance, Fiscal Years 2003 and 2004

	Fiscal Year 2003				
Region	**Disabled**	**Wards of DCFS**	**Family Health**	**SCHIP**	**Total**
Northwestern IL	12,253	2,590	120,772	2,837	138,452
Central IL	12,119	2,025	114,648	3,240	132,032
Southern IL	16,794	1,454	119,259	2,332	139,838
Cook County	100,238	61,029	600,744	10,292	772,302
Collar Counties	12,983	2,340	143,064	4,670	163,056
Statewide Total	154,387	69,436	1,098,486	23,371	1,345,680
	Fiscal Year 2004				
Region	**Disabled**	**Wards of DCFS**	**Family Health**	**SCHIP**	**Total**
Northwestern IL	13,053	2,651	137,684	8,109	161,498
Central IL	12,718	2,261	128,138	8,344	151,460
Southern IL	17,219	1,567	129,300	7,762	155,849
Cook County	101,915	59,330	637,221	41,291	839,756
Collar Counties	13,954	2,246	163,658	16,034	195,892
Statewide Total	158,859	68,055	1,196,001	81,539	1,504,454
	Percentage Increase, 2003-2004				
Region	**Disabled**	**Wards of DCFS**	**Family Health**	**SCHIP**	**Total**
Northwestern IL	6.5%	2.4%	14.0%	185.8%	16.6%
Central IL	4.9%	11.6%	11.8%	157.5%	14.7%
Southern IL	2.5%	7.8%	8.4%	232.9%	11.4%
Cook County	1.7%	-2.8%	6.1%	301.2%	8.7%
Collar Counties	7.5%	-4.0%	14.4%	243.3%	20.1%
Statewide Total	2.9%	-2.0%	8.9%	248.9%	11.8%

Figures exclude persons with Medicare and/or spend-down coverage.

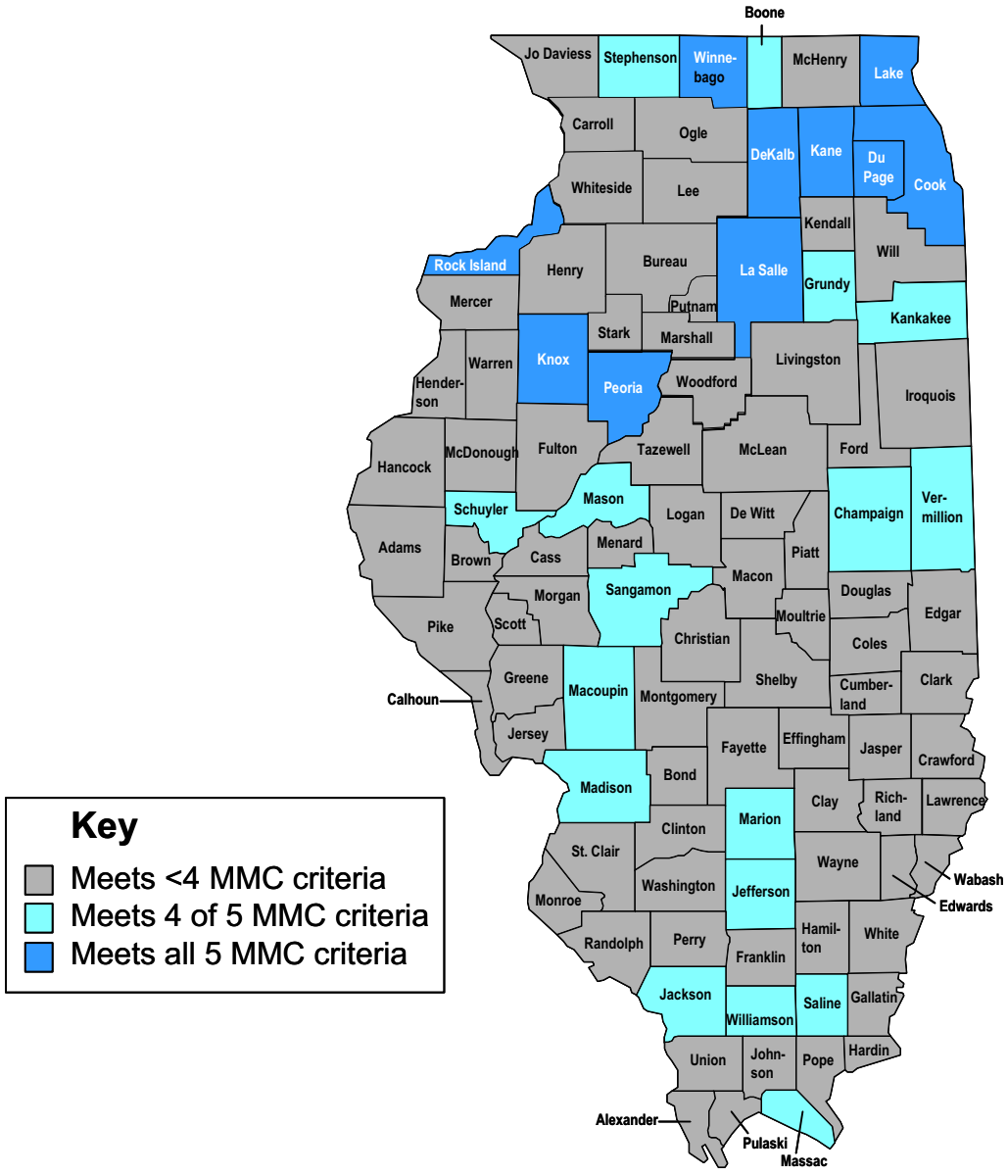
In assessing the feasibility of network-based managed care models, particularly capitation-based approaches that involve competing health plans, we have also conducted some assessments at the county level. Each county was assessed according to five criteria:

- Rural Designation Code. These are indicators developed by the Department of Agriculture to classify counties on an urban-rural scale from 0-9. We have set the minimum threshold for this assessment to be a rural designation code no greater than 4. of Illinois' 102 counties, 45 meet this threshold, with these counties encompassing 90.4 percent of the state's population.

- Population Size. Counties with at least 30,000 residents meet this criteria; 50 counties meet this threshold, with these counties encompassing 94.1 percent of the state's population.
- Population Per Square Kilometer. Counties with at least 25 persons per square kilometer; 39 counties meet this threshold, with these counties encompassing 90.8 percent of the state's population.
- Physicians Per Capita. Counties with at least one physician per 1,000 population; 36 counties meet this threshold, with these counties encompassing 81.8 percent of the state's population.
- Hospitals Per Capita and Per County. Counties with 3 or more hospitals or a rate of at least 0.03 hospitals per 1,000 population; 60 counties meet this threshold, with these counties encompassing 80.5 percent of the state's population.

The map in ***Exhibit B*** depicts the counties that met all five of these criteria (shaded in blue), those that met four of the five (shaded in turquoise), and those that met three or fewer (shaded in grey). This analysis is used to define some potential capitation regions later in the report. The county-specific statistics with regard to each of the five criteria are presented in ***Appendix 2***.

Exhibit B. Map Indicating Potential Amenability of Each County to Competitive, Network-Based Models of Medicaid Managed Care



D. Special Financing Arrangements and Considerations

1. Cook County Bureau of Health Services Intergovernmental Transfer (IGT)

Illinois uses a complex set of Intergovernmental Transfer (IGT) arrangements to help support the viability of the Cook County Bureau of Health Services, one of the nation's largest public hospital systems and a massive "safety net" provider in the Chicago area.

The component of the IGT arrangement that is most relevant to the State's Medicaid managed care options is a claims mechanism that pays a substantially enhanced rate to the Cook County Bureau of Health Services for every Medicaid fee-for-service patient day. These payments currently average more than $5,000 per patient day. ***Table 5*** indicates the aggregate amount of these payments during fiscal years 2003 and 2004 across the entire Medicaid program. ***Table 6*** presents the same information, but limited to the subgroup of Medicaid recipients who do not have Medicare coverage and/or are not spend-down recipients. Both tables convey the actual amounts paid, as well as "repriced" amounts that reflect the amount that would have been paid had Cook County been paid at the average rate of other area hospitals. The enhanced rates for inpatient care are roughly seven times the amounts paid to other hospitals; the enhanced rates for outpatient care are roughly three times the rates paid to other hospitals.

Table 5. Cook County Bureau of Health Services IGT Impact from Enhanced Claims, All Eligibility Groups, FY 2003-2004

Fiscal Year 2004	Inpatient	Outpatient	Total
Actual Payments	$412,274,344	$36,747,184	$449,021,528
"Repriced" Payments	$62,659,550	$12,149,688	$74,809,238
Difference, Actual vs. Reprice	$349,614,794	$24,597,496	$374,212,290
Fiscal Year 2003			
Actual Payments	$458,339,820	$35,775,606	$494,115,426
"Repriced" Payments	$67,767,268	$11,698,011	$79,465,279
Difference, Actual vs. Reprice	$390,572,552	$24,077,595	$414,650,148

Table 6. Cook County Bureau of Health Services IGT Impact from Enhanced Claims, Persons Without Medicare or Spend-Down

Fiscal Year 2004	Inpatient	Outpatient	Total
Actual Payments	$357,379,704	$33,984,611	$391,364,314
"Repriced" Payments	$50,717,727	$11,314,211	$62,031,938
Difference, Actual vs. Reprice	$306,661,977	$22,670,400	$329,332,377
Fiscal Year 2003			
Actual Payments	$379,753,732	$32,368,469	$412,122,201
"Repriced" Payments	$52,452,687	$10,678,581	$63,131,267
Difference, Actual vs. Reprice	$327,301,045	$21,689,888	$348,990,933

Table 6 indicates that the enhanced claims payments for the non-Medicare, non-spend-down population totaled approximately $400 million in fiscal years 2003 and 2004, with the amount dropping by $21 million in 2004. *Table 7* presents a breakdown of these 2004 IGT funds by category of assistance, indicating that the majority (55 percent) of the claims-based IGTs (for non-Medicare, non-spend-down persons) are derived through care of disabled persons. Another 39 percent of these claims accrue through caring for patients in the Family Health Plan category.

Table 7. Distribution of FY2004 Enhanced Claims Payments To Cook County Bureau of Health Services by Category of Assistance; Persons Without Medicare or Spend-Down

Disabled	Inpatient	Outpatient	Total
Actual Payments	$197,925,922	$14,744,557	$212,670,478
"Repriced" Payments	$27,130,764	$4,498,177	$31,628,941
Difference, Actual vs. Reprice	$170,795,158	$10,246,379	$181,041,537
Wards of DCFS			
Actual Payments	$7,312,375	$708,250	$8,020,625
"Repriced" Payments	$865,860	$241,817	$1,107,677
Difference, Actual vs. Reprice	$6,446,515	$466,433	$6,912,949
Family Health Plan			
Actual Payments	$137,609,903	$15,927,706	$153,537,610
"Repriced" Payments	$20,562,381	$5,483,321	$26,045,702
Difference, Actual vs. Reprice	$117,047,523	$10,444,385	$127,491,908
SCHIP			
Actual Payments	$14,531,503	$2,604,098	$17,135,601
"Repriced" Payments	$2,158,723	$1,090,895	$3,249,618
Difference, Actual vs. Reprice	$12,372,780	$1,513,203	$13,885,983
Total			
Actual Payments	$357,379,704	$33,984,611	$391,364,314
"Repriced" Payments	$50,717,727	$11,314,211	$62,031,938
Difference, Actual vs. Reprice	$306,661,977	$22,670,400	$329,332,377

Other forms of IGT payments to Cook County Bureau of Health Services occur on a regular, "lump sum" basis. While most of these payments will occur independent of the volume of the admissions and days that are "countable" in deriving the enhanced payments that occur, IDPA estimates that in FY2006 approximately $200 million of additional (non-enhanced claim) IGT payments could become "exposed" to the impacts of Medicaid managed care. Such costs would be above and beyond the figures in *Table 7*. Given the magnitude of these safety net funds and the current arrangement whereby the Cook County Bureau of Health Services is paid entirely through Federal funds, the impacts of various Medicaid managed care models on the IGT funding must be a central consideration in assessing and designing Medicaid managed care models in Cook County.[8]

[8] Note that the IGT funding issues predominantly involve residents of Cook County. Approximately 2 percent of IGT claims are created by residents of the Collar Counties.

Expansions of managed care programs can lower the IGT funding levels in two ways. First, such models often decrease the rates of utilization for inpatient care, which would likely result in fewer Medicaid patient days occurring at the Cook County Bureau of Health Services. Also, to the extent that enrollment into capitated health plans increases in the Chicago area and the Cook County Bureau of Health Services is paid for services by a capitated health plan, the enhanced rate does not apply.

Overall IGT funding levels are diminishing each year to comply with Federal limits. Initially, the lump sum components of the IGT payments will be reduced as necessary to comply with the CMS limits (rather than the enhanced claims). Beginning in FY2009, DPA anticipates that the enhanced claims component of the IGTs will also need to be reduced.

2. *Provider Assessments*

The State currently collects approximately $560 million from hospitals during FY2005 through a provider assessment program, which will yield approximately $560 million in Federal Medicaid match funds. Medicaid payment rates to hospitals are enhanced through a formula such that hospitals receive about $860 million from the program, collectively realizing a net gain of $300 million. The assessment program also results in enhanced payments to some other Medicaid providers (e.g., nursing homes).

The exact configuration of this assessment program beyond FY2005 has not yet been determined. To the extent the provider assessment program remains intact in largely its current form and at current funding levels, new Medicaid managed care initiatives can impact the funds flow. As with the IGT program, reductions in inpatient volume can lower the amount of care through which hospitals receive enhanced payments. Also, capitated Medicaid managed care days cannot be counted in qualifying a given hospital for enhanced payments.

E. Illinois' Experience With Managed Care To Date

Illinois currently ranks 47th among the 51 Medicaid programs (including the District of Columbia) in terms of managed care penetration, with on average just 10 percent of its 1.8 million Medicaid beneficiaries enrolled in managed care programs during calendar year 2004.[9] About 180,000 Illinois Medicaid recipients were enrolled in a Medicaid health plan during both 2003 and 2004. These enrollees predominantly received coverage (about 99 percent in 2003 and 97 percent in 2004) through the Family Health Plan category of assistance. Nearly all the remaining capitated enrollees were SCHIP recipients.

Five health plans currently serve the Illinois Medicaid population, as shown in ***Table 8***. All five plans served Cook County and Harmony also operates in eight counties in southwestern Illinois.

[9] Kaiser Family Foundation, State Health Facts. http://www.statehealthfacts.kff.org

Table 8. Capitated Medicaid Activity in Illinois as of April 2005

Health Plan	Enrollment as of April 2005	Service Areas
AmeriGroup Illinois	39,072	Cook
Family Health Network (MCCN)	21,665	Cook
Harmony Health Plan	67,727	Cook, Madison, St. Clair, Washington, Randolph, Perry, Jackson, Franklin, Williamson
Humana Health Plan	19,517	Cook
United Health Care	27,480	Cook
Total	**175,461**	

Table 9 summarizes the distribution of the Family Health Plan capitated enrollees by region. Most of the State's capitated enrollees (90 percent) reside in Cook County, where one-fourth of the Family Health Plan population is enrolled in a capitated health plan. Another 16,000 managed care enrollees reside in the Southern Illinois Region, where 12 percent of the Family Health Plan population is enrolled in a capitated health plan. Capitated enrollment in the other three regions is nearly non-existent, accounting for less than one percent of the Family Health Plan population. Statewide, the managed care penetration rate (enrollees divided by total eligibles) within the Family Health Plan population averaged 15 percent during 2004. Capitated enrollment declined slightly between fiscal years 2003 and 2004.

Table 9. Family Health Population Size and Distribution, 2003-2004

Fiscal Year 2004			
Region	**Average Eligibles**	**Average Managed Care Enrollees**	**Managed Care as Percent of Total Enrollment**
Northwestern IL	137,684	353	0.3%
Central IL	128,138	430	0.3%
Southern IL	129,300	15,832	12.2%
Cook County	637,221	158,354	24.9%
Collar Counties	163,658	818	0.5%
Statewide Total	1,196,001	175,788	14.7%

Fiscal Year2003			
Region	**Average Eligibles**	**Average Managed Care Enrollees**	**Managed Care as Percent of Total Enrollment**
Northwestern IL	120,772	203	0.2%
Central IL	114,648	298	0.3%
Southern IL	119,259	18,652	15.6%
Cook County	600,744	159,480	26.5%
Collar Counties	143,064	711	0.5%
Statewide Total	1,098,486	179,344	16.3%

The State's capitated program uses a voluntary enrollment model, whereby the health plans essentially compete both with one another as well as with the fee-for-service coverage program to attract and retain Medicaid enrollees.

The financial outcomes of the State's capitated programs to date have been disappointing in many respects. ***Table 10*** summarizes various Illinois health plans' financial experience with their Medicaid line of business during calendar years 2002 and 2003. ***Table 11*** compares the Illinois experience to the aggregate results of capitated Medicaid managed care programs in several other states, an analysis that encompasses 168 plan-years of Medicaid experience.

Table 10. Financial Results from Illinois' Capitated Medicaid Program, 2002-2003

	Member Months	Medical Loss Ratio	Admin Percentage	Gain/(Loss) Percentage	Gain (Loss) % After Tax, Investment Income
Illinois, 2002					
AmeriGroup	423,111	48.9%	39.1%	12.0%	8.2%
Harmony Health Plan	812,011	75.0%	19.2%	5.8%	3.7%
Illinois Aggregate, 2002*	1,235,122	65.8%	26.2%	8.0%	5.3%
Illinois, 2003					
AmeriGroup	378,909	49.3%	42.4%	8.2%	3.9%
Harmony Health Plan	929,767	72.6%	21.1%	6.3%	4.2%
United HealthCare, Illinois (Medicaid line of business)	313,214	79.1%	10.3%	10.6%	10.6%
John Deere (Medicaid line of business)	313,582	99.0%	10.3%	-9.4%	-9.4%
Illinois Aggregate, 2003	1,935,472	74.0%	21.7%	4.4%	2.5%

* Table excludes health plans for which Lewin did not obtain financial data. Several plans were not available for 2002, only Family Health Network is missing in 2003.

Table 11. Financial Comparison Across Seven States' Medicaid Capitation Programs

State	Year	# of Health Plans	Medical Loss Ratio	Admin Cost Ratio	Operating Gain (Loss)
Pennsylvania	1996	2	88.6%	13.7%	-2.3%
Pennsylvania	1997	3	89.6%	13.1%	-2.7%
Pennsylvania	1998	3	88.7%	11.7%	-0.3%
Pennsylvania	1999	4	87.9%	8.9%	3.1%
Pennsylvania	2000	4	88.7%	8.8%	2.5%
Pennsylvania	2001	5	87.9%	9.8%	2.2%
Pennsylvania	2002	6	88.3%	9.1%	2.6%
Pennsylvania	2003	6	88.5%	8.4%	3.1%
Pennsylvania	2004	3	89.9%	7.6%	2.3%
Texas	2001	10	84.8%	14.2%	1.0%
Texas	2002	12	82.6%	14.0%	3.3%
Texas	2003	8	82.6%	14.0%	3.3%
West Virginia	2000	2	88.2%	9.8%	2.0%
West Virginia	2001	2	87.2%	9.9%	2.9%
West Virginia	2002	2	89.5%	8.4%	2.1%
West Virginia	2003	2	88.1%	8.9%	3.0%
New York	2002	18	73.7%	19.2%	7.1%
New York	2003	18	76.7%	16.2%	7.1%
Washington State	1999	6	88.5%	110.0%	0.5%
Washington State	2000	6	86.7%	12.0%	1.3%
Washington State	2001	6	85.3%	13.5%	1.2%
Washington State	2002	6	85.3%	13.3%	1.4%
Arizona	2003	10	92.0%	7.6%	0.4%
Illinois	2002	2	65.8%	26.2%	8.0%
Illinois	2003	4	74.0%	21.7%	4.4%
Illinois	2004	5	74.4%	24.2%	1.4%

Collectively, the Illinois health plans have used an unusually small proportion of the State's payments to pay for their enrollees' health care and a disturbingly high proportion for administration and profit. Successful Medicaid managed care programs experience medical loss ratios (the proportion of capitation payments used to pay providers for health care services to enrollees) around 85-92 percent, with administrative costs consuming no more than 10 percent of revenues and the health plans achieving a modest but stable operating margin of 1-3 percent. With the Illinois health plans retaining more than 25 percent of the revenue they receive from the State for administration and profit, it is a virtual certainty that the Medicaid program lost – rather than saved – money from 2002 – 2004.[10]

[10] Note that one health plan, AmeriGroup, has consistently experienced medical loss rates that are far below those of the other four Illinois plans. Removing AmeriGroup from the 2004 figures in Table 11 would increase the average medical loss rate from 74.4 percent to 78.4 percent.

The voluntary enrollment model appears to be creating a series of problems for the State. First, the large administrative costs of the health plans, collectively exceeding 20 percent of revenues, suggest that a large marketing expense is necessary (or is at least occurring) to attract enrollees. In the Medicaid managed care arena, a general objective should be for resources to be focused on "serving" to the greatest possible degree and on "selling" to the smallest possible degree. While no comparison state in ***Table 11*** is even within five percentage points of the Illinois average in terms of administrative cost ratios, the nearest state (New York) also uses a voluntary enrollment model.

Another weakness of the voluntary enrollment model is the potential for selection bias to occur. In general, one can expect that persons who have strong ties to certain providers or who have significant health needs that involve use of an array of providers will be relatively less likely to choose an HMO coverage model, which involves a restricted network and limits a patient's freedom to navigate the health system. The literature regarding selection bias in the HMO setting is fairly compelling that in a voluntary enrollment situation, the health plans are likely to enroll healthier-than-average persons. One can reasonably infer from the figures in ***Tables 10*** and ***11*** that the Illinois health plans collectively (and AmeriGroup in particular with a medical loss ratio below 50 percent in both 2002 and 2003) have attracted healthier-than-average enrollees and have enjoyed capitation payment rates that appear to presume little or no selection bias is in fact occurring. While the degree to which favorable selection has occurred is always elusive to quantify, the key issue is that the Illinois Medicaid managed care program has not been cost-effective to date in terms of yielding savings to the Medicaid program. Medicaid managed care services are being purchased in other states for an administration and profit cost that is far below the amounts Illinois has been paying.

Such experience gives many stakeholders and policymakers pause in considering options to expand the use of capitation in the Medicaid program, both in terms of the health plans having been overly involved in "selling" and enrolling a favorable mix of persons, and the State not adjusting the payments appropriately to reflect what is taking place. While we are mindful of this adverse baseline of experience, it would be inappropriate to simply conclude that the capitated model cannot work in the Illinois Medicaid program. However, some modifications are clearly needed for this model to work more effectively.

In addition to the capitated program, the State also implements a set of fee-for-service based cost containment programs. Some of these include:

- **Perinatal Case Management.** DPA implements a Family Case Management Program (FCM) to promote "early and often" prenatal care. This program has been successful in preventing costly, adverse birth outcomes. DPA estimates that for every dollar spent on FCM, $7 in savings has occurred through reduction in non-normal births.[11]

[11] Savings from this program are difficult to measure accurately given that women who participate in the program by definition are enrolled in Medicaid for much of their pregnancy. Conversely, many Medicaid-reimbursed deliveries occur by virtue of an uninsured woman accessing the health system only once in labor, with Medicaid coverage being granted retrospectively. Also, FCM participants may have a relatively strong interest in accessing prenatal care and engaging in behaviors that promote better birth outcomes. Thus, the Medicaid deliveries not in the case management program probably represent, on average, worse outcomes than the deliveries that occur within the program (independent of the impacts of the case management itself).

- **Utilization Review.** Illinois DPA has a contract with the HealthSystems of Illinois (HSI) to provide utilization review for FFS claims. In FY 2004, HSI conducted reviews of approximately 27% of Medicaid FFS hospitalizations. Utilization review was conducted to determine billing accuracy and identify potential quality issues. HSI also operates a provider hotline to answer questions involving hospital billing and payment. HSI generates direct savings to the FFS program through denial of hospitalizations or days of care.[12]

While the cost containment approaches undertaken to date have appeared to be highly successful, DPA leadership staff are uncertain about the prospects for budget allocations to occur that would enable DPA to directly ramp up these activities and provide case management services and support on a larger scale.

F. Memisovski Lawsuit

A class action lawsuit, *Memisovski et al. v. Maram and Adams*, (*Memisovski*) was filed in 1992 against the State asserting that the State had not complied with the equal access provision and the EPSDT provisions of the federal Medicaid Act. After trial in May 2004. Judge Joan Lefkow issued a decision in August 2004 that held that the defendants had not complied with the equal access provision (42 U.S.C. § 1396a(a)(30)(A)) and the EPSDT provisions concerning provision of preventive care to Medicaid-enrolled children.

Specifically, the Court ruled that the state has failed its obligation to provide these children with access to care from doctors that is equal to the access to care of privately insured children, and to ensure that these children receive preventive health services required by the federal Medicaid program called Early and Periodic Screening, Diagnostic, and Treatment services (EPSDT).

In her opinion, Judge Lefkow explained the meaning of "equal access" to medical care contained in Medicaid law: "[t]he [children] are entitled to access equal to that of children with private insurance." The Court concluded that: "the [children] have met their burden of establishing that the defendants have violated their rights by failing to provide them with equal access to medical services. Plaintiffs simply do not have access to medical services which is equal to that of privately insured children."

In addition, Judge Lefkow ruled that the state has failed to establish "a Medicaid program designed to provide all EPSDT services to all Medicaid-enrolled children on a timely basis." Under the EPSDT program, the state is obligated to ensure that children received well-child care, including regular examinations and immunizations, and the state must "effectively inform all eligible individuals of the availability of these EPSDT services."

The Court also ruled that managed care organizations (MCOs), have failed to provide requisite levels of preventive health care. The evidence, taken from HCFA-416 reports, Cornerstone immunization and well-child exam records, and HEDIS reports, showed that the rate at which children on Medicaid receive preventive health care screening from managed care organizations was lower than the rate for children on Medicaid who are not in managed care.

[12] HealthSystems of Illinois Annual Report 2004

Specifically, the evidence showed that children served by MCOs had lower rates of preventive care than children in fee-for-service practices in all areas measured: well-child exams, hearing screens, vision screens, dental screens, blood lead screens, and immunizations required in a child's first three years of life. At the trial, State witnesses testified that no MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has met the EPSDT requirements set forth in their contracts with IDPA.[13]

The Memisovski decision poses a strict requirement for any capitated model in Illinois: models that cannot document that the children they serve are receiving scheduled preventive health care will violate *Memisovski*. As a result of *Memisovski*, IDPA will continue to focus on MCO performance in providing preventive health care to children. Thus, a clear message has been sent to any MCO operating in Illinois, health plans must ensure that children receive timely preventive health care services.

At the same time, it is not clear that the Memisovski decision bodes poorly regarding the expansion of capitated models and/or other forms of Medicaid managed care in Illinois. Coordinated care programs create systems of care that have greater potential to promote and track the provision of EPSDT (and other preventive care) services than can the traditional fee-for-service environment. A current Lewin assessment of Pennsylvania's capitated Medicaid program, for example, has shown that in every aspect of promoting access to care, the steps taken by the state's MCOs far surpass what occurs in the Medicaid fee-for-service setting. The PCCM model also provides a valuable "medical home" and a point of access and accountability for the provision of preventive services. Thus, while some view the Memisovski case as posing a barrier to further Medicaid managed care implementation, it is possibly best viewed in the opposite direction: a well-designed expansion of Medicaid managed care can enhance the State's ability to deliver and monitor EPSDT service provision to Medicaid-covered children.

[13] Notwithstanding the court's decision, MCOs argue that these issues primarily represent documentation challenges related to getting their encounter data accepted by the State's MIS system.

III. DESCRIPTION OF MEDICAID MANAGED CARE MODELS CONSIDERED

According to the Centers for Medicare and Medicaid Services (CMS), 59 percent of the Medicaid population is enrolled in some form of managed care, while the remainder is served through traditional fee-for-service programs. Of the Medicaid managed care population, 51 percent are enrolled in capitated managed care organizations, 31 percent are enrolled in either a prepaid inpatient or prepaid ambulatory health plan, 18 percent are enrolled in primary care case management (PCCM) and one percent is enrolled in some other type of managed care program.[14]

A. Capitated Health Plans

Across the country, states have adopted capitated managed care models with goals of improving recipient access to medical care, improving the quality of care received and reducing overall medical costs. Studies have shown capitated managed care models have had positive impacts on access and continuity of care while reducing overall medical costs.[15]

Under a capitated model, a managed care organization (MCO) is paid a fixed monthly premium per recipient and assumes either partial or full financial risk for the delivery of services. Traditionally, full risk capitated models generate a greater savings compared with fee-for-service and Primary Care Case Management (PCCM) programs, maximizing the state's savings. While the state maintains risk for services under a PCCM program, risk is transferred to the MCO in a risk-based model. Because the MCO receives a monthly capitated rate per member, there is incentive for the MCO to manage care, monitor utilization, and ensure that recipients receive the most appropriate care.

Populations, services and geography included in managed care programs vary by state. The Federal Balanced Budget Act of 1997 (BBA) sets the minimum standards for all state Medicaid managed care contract specifications. However, the minimum standards leave a great deal of latitude to the state to design a program that addresses state-specific concerns or reflects legislative direction. Often these variations leave recipients with the highest medical costs and some of the highest cost services outside of capitated managed care, resulting in 88 percent of Medicaid expenditures remaining in fee-for-service.[16]

- **Voluntary/Mandatory Enrollment.** Originally, many states allowed recipients to enroll voluntarily in managed care, but increasingly more states are moving towards mandatory enrollment.
- **Populations Enrolled.** Low-income children and pregnant women are more often enrolled in managed care than the aged, blind, and disabled (ABD) populations, although more states are moving towards enrolling these populations on a mandatory basis.

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[14] Analysis of *CMS Medicaid Managed Care Enrollment Report, June 2003*.

[15] *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen States*, The Lewin Group, July 2004.

[16] *Medicaid Managed Care Cost Savings – A Synthesis of Fourteen States*, The Lewin Group, July 2004.

- **Carve out.** Services included in capitated programs vary, with states often "carving out" (excluding) certain services such as prescription drugs, mental health, and long-term care services. Populations may also be carved out within a mandated aid category. For example, many states exclude foster children from managed care. When a service or population is carved-out of managed care, the state pays for the services through its fee-for-service system.

- **Geography.** The majority of states operate capitated programs in their urban areas and surrounding counties. Prior to 2002, rural managed care was considered virtually impossible due to the CMS requirement for choice of two health plans for each member. In 2002, states were granted authority by the federal government to contract with a single managed care plan in rural areas.[17] Under this waiver option, CMS allows rural areas to waive the federal Medicaid managed care requirement of choice for recipients between at least two MCOs. The program design allows Medicaid recipients to be served by one MCO as long as choice between two providers is available. Now states are expanding or considering expansions of capitated Medicaid managed care into rural areas under the single health plan model.

Figure 3 below illustrates the major components states must consider when designing a capitated managed care program. Within the requirements of the BBA, states must address each issue, determining what state-specific requirements should be in its managed care contracts and how to monitor and enforce compliance.

Figure 3: Managed Care Design Components

Business Components	Operational Components
▪ Legal relationship between state and health plan ▪ Compliance with state and federal laws ▪ Term and termination ▪ Service area ▪ Payment rates ▪ Sanctions ▪ Reporting	▪ Enrollment/disenrollment ▪ Enrollee rights/protections ▪ Marketing ▪ Service coverage ▪ Quality of care ▪ Access and availability ▪ Utilization management ▪ Case management/care coordination ▪ Provider network ▪ Complaints and grievance ▪ Fraud and abuse

1. Affirmative Choice

In Illinois, the Medicaid Managed Care Task Force has been presented with a model of managed care called Affirmative Choice.[18] Although we will discuss Affirmative Choice in the

[17] Federal Balanced Budget Act of 1997 enabled use of the single plan model. Final regulations were effective August 2002.

[18] This model was presented to the Illinois Managed Care Task Force by the Illinois Association of Health Plans.

Capitated Managed Care section of this report, the model contains both capitated managed care and a Primary Care Case Management (PCCM) component. The Affirmative Choice model proposes a three year conversion from existing care models to mandatory managed care for Family Health Plan recipients residing in Cook County and the "Collar" counties.[19]

Currently, the Illinois capitated program accounts for approximately 125,000 enrollees in Cook and "Collar" counties, with fee-for-service accounting for the remaining 645,000 Medicaid Family Health Plan recipients. The proposal divides all Family Health Plan recipients between capitated health plans (50 percent) and PCCM (50 percent). Recipients will be allowed to make a choice of between health plans and PCCM. For any recipient not making a choice, the proposal assigns the recipient to a health plan based on an algorithm which steers recipients towards plans exhibiting better quality and health outcomes. The proposal also recommends a 12 month lock-in period for all members, with a 90 day trial period when changes could be made without cause.

B. Primary Care Case Management/Disease Management

Nationwide, 29 states operate PCCM programs and at least 28 states operate disease management programs.[20] Typically, these programs operate separately and distinctly from each other. Many states are currently reviewing their PCCM programs to look for enhancements to increase quality of care outcomes and potential savings in medical costs. As states evaluate possible enhancements, the integration of PCCM and disease management is likely to become more common.

1. Primary Care Case Management

Under the Primary Care Case Management model, each Medicaid recipient is guaranteed a medical home, through the designation of a primary care provider (PCP). The patient's PCP acts as a "gatekeeper" to approve and monitor the provision of services to recipients. Studies have shown that PCCM models improve access to care for members compared to the fee-for-service system.[21]

PCCM providers do not assume financial risk for the provision of services, and typically receive a per-member per-month case management fee around $3. Under this model, the state maintains the financial risk for the recipients and the state (or its contractor) reimburses providers on a fee-for-service basis. Traditionally, PCCM generates a small savings compared with fee-for-service but fewer savings than full risk capitated models.

2. Disease Management

Disease management programs have traditionally been managed as stand-alone programs for persons in any care model, generating savings through patient education and better care management, which leads to more appropriate use of health care. These programs often target

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[19] "Collar" counties include DuPage, Grundy, Kane, Kankakee, Kendall, Lake, Mason and Will.

[20] Analysis of *CMS Medicaid Managed Care Enrollment Report, June 2003*.

[21] Smith, Vernon et al. "CHCS Informed Purchasing Series, Exemplary Practices in Primary Care Case Management," June 2000.

high-risk recipients with specific diseases such as asthma, diabetes and heart disease. Medicaid health plans have consistently utilized disease management strategies in their overall management of care. In addition to disease management through MCOs, states have the option to contract with a designated DM vendor or to build and operate a fee-for-service based program.

At least 28 states are operating, have approved, or are considering a disease management program for Medicaid enrollees. Programs currently in operation take a variety of forms. Indiana, Montana, Mississippi, and Florida have established similar programs in which all patients with covered diseases have access to, and are managed by, care managers at a central call center. High-risk patients receive more intensive care management from local or field-based care managers. Other states that have adopted disease management programs may target different diseases or combinations of diseases. Programs also vary in structure: some address patient education through pharmacists (Mississippi); some contract with mail-order pharmacies to provide Medicaid patients with discounted drugs and educational materials (Tennessee); some contractually require managed care organizations to provide disease management services (New Mexico).[22] Savings estimates have been difficult to quantify and many of the programs are still in the first years of development. In FY2004, a total of 19 states planned to take action to implement or expand disease management programs. [23]

Illinois Disease-Specific Baseline Information -- Individuals with Disabilities

In order to better assess the applicability of disease management programs in Illinois, Lewin analyzed IDPA data flagging individuals as having each of the following conditions (if their claims so indicated): asthma, cardiovascular illness, diabetes, or AIDS. The percentage of persons whose claims indicated the presence of one or more of the targeted diseases is summarized in ***Table 12***. Roughly 40% of the disabled population are afflicted with at least one targeted disease, versus less than 10 percent of the Family Health population.

Table 12. Prevalence of Targeted Diseases in Illinois Medicaid Population, FY2004
(Persons with Medicare and/or Spend-Down Coverage Excluded)

Region	Percentage of Disabled Population With One or More of Targeted Diseases	Percentage of Family Health Population With One or More of Targeted Diseases
Northwestern IL	36.7%	8.7%
Central IL	38.8%	9.4%
Southern IL	39.6%	6.8%
Cook County	47.1%	6.4%
Collar Counties	39.0%	8.3%

[22] Lewin ongoing disease management research.

[23] Smith, V., Ramesh, R., Gifford, K., Ellis, E., Wachino, V., and O'Malley, M. "States Respond to Fiscal Pressure: A 50-State Update of State Medicaid Spending Growth and Cost Containment Actions," Kaiser Commission on Medicaid and Uninsured, January 2004.

Among the disabled population, the FY2004 PMPM costs of persons with each of these diseases (as well as those with one or more of the four diseases) are summarized in ***Table 13.***

Table 13. PMPM Costs by Disease & Region for the Non-Medicare Disabled Population, FY2004

Region	Asthma	Cardiovascular	Diabetes	AIDS	Any Disease
Northwest IL	$999	$1,239	$1,707	$1,716	$1,138
Central IL	$1,045	$1,148	$1,481	$2,153	$1,063
Southern IL	$1,154	$1,167	$1,730	$1,756	$1,129
Cook County	$1,536	$1,600	$2,226	$3,047	$1,499
Collar Counties	$1,590	$1,476	$2,113	$2,978	$1,426
Average	$1,431	$1,491	$2,058	$2,934	$1,400

Cook County experienced the highest PMPM costs for cardiovascular disease, diabetes, and AIDS, and the Collar Counties had the highest PMPM cost for asthma. The Northwest Illinois Region had the lowest costs for asthma and AIDS while the Central Region had the lowest costs for cardiovascular disease and diabetes. Overall, Cook County had the highest PMPM cost for individuals with any disease.

Compared to the disabled population, PMPM costs were substantially lower among members of the Family Health population within each disease category, as summarized in ***Table 14***. ***Table 15*** presents the disease-specific PMPM costs for the Family Health population by geographic region.

Table 14. Comparison of Disease-Specific PMPM Costs, Disabled vs. Family Health Population, FY2004

Disabled and Family Health: Disease PMPMs					
Population	**Asthma**	**Cardiovascular**	**Diabetes**	**AIDS**	**Any Disease**
Disabled	$1,431	$1,491	$2,058	$2,934	$1,400
Family Health	$321	$1,007	$839	$1,101	$493
Difference	$1,110	$485	$1,219	$1,833	$907

Table 15. PMPM Costs by Disease & Region for the Family Health Population, FY2004

Population	Asthma	Cardiovascular	Diabetes	AIDS	Any Disease
Northwest IL	$288	$1,112	$784	$840	$480
Central IL	$273	$842	$752	$808	$411
Southern IL	$301	$856	$761	$764	$462
Cook County	$355	$1,007	$884	$1,152	$526
Collar Counties	$289	$1,218	$857	$1,241	$480
Average	$321	$1,007	$839	$1,101	$493

Note: Costs in the "any disease" category in Tables 14 and 15 are perhaps lower than one would expect them to be when looking at the costs across each disease category. This is because the highest-cost persons often have multiple diseases and thus appear in multiple categories whereas low-acuity persons are more likely to appear in just one disease category. In the "any disease" category, all persons appear equally (i.e., once) regardless of their co-morbidities.

3. Integrated PCCM/DM

In proposals made to the Illinois Managed Care Task Force, an integrated PCCM and disease management program was proposed although there were few details in how the program would operate. Although typically these programs have been operated separately, there is some discussion occurring in states around the potential benefits of a blended model. In Pennsylvania, the state is creating an enhanced PCCM program integrated with a disease management model. This model of collaborative programming is intended to promote integration of disease management approaches with the physician's treatment strategies. The disease management vendor has access to physician offices and has a nurse who spends time working in the physician's office. The Pennsylvania approach eliminates the monthly PCP fee and instead offers the physician a pay for performance bonus system based on metrics run through the disease management vendor.[24]

C. Complex Case Management

Dr. John Lynch, Associate Professor of Medicine at Washington University School of Medicine in St. Louis, has proposed a model of Care Coordination for the Complex Case. This model is based on three principles. First, the vast majority of health care costs in a population are incurred by a relatively small group of individuals. Dr. Lynch suggests that the sickest 15 percent of the population accounts for up to 50 percent of medical costs. A Care Coordination model would focus on the 0.5 to 5 percent of the population that comprises "the sickest of the sick."

In order to establish a baseline for applying this approach to the Illinois Medicaid population, Lewin analyzed claims data for the Medicaid only recipients (non-Medicare, non-Spend-down). The claims data represents all claims paid on behalf of a recipient, except for nursing facility and other institutional costs. As ***Figure 4*** indicates, for all aid categories a relatively small percentage of people generate a very high percentage of medical costs.

If one considers high cost individuals as those with claims cost of $25,000 and above, approximately 10 percent of the ABD reaches this level and population accounts for more than 60 percent of claims costs. For DCFS, approximately 3 percent of the population accounts for 57 percent of costs. The percentage of high cost persons and claims smaller in the FHP and SCHIP populations but still have a considerable impact on the program, both with less than 1 percent of the population accounting for approximately 25 percent of medical costs.

Note that retroactive eligibility has not been removed from this data, which is most likely to impact the FHP population. Retroactive eligibility is often seen with pregnant women who come to a hospital to deliver a baby and then gain Medicaid eligibility with three months prior coverage. No care management system can influence retroactive eligibility months. Most likely, the impact of retroactive eligibility on the FHP population would be to further reduce the percentage of persons who have high cost that can be impacted by the coordinated care approach.

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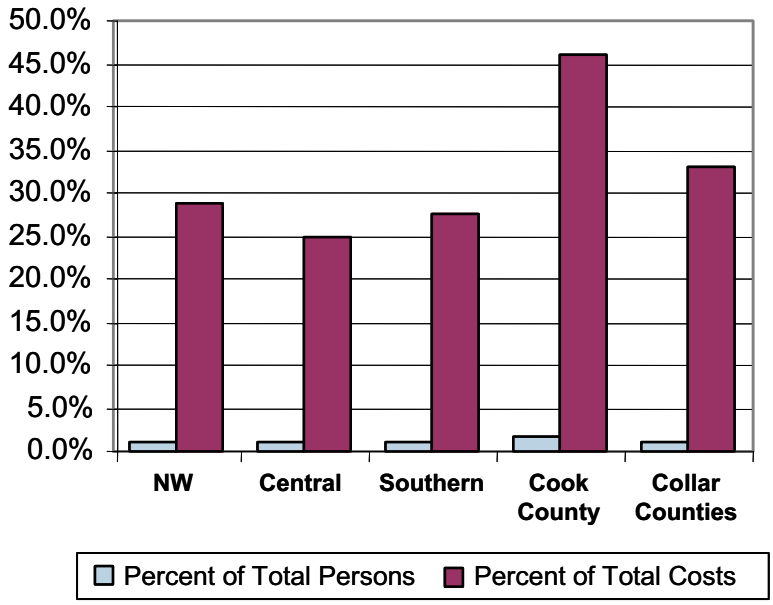
[24] Discussion with McKesson Corporation, March 30, 2004, and http://www.dpw.state.pa.us/omap/hcmc/accessplus.asp.

Figure 4. Cases over $25,000 by Region, FY2004



Lewin also analyzed the claims data by region to determine if significant variances appeared based on geography. Overall, the five regions break out in a similar manner when comparing the percent of persons and the percent of claims cost they represent. The one variance appears to be in Region 4 (Cook County), where the highest cost individuals account for an even larger percentage of overall claims cost. In other regions the top one to two percent of persons account for 25 to 33 percent of costs while in Region 4 those persons account for 46 percent of all costs. A detailed distribution of claims costs and beneficiaries by individual claims cost cohort is presented in ***Table 16***.

Table 16. Percentage Distribution of Illinois Medicaid Population by FY2004 Individual Claims Cost Levels (non-Medicare, non-spend-down population only)

	Percent of People				Percent of Cost			
Cost Corridor	**ABD**	**DCFS**	**FHP**	**SCHIP**	**ABD**	**DCFS**	**FHP**	**SCHIP**
$0	7.0%	12.1%	8.8%	9.5%	0.0%	0.0%	0.0%	0.0%
$1-$999	25.9%	60.6%	67.0%	57.2%	0.8%	5.3%	13.4%	10.6%
$1000-$9999	41.6%	21.3%	22.3%	31.1%	16.4%	21.5%	45.5%	52.3%
$10,000-$24,999	15.1%	3.2%	1.3%	1.5%	22.5%	16.2%	13.0%	11.6%
$25,000-$49,999	**6.2%**	**1.7%**	**0.3%**	**0.4%**	**20.3%**	**19.7%**	**7.5%**	**6.5%**
$50,000-$99,999	**3.0%**	**0.7%**	**0.1%**	**0.2%**	**19.1%**	**16.0%**	**6.3%**	**6.2%**
$100,000+	**1.2%**	**0.3%**	**0.1%**	**0.1%**	**20.8%**	**21.4%**	**14.3%**	**12.8%**
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Dr. Lynch's second principle is that risk assessment models can predict which individuals are at high risk of joining the high-cost population. He describes six characteristics of individuals in this high risk population:

- At risk for high acuity care within the year
- Identified proactively
- Diagnosed with co-morbidities
- Facing social and psychological difficulties
- Deteriorating clinically
- Susceptible to growing dependence on the medical system

Dr. Lynch's third principle is that aggressive management of these populations can produce significant clinical and financial results. Intensive support of the sickest patients can "break the cycle" of reliance on high-cost treatment, and DM support can help at-risk individuals avoid future high-cost care.

Even with aggressive medical care coordination, this model cannot achieve its full potential through medical case management support alone. Non-medical barriers can be a substantial barrier to effective case management. Social and environmental challenges such as drug abuse, domestic violence, and poor housing conditions can make effective medical treatment very difficult to maintain. Case mangers implementing the complex care coordination model need to be skilled at accessing these environmental factors and at linking patients to available community resources.

D. Fee-for-Service

Fee-for-service is the traditional design of Medicaid programs where doctors, hospitals and other providers are paid for each service they provide and recipients choose any doctor willing to accept Medicaid. In fee-for-services programs, recipients are often left on their own to manage the health care system. Typically, fee-for-service programs offer little to no beneficiary education, case management or provider profiling. It is up to the recipient to determine whether a provider is accepting Medicaid patients; hours of operation; physical access for the disabled and provider credentials or specialties.

Providers are paid for claims submitted to the state or the state's contracted fiscal intermediary for payment and the state is at full risk for the cost of medical care. All providers are paid from a state determined fee schedule, typically all physicians receive the same payment for the same services. This system has little to no prior authorization, utilization review, provider education or quality monitoring as a means to control costs or improve quality of care.

IV. KEY CONSIDERATIONS IN SELECTING A MODEL

In selecting a model or models for potential managed care expansion, it is necessary to assess the various cost and quality impacts of each approach. In this section, we discuss the following key considerations within the context of the alternative approaches under evaluation:

- **Medical Cost Impacts.** The ability of the model to contain medical costs is the primary cost consideration. While other cost impacts also come into play (e.g., the effects on administrative costs and on special financing arrangements), the impact on medical costs generally is the central factor influencing the feasibility of any model. It is the medical cost containment capacity of any given model that, in the long term, has the greatest potential to avoid the need to impose benefit and/or eligibility reductions in the program.

- **Vendor Administration and Profit Needs.** Each model—including the FFS model—has administrative costs associated with its operation. In addition, contracting with managed care vendors (whether fully-capitated health plans or disease management, case management, or PCCM vendors) creates vendor profit needs. The level of administration and profit needs, and the degree to which they offset the model's medical cost impacts, vary across models and are important considerations.

- **State Administrative and Oversight Requirements.** Contracting with third parties to administer any type of Medicaid managed care program does not completely transfer administrative responsibility and costs from the state to the vendor(s). In fact, Medicaid managed care programs are most successful when the state maintains vigorous vendor management and oversight responsibility. Thus, the potential State administrative costs associated with each model, in addition to the vendors' administrative costs, are important financial considerations.

- **Impact on Special Financing Arrangements.** The model's interaction with the state's special financing arrangements (namely IGT and provider assessments) and the resulting impact on the state's existing "safety net" funding approaches need to be understood. Not only is whether and how such funding might be compromised important; it is also essential to assess the long-term viability of such approaches (and therefore whether impacts on such approaches will be moot in the near future), and whether alternative safety net funding approaches might be available that are unaffected by—or supported by—the model.

- **Cash Flow Impact.** Assessments of medical cost savings are generally made on the basis of incurred costs. However, since the relationship between date of service and date of payment varies between capitated and non-capitated models, transitioning from one model to another can have a significant one-time cash flow impact.

- **Provider Participation.** Although it can be difficult to assess whether managed care increases the number of providers actively participating in Medicaid, it does create a baseline of provider participation at inception of the managed care program and how it

changes over time.[25] Health plan contracts require specified levels of provider participation and monitoring of changes in provider participation. States require health plans to report when a provider joins or leaves the network and the level of provider participation, such as whether the provider is accepting new patients. The HMO model also allows more flexibility in provider contracting and payment rates. This can be particularly useful when attempting to engage hard-to-recruit specialty providers. For example, in Pennsylvania health plans sometimes pay 30-40 percent above the Medicaid fee schedule to secure participation of certain specialists.

- **Beneficiary Impacts.** As we stated in the Introduction, our objective in assessing alternative models is not only to determine how the State can best meet its financial objectives, but also how it can do so while strengthening the quality of and access to health care for Medicaid beneficiaries. Traditional fee-for-service often leaves the beneficiary with the sole responsibility for navigating the health care delivery system. The beneficiary is left to seek out a doctor who accepts Medicaid as payment, which can be difficult given the degree to which Medicaid payment rates discourage "mainstream" physician participation. Although PCCM and HMO models may not dramatically change the number of participating physicians, it does change the method in which the beneficiary accesses physicians and other health care information. For example, in both PCCM and HMO models, the beneficiary is required to have a primary care physician coordinating care and helpline phone numbers are typically available to assist in finding a PCP. The HMO model also requires a provider directory be given to each member with information on physicians such as whether the physician is accepting new patients, phone number, address and accessibility for the disabled. In all managed care models, health education is provided to beneficiaries to increase their awareness of preventative health strategies and disease management.

A. Medical Cost Containment Attributes of Each Model

The medical cost impacts of the various models under consideration were developed by considering the cost containment attributes. These attributes are depicted in ***Exhibits C*** and ***D*** on the following pages. ***Exhibit C*** presents a summary of the ratings of each model, with the chart in ***Exhibit D*** providing text that explains and supports the ratings. The ratings in these Exhibits use the following scheme.

●	Model fully implements the cost containment measure shown
◎	Model employs a limited use of the cost containment measure shown, or broad use for small portion of beneficiary population
○	Model does not use the cost containment measure shown

[25] It is difficult to assess the FFS program as a baseline since providers join the program but little information is maintained on their level of participation. For the most part, physicians who/that participate in FFS also participate in managed care.

Exhibit C. Summary Comparison of Cost Containment Features of Various Medicaid Models

Medical Cost Containment Techniques	UNMANAGED FFS	PCCM/ DISEASE MGMT	COMPLEX CASE CARE MGMT	PCCM/ DM/ CARE COORD	HMO
General Attributes					
Channels Patient Volume Using Contracted Network	○	◉	○	◉	●
Eliminates Unnecessary Services	○	◉	◉	◉	●
Uses Lower-Cost Services Where Available	○	◉	◉	◉	●
Vendor At Risk For Medical Costs	○	◉	◉	◉	●
Directly Pays For Services and Negotiates Prices	●	○	○	○	●
Specific Attributes					
Primary Care Physician Required	○	●	○	●	●
Prior Authorization for Costly Services	○	●	◉	●	●
Referrals Required for Outpatient Specialty Care	○	◉	○	◉	●
Disease Management	○	●	◉	●	◉
Individually Tailored Care Management	◉	◉	◉	●	●
Enrollee Outreach and Education	○	◉	◉	◉	●
Can Pay for Uncovered Services on Exception Basis	○	○	○	○	●
Provider Profiling/Reporting	◉	◉	◉	◉	●

KEY:	
●	Model fully implements the cost containment measure shown
◉	Model employs a limited use of the cost containment measure shown, or broad use for small portion of beneficiary population
○	Model does not use the cost containment measure shown

As identified in ***Exhibits C*** and ***D***, the capitated HMO model adopts the widest set of measures to contain health care costs, and implements these measures most aggressively due to the financial risk the capitated health plans accept. The other managed care models (PCCM/DM, Complex Case Care Management, and PCCM/DM/CM) are primarily administrative services only models, with the vendors bearing comparatively little financial risk. Furthermore, as payers, HMOs have a close contractual relationship with network providers. Under the other managed care models, the State's vendors would hold little or no such leverage, and the vendor would be only minimally affected by the physicians' treatment decisions.

Note that even the "unmanaged FFS model", which is currently in place for the majority of Illinois' Medicaid beneficiaries, incorporates some cost containment measures, most notably case management services for pregnant women and children under one year of age. Thus, the current FFS model is not completely unmanaged. However, imposing very low payment rates on the provider community remains the key cost containment feature at this model's disposal.

Falling somewhere between the FFS model and the HMO model with respect to cost containment features are the various "managed FFS" models: PCCM/Disease Management, Complex Case Care Management, and the model combining all of these approaches. While Disease Management and Complex Case Care Management are similar in the number and strength of cost containment attributes, we have not considered Disease Management as a stand-alone approach but rather in conjunction with a PCCM model. Thus, the Complex Case Care Management approach alone has fewer cost containment features than the combined PCCM/DM model. While there is some overlap between Disease Management and Complex Case Care Management in terms of the populations targeted, there is nevertheless some additional impact from establishing both programs. Therefore, the model combining the three managed FFS approaches is somewhat stronger than both the Complex Care Management stand-alone or the PCCM/DM model in terms of potential for medical cost savings.

For purposes of medical cost modeling conducted as part of this engagement, the cost factors are all tied to current FFS expenditure levels. Thus, the FFS setting receives a factor of 1.000 for all medical service categories and geographic regions, with the HMO model receiving factors furthest below 1.000 at the other end of the spectrum.

Exhibit D. Detailed Chart Comparing Cost Containment Attributes of Each Model

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
General Attributes					
Ability to Channel Patient Volume to Cost-Effective Providers Using a Contracted Network	None – FFS program accepts all willing providers and has no patient channeling aspect. 	Minimal – PCCM programs have contracted PCP networks; PCPs that participate may receive higher patient volume. 	None – Case management is provided within a FFS setting, with no patient channeling aspect. 	Minimal – PCCM programs have contracted PCP networks; PCPs that participate may receive higher patient volume. 	Medium to Strong – HMOs develop competitive provider networks and direct patient volume to those networks. However, Medicaid's low payment rates in many service categories (e.g., physician services) limits the ability of HMOs to leverage their patient channeling power – many providers do not want more Medicaid patient volume. 

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
General Attributes					
Eliminating Unnecessary Services	Minimal – FFS setting is highly vulnerable to unnecessary usage of services. 	Some – Through PCP-driven model, PCCM program seeks to eliminate beneficiary freedom to self-refer throughout the delivery system for care and conducts utilization management. In addition, DM model seeks to ensure appropriate mix and level of services for the population being disease managed. However, neither model is designed to aggressively weed out unnecessary usage for the entire program population. 	Some – For the small proportion of the Medicaid population receiving care coordination services from care managers, individualized care plans will seek to avoid unnecessary care. 	Medium – The combination of primary care case management, disease management for recipients with specified chronic illnesses, and care coordination for additional high-cost complex patients, unnecessary care may be avoided more often than if just one or two of these approaches are in place. 	Strong – HMOs implement wide range of measures to identify and avoid unnecessary usage. They bear full risk of the cost of unnecessary care and are thus highly motivated. 

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Using Lower-Cost Services Where Available	None – FFS actually does the opposite, as its payment structure promotes care occurring at relatively high-cost settings. For example, low physician fee schedule and relatively adequate payments to hospitals promotes a shift in care away from office setting and towards institutional setting. ○	Some – Through PCP-driven model, PCCM program seeks to render more "front-line" services in lower-cost settings; and DM seeks to ensure preventive and primary services are provided at appropriate points to avoid exacerbation of condition and need for more costly services. However, PCPs and PCCM contractors generally do not have incentives to refer care to more cost-effective settings, and DM vendors have relatively weak incentives since they are not at dollar-for-dollar risk. ◐	Some – CM seeks to ensure patients receive necessary social supports, preventive and primary services that will help to avoid exacerbation of condition and need for more costly services. However, CM contractors typically do not have incentives to refer care to more cost-effective settings. ◐	Some – through combination of PCCM, DM and CM approaches, this model can have an impact on a larger portion of the population than any single approach or combination of two of the three approaches. However, this approach still does not provide strong incentives to refer care to more cost-effective settings. ◐	Strong – HMOs seek to move services to lowest-cost setting and provider type. HMOs can also have some success in smoothing out payment anomalies between Medicaid providers (FFS can pay vastly different amounts for the same service depending on who provided the service.) ●
Directly Pays For Services and Negotiates Prices	State has significant leverage as one of the largest payers in the market, plus the fact that those covered by Medicaid would otherwise be uninsured. ●	PCCM programs often pay case management fees or enhanced rates to PCPs, with other providers receiving Medicaid FFS rates. PCCM and DM contractors typically do not serve as payers. ○	Medicaid FFS rates apply, but the case management contractor does not serve as a payer. ○	PCCM programs often pay case management fees or enhanced rates to PCPs, with other providers receiving Medicaid FFS rates. ○	HMO can base its negotiated prices at or near Medicaid levels in securing network participation. ●

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Specific Attributes					
Primary Care Physician Required	Beneficiaries do not choose a PCP and may be treated by any MD that accepts Medicaid patients. ○	Beneficiaries must select a PCP – PCPs may include: general practitioners, OB/GYNs, pediatricians. PCP is expected to: Assess members' medical needs; make referrals; coordinate care after referrals; make arrangements with home and community support services agencies; coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services; and coordinate inpatient hospital care (pre-admit and discharge). Specialists and other providers in majority of PCCM programs are paid without conferring with the PCP, simply by knowing who the enrollee's PCP is. ●	Beneficiaries do not select a PCP; PCP gatekeeper model is not used. ○	Beneficiaries must select a PCP – PCPs may include: general practitioners, OB/GYNs, pediatricians. PCP is expected to: Assess members' medical needs; make referrals; coordinate care after referrals; make arrangements with home and community support services agencies; coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services; and coordinate inpatient hospital care (pre-admit and discharge). Specialists and other providers in majority of PCCM programs are paid without conferring with the PCP, simply by knowing who the enrollee's PCP is. DM and care management program scope and efficacy are broadened in the PCCM setting. ●	Beneficiaries must select a PCP. PCP is expected to: Assess members' medical needs, make referrals, coordinate care after referrals, make arrangements with home and community support services agencies, coordinate care with other entities that provide medical, nutritional, behavioral, educational and outreach services, coordinate inpatient hospital care (pre-admit and discharge). Adherence to PCP model is most stringent in HMO setting, where unique referrals are typically needed for other providers to obtain payment. ●

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Prior Authorization for Inpatient Care	Prior authorization is not necessary. ○	Typically in PCCM programs, prior authorization is necessary and program contractor also receives notification of admission for non-emergent care to determine whether the care is medically necessary. ●	Prior authorization is not necessary. ○	Typically in PCCM programs, prior authorization is necessary and program contractor also receives notification of admission for non-emergent care to determine whether the care is medically necessary. ●	Prior authorization is necessary. HMOs try to achieve inpatient cost-savings in many ways; their prior authorization process is deemed more stringent than PCCM techniques. ●
Referrals Required for Outpatient Specialty Care	Referrals are not necessary. ○	Typically in PCCMs, patients need a referral for specialty care. However, the process typically is less formal and rigorous than in most HMOs (it suffices for the specialist to provide the referring PCP's ID number, so that requirement to obtain an explicit referral may possibly be sidestepped). ◉	Referrals are not necessary. ○	Typically under PCCM, patients need a referral for specialty care. However, the process typically is less formal and rigorous than in most HMOs (it suffices for the specialist to provide the referring PCP's ID number, so that requirement to obtain an explicit referral may possibly be sidestepped). ◉	Typically, service-specific referrals are required for non-emergent care. Specialists cannot generate follow-up care, tests, surgeries, etc. without PCP approval and explicit referral number. ●

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Disease Management (DM)	Does not incorporate any formal DM programs. ○	"Traditional" PCCM program is enhanced/integrated with formal DM programs for specified beneficiaries with specified conditions (e.g., diabetes, asthma, CHF). ●	Does not incorporate any formal DM programs. ○	"Traditional" PCCM program is enhanced/integrated with formal DM programs for specified beneficiaries with specified conditions (e.g., diabetes, asthma, CHF), as well as with formal case management programs (see below). ●	HMOs use variety of DM strategies, based on their own assessments of what is cost-effective to implement. However, scope of DM programs *may* not be as extensive as under a PCCM/DM or PCCM/DM/CM model in each HMO. ◎
Case Management (CM)	Family Case Management Program provide case management to pregnant women and infants ◎	CM for the broad population is accomplished primarily through PCPs, who are expected to provide CM as part of their contractual responsibility. However, PCPs may have little resources (or incentive) to fulfill this role effectively. The population receiving disease management may also have care and services unrelated to their qualifying condition coordinated by the disease manager. ◎	CM approach using integrated clinical and psychosocial model is applied to the identified "highest-risk" beneficiaries. ◎	Provides various levels of care coordination/case management, including more intensive care management for high-risk beneficiaries with complex needs. ●	Multiple levels of CM are generally used extensively by HMOs. ●

Medical Cost Containment Measures	Unmanaged FFS	PCCM/Disease Management	Complex Case Care Management	PCCM/DM/CM	HMO
Enrollee Outreach and Education	The FFS program does not provide enrollee education or outreach services, with the exception of EPSDT services for children and for women with high risk pregnancies. ○	Typically include an enrollee education and outreach component, though generally not as rigorous as seen in the HMO setting. ◕	Includes an enrollee education and outreach component for identified high-risk beneficiaries. ◕	Includes enrollee education and outreach component. ◕	HMOs implement a variety of enrollee education and outreach programs. ●
Vendor At Risk for Medical Costs	The vendor acts purely as a claims administrator and bears no risk. ○	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and usually just for those enrolled in DM component). ◕	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and just for those enrolled in CM component). ◕	The vendor conducts a range of cost containment programs, but bears only limited risk for claims costs incurred by the enrollee (and just for those enrolled in DM and/or CM components). ◕	HMOs are fully at risk for the medical costs of their enrollees, except for pharmacy services, which are carved out. ●
Provider Monitoring/Profiling, Accountability for Quality of Care and Cost-Effectiveness	FFS setting is very weak at fostering accountability and measuring provider performance. ◕	PCCM generates provider monitoring reports, including tracking ER usage. Reports traditionally used only for informational/educational purposes, although some PCCM programs are building in "Pay for Performance." ◕	Incorporates some accountability and monitoring of provider performance, although reports used only for informational/educational purposes. ◕	PCCM generates provider monitoring reports, including tracking ER usage. Reports traditionally used only for informational/educational purposes, although some PCCM programs are building in "Pay for Performance." ◕	HMO environment is conducive to extensive data reporting, profiling and monitoring, and (where necessary) provider sanctioning. ●

B. Vendor Administration and Profit Needs

It is important to recognize that all aspects of the health care system have administrative components. On the FFS side, states experiences cost associated with paying FFS claims and with its Family Case Management program (for which the Illinois Department of Human Services currently provides $44.6 million), for instance. On the managed care side, the states incur vendor costs, such as the internal administration charged by HMOs, PCCM contractors, and disease management vendors. (States also directly incur additional administrative costs when they engage external contractors, as a result of their contract management and oversight responsibilities; these costs are discussed in ***Section C.***)

Any administrative spending can be effective, efficient, ineffective or excessive. The magnitude and value of vendor administrative spending can vary based on several factors, including but not limited to the number of persons served, the type of managed care model, the efficiency of the vendor, and the structure of the contract.

1. Capitated HMO Model

A widely-held public perception is that HMO administrative costs represent dollars that are taken away from the health care system. As stated above, however, the balanced reality is that there are administrative components that take place in health care, and that an organization's administrative spending levels can fall anywhere on the continuum from efficiency to excess.

In the Medicaid HMO setting, the purpose of administrative functions is to create an integrated system of care delivery, access, patient education and cost-effectiveness. Certainly, when designed and implemented well, such efforts do not represent negative "takeaways." To the contrary, the administrative functions performed by HMOs in successful capitated Medicaid managed care programs are exceptionally effective and valuable to the programs, and represent "spending to save" initiatives. In other words, medical cost savings cannot occur without significant administrative investment.

Administrative costs in successful Medicaid mandatory managed care programs that serve a broad mix of eligibility categories (i.e., blind and disabled as well as TANF and TANF-related categories) consume approximately 8 percent of revenues. In general, administrative percentages decrease as per member per month medical costs increase; as total medical costs increase there is a larger base over which fixed costs can be spread. Thus, capitated programs serving only TANF and TANF-related categories of beneficiaries often experience administrative costs approximating 10 percent of revenue, while those serving only blind and disabled beneficiaries generally spend only about 6 percent of revenue on administration.

In addition to requiring payment for administrative services provided, contractors will not do business with a state Medicaid agency without a realistic opportunity to achieve a favorable operating margin. Profit needs of HMOs generally are higher than the profit needs of non-capitated vendors because of the large downside financial risk that capitated health plans bear. We have factored into the cost estimates a profit margin for the capitated contractors of two to three percent of capitation revenue, again based on the HMO operating surpluses commonly seen in the most successful capitated Medicaid managed care programs.

As noted in ***Section IV***, HMO administrative efficiencies are far easier to achieve in mandatory HMO only enrollment settings than in voluntary enrollment models because of the large marketing expense needed in the voluntary model and because of the economies of scale advantages associated with the larger enrollment that occurs under mandatory enrollment. Therefore, we have factored in significantly larger administrative percentages for HMOs in the Affirmative Choice model than in the mandatory HMO model. While the PCCM portion of the Affirmative Choice model is assumed to experience lower administrative percentages than the HMO portion, the total administrative costs for the Affirmative Choice model are assumed to be higher than for the mandatory HMO only enrollment model.

2. *Managed FFS Models*

For all the managed FFS models under consideration we assume that external contractors will be engaged to implement the selected approaches. PCCM, DM, and case management vendors will also incur and need to be reimbursed for administrative costs associated with operating these programs. These administrative costs will be significantly lower than (generally less than half of) those associated with the HMO model, simply because, the managed FFS models engage in fewer cost containment initiatives and do so less aggressively than do capitated HMOs (as described in ***Section A,*** above). Profit needs also are assumed to be somewhat lower than in the HMO model due to the lower level of financial risk borne by the contractors in the managed FFS models.

C. State Administrative and Oversight Requirements

As noted previously, states that contract with external vendors for managed care program administration continue to perform various administrative functions internally (and/or through specialized vendors), and thus incur administrative costs that are in addition to the managed care program vendor's administrative costs. Administrative services typically contracted for include enrollment broker services, quality review, and actuarial services. In addition, states incur direct personnel costs associated with managing the contracts with the various vendors, as well as systems costs (e.g., for modifications necessary to monitor program operations). Many states also operate a beneficiary complaint line, a state-level appeals process, and program integrity units, and the costs of these functions are at least partially allocated to the HMO program.

Again, state administrative costs are considerably lower in the managed FFS models than in the HMO model, but these approaches also requires some system redesign, oversight, and financial reconciliation monitoring.

D. Impacts on Special Financing Arrangements

In ***Section II***, we described the special financing arrangements that currently exist in Illinois used to bolster the viability of the State's safety net providers: Intergovernmental Transfer (IGT) arrangements that apply to Cook County Bureau of Health Services; and, for all other counties, hospital assessments that yield Federal Medicaid match funds and allow for redistribution of hospital payments based on Medicaid utilization levels.

There are two IGT arrangements, one comprising enhanced, claims-based payments and the other a quarterly, lump-sum payment to Cook County Bureau of Health Services. Only the claims-based payments would be affected by changing the State's Medicaid managed care programs. Expansion of the capitated HMO model would potentially have the strongest impact on the funding levels made possible by this IGT component, since the enhanced payment rates do not apply to hospital days provided to capitated Medicaid beneficiaries. Further, expansion of capitated managed care for the SSI population in Cook County would be the most problematic, since this population consumes the lion's share of inpatient services. Implementation of managed FFS models in Cook County also would potentially lower aggregate IGT payments to Cook County Bureau of Health Services, since these models are likely to reduce hospitalization rates. However, the implementation of these models would not be expected have as large an impact on IGT funding.

For those non-Cook County Bureau of Health Services providers that currently benefit from the funding arrangements made possible by hospital assessments, the impact of the various models would be very similar to that described above. That is, reductions in inpatient volume can lower the amount of care through which hospitals receive enhanced payments. Also, capitated Medicaid managed care days cannot be counted in qualifying a given hospital for enhanced payments.

However, we anticipate that other financing options exist within a capitated structure that would preserve the flow of funds that safety net providers are receiving. For instance, some states assess HMO premium taxes to collect additional funds, then redirect the extra funds to targeted safety net providers. Of course, this type of financing scheme may also eventually be disallowed by the Federal government. However, a good case can be made that the Federal policies that do evolve with respect to funding support for safety net providers are unlikely to favor approaches (e.g., enhanced claims payments that apply only to FFS days) that inhibit the implementation of cost-effective initiatives.

E. Cash Flow Impacts

Because vendors are paid up-front under most Medicaid managed care models, from a cash flow perspective many of the models (particularly capitation and monthly administrative fee approaches) create short-term cash flow disadvantages at the point the program is implemented. (Conversely, there can be cash-flow advantages to a state when it transitions from a capitated model back to a FFS model.)

While cash flow impacts tend to be one-time impacts, such impacts can be extremely important to a state that is dealing with immediate and severe budget constraints. There are, fortunately, some mechanisms at a state's disposal that can soften the negative cash flow impacts of moving to otherwise more cost-effective program models. For instance, while most states make monthly capitation or administrative payments to their contractors by the 15th of the month in which the services are incurred, some states have delayed payments (e.g., Illinois pays by the 15th of the month following the month in which services were incurred). Phased-in implementation of the managed care program can also be used to lessen the negative cash-flow impact.

V. COST MODELING

A. Baseline Costs

Lewin's cost estimates are built from a base year of fiscal year 2004 Illinois Medicaid costs.[26] Persons with Medicare coverage (dual eligibles) and those who obtained coverage through the program's spend-down provisions were excluded from all the modeling, as these subgroups were not deemed conducive to managed care savings.

Table 17 presents costs for each of the four major categories of assistance: disabled, DCFS wards, family health, and SCHIP. The disabled and family health categories together account for the vast majority of the claims costs in these subgroups representing 48 percent and 43 percent of claims costs, respectively. Costs are grouped into the following seven medical service categories: inpatient hospital, nursing home, other institutional (e.g., mental retardation facilities), pharmacy, capitation (prepaid payments to managed care organizations), waiver, and all other (e.g., physician, clinic, outpatient hospital, and other services).

Costs are shown for each of the five geographic regions and totaled statewide. Cook County (Region 4) accounts for roughly 60 percent of statewide claims costs, including 65 percent of costs in the disabled category and 55 percent of costs in the family health category.

Table 18 presents similar information as is in ***Table 17***, but converts all the figures into "per member per month" (PMPM) values. The eligibility data provided by DPA was at the "covered day" level; translation into PMPM figures involves dividing covered days by 30.42 (the average number of days per month). The average number of Medicaid-covered persons in each region and category of assistance can be derived by dividing the covered month figure by twelve. The right-hand column of ***Table 18*** presents the costs exclusive of long-term care related services (nursing home, other institutional, and waiver), since the remaining services are those that are most likely to be influenced by the managed care models being assessed.

The ***Table 18*** figures identify several noteworthy characteristics of Illinois claims costs. (Again, note that more than 90 percent of the costs shown occur in the disabled and family health categories of assistance.) PMPM costs in Cook County in the disabled category are much higher than in the other regions and these differences are entirely attributable to inpatient PMPM costs, which can largely be explained by the enhanced payments made to the Cook County Bureau of Health Services. However, in the family health category, overall PMPM costs are closely similar across the regions despite the existence of relatively high inpatient PMPM costs in Cook County.

Baseline costs specific to the various conditions targeted for potential disease management interventions were presented earlier (***Tables 12*** through 14). Also, baseline costs relevant to high cost cases and the complex care coordination managed care model were presented in Figure 4.

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[26] The State of Illinois fiscal years extend from July through June (e.g., FY2004 begins on 7/1/03 and ends 6/30/04).

Table 17. Baseline Claims Costs, Fiscal Year 2004 (excludes dual eligibles, spend-down eligibles)

Disabled

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total
Northwestern IL	$35,122,538	$16,307,780	$35,316,782	$38,651,309	$0	$27,907,970	$38,992,596	$191,911,289
Central IL	$31,754,556	$12,625,297	$31,150,668	$36,512,974	$0	$21,982,479	$36,465,244	$170,268,648
Southern IL	$43,164,450	$11,698,131	$49,355,914	$51,620,807	$2,127	$26,332,542	$54,264,246	$236,209,627
Cook County	$609,080,195	$210,391,944	$83,902,632	$249,857,010	$27,786	$96,413,365	$305,854,342	$1,554,175,439
Collar Counties	$63,555,619	$32,847,246	$50,268,337	$39,759,149	$0	$27,012,815	$39,522,484	$252,564,799
Statewide Total	$782,677,358	$283,870,398	$249,994,334	$416,401,249	$29,913	$199,649,170	$475,098,913	$2,405,129,801

DCFS Wards

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total
Northwestern IL	$2,042,848	$0	$319,598	$2,636,953	$0	$152,175	$7,308,447	$12,452,700
Central IL	$2,024,211	$3,857	$171,982	$2,308,091	$0	$535,578	$6,935,372	$11,937,288
Southern IL	$985,582	$0	$300,212	$1,205,378	$2,578	$21,258	$4,435,787	$6,950,267
Cook County	$54,355,659	$278,623	$7,158,822	$29,484,951	$96,746	$2,386,489	$105,602,121	$199,261,007
Collar Counties	$4,539,415	$95,031	$212,166	$2,482,092	$1,012	$173,389	$14,443,962	$21,936,298
Statewide Total	$63,947,714	$377,511	$8,162,780	$38,117,465	$100,336	$3,268,889	$138,725,688	$252,537,561

Family Health

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total
Northwestern IL	$78,833,263	$248,159	$412,282	$46,404,997	$58,202	$2,865,667	$113,118,680	$241,868,160
Central IL	$65,513,668	$147,876	$197,827	$45,026,330	$65,413	$879,300	$107,447,957	$219,252,009
Southern IL	$65,220,912	$184,784	$1,583,952	$45,064,500	$22,981,344	$1,337,540	$107,959,138	$244,320,712
Cook County	$493,854,615	$2,811,005	$1,215,666	$120,257,450	$172,448,847	$3,139,270	$392,358,179	$1,185,972,724
Collar Counties	$106,960,879	$270,522	$349,929	$42,692,323	$154,797	$1,014,925	$131,269,297	$282,675,982
Statewide Total	$810,383,337	$3,662,345	$3,759,657	$299,445,601	$195,708,602	$9,236,703	$852,153,251	$2,174,089,588

SCHIP

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total
Northwestern IL	4,235,810.56	9,682.85	0.00	3,418,300.91	2,601.34	44,055.20	7,690,872.40	15,401,331.51
Central IL	3,408,538.25	234.84	0.00	4,007,701.04	3,479.52	8,845.83	7,478,289.63	14,908,710.81
Southern IL	3,279,427.47	0.00	21,980.00	4,438,219.03	781,057.06	30,705.79	7,331,495.10	15,884,106.61
Cook County	66,686,264.27	56,847.83	76,565.02	10,901,497.28	5,459,226.32	88,788.88	48,903,404.19	132,166,075.06
Collar Counties	23,248,460.66	13,265.47	0.00	4,745,104.75	11,705.32	57,027.35	20,306,013.94	48,379,566.65
Statewide Total	100,858,501.21	80,030.99	98,545.02	27,510,823.01	6,258,069.56	229,423.05	91,710,075.26	226,739,790.64

Total, All Categories

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total
Northwestern IL	$120,234,460	$16,565,622	$36,048,663	$91,111,560	$60,803	$30,969,867	$167,110,595	$461,633,481
Central IL	$102,700,973	$12,777,265	$31,520,477	$87,855,096	$68,892	$23,406,203	$158,326,862	$416,366,656
Southern IL	$112,650,371	$11,882,914	$51,262,059	$102,328,904	$23,767,106	$27,722,046	$173,990,667	$503,364,712
Cook County	$1,223,976,734	$213,538,419	$92,353,685	$410,500,909	$178,032,606	$102,027,912	$852,718,046	$3,071,575,246
Collar Counties	$198,304,374	$33,226,064	$50,830,432	$89,678,669	$167,514	$28,258,157	$205,541,757	$605,556,646
Statewide Total	$1,757,866,911	$287,990,284	$262,015,316	$781,475,139	$202,096,921	$212,384,185	$1,557,687,927	$5,058,496,741

Figures exclude costs for persons with Medicare and/or spend-down coverage.

Table 18. FY2004 Per Member Per Month (PMPM) Costs

Disabled

Region	Coverage Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total	Total Excluding LTC-Related
Northwestern IL	156,598	$224.28	$104.14	$225.52	$246.82	$0.00	$178.21	$249.00	$1,226	$718
Central IL	152,556	$208.15	$82.76	$204.19	$239.34	$0.00	$144.09	$239.03	$1,116	$685
Southern IL	205,651	$209.89	$56.88	$240.00	$251.01	$0.01	$128.04	$263.87	$1,149	$724
Cook County	1,215,273	$501.19	$173.12	$69.04	$205.60	$0.02	$79.33	$251.68	$1,279	$957
Collar Counties	167,390	$379.69	$196.23	$300.31	$237.52	$0.00	$161.38	$236.11	$1,509	$851
Grand Total	1,897,469	$412.48	$149.60	$131.75	$219.45	$0.02	$105.22	$250.39	$1,268	$881

DCFS Wards

Region	Coverage Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total	Total Excluding LTC-Related
Northwestern IL	31,810	$64.22	$0.00	$10.05	$82.90	$0.00	$4.78	$229.75	$391	$377
Central IL	27,128	$74.62	$0.14	$6.34	$85.08	$0.00	$19.74	$255.66	$440	$414
Southern IL	18,808	$52.40	$0.00	$15.96	$64.09	$0.14	$1.13	$235.84	$370	$352
Cook County	711,955	$76.35	$0.39	$10.06	$41.41	$0.14	$3.35	$148.33	$280	$266
Collar Counties	26,955	$168.41	$3.53	$7.87	$92.08	$0.04	$6.43	$535.86	$814	$796
Grand Total	816,656	$78.30	$0.46	$10.00	$46.68	$0.12	$4.00	$169.87	$309	$295

Family Health

Region	Coverage Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total	Total Excluding LTC-Related
Northwestern IL	1,652,211	$47.71	$0.15	$0.25	$28.09	$0.04	$1.73	$68.47	$146	$144
Central IL	1,537,651	$42.61	$0.10	$0.13	$29.28	$0.04	$0.57	$69.88	$143	$142
Southern IL	1,551,606	$42.03	$0.12	$1.02	$29.04	$14.81	$0.86	$69.58	$157	$155
Cook County	7,646,650	$64.58	$0.37	$0.16	$15.73	$22.55	$0.41	$51.31	$155	$154
Collar Counties	1,963,896	$54.46	$0.14	$0.18	$21.74	$0.08	$0.52	$66.84	$144	$143
Grand Total	14,352,013	$56.46	$0.26	$0.26	$20.86	$13.64	$0.64	$59.38	$151	$150

SCHIP

Region	Coverage Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total	Total Excluding LTC-Related
Northwestern IL	97,313	$43.53	$0.10	$0.00	$35.13	$0.03	$0.45	$79.03	$158	$158
Central IL	100,124	$34.04	$0.00	$0.00	$40.03	$0.03	$0.09	$74.69	$149	$149
Southern IL	93,141	$35.21	$0.00	$0.24	$47.65	$8.39	$0.33	$78.71	$171	$170
Cook County	495,489	$88.83	$0.11	$0.15	$22.00	$11.02	$0.18	$98.70	$267	$266
Collar Counties	192,406	$120.83	$0.07	$0.00	$24.66	$0.06	$0.30	$105.54	$251	$251
Grand Total	978,473	$103.08	$0.08	$0.10	$28.12	$6.40	$0.23	$93.73	$232	$231

Figures exclude persons with Medicare and/or spend-down coverage. Pharmacy costs are pre-rebate.

B. Trending

Costs have been modeled for each calendar year from 2006-2010. The annual trend factors assumed in each category are: 2 percent increase for member months, 5 percent increase for all medical service categories except pharmacy, and 15 percent for pharmacy.[27] Baseline cost estimates for each year, region, and category of eligibility are shown in ***Appendix 3.***

C. Medical Costs Estimates

The medical cost impacts of various managed care approaches have been modeled in relation to the baseline fee-for-service costs derived for each year. Note that this baseline is not a completely unmanaged program where no cost containment initiatives occur; instead it includes the programs (such as the Family Case Management Perinatal Program) that are in place. The factors developed by Lewin assume that substantial savings will be realized in the inpatient, pharmacy, and "all other" categories, particularly in the HMO setting due to the breadth and depth of cost containment approaches used in this model (as delineated earlier in ***Section III***). Substantial savings in the mandatory enrollment Medicaid capitated setting have also been documented in objective research studies.[28]

Table 19 presents the medical cost factors used for CY2006 impacts for disabled persons for each model: HMO, PCCM/Disease Management (DM), Complex Care Coordination (CCC), and a combination approach including PCCM/DM/CCC. Our projections through 2010 for each model assume that medical cost savings will grow steadily over time (i.e., the medical cost factors are reduced by 0.5 – 1.0 percentage points each year for the inpatient, pharmacy, and "all other" service categories. A listing of the cost factors used for each model, eligibility category, and year is presented in ***Appendix 4.***

The medical savings for the combination model of PCCM/DM/CCC are only slightly larger than the PCCM/DM model because the majority of persons with annual claims costs above $25,000 (which is the population being modeled for CCC interventions) also possess one or more of the targeted diseases. Thus, there is considerable overlap in the savings estimates assumed for the PCCM/DM and the CCC models, particularly in the disabled eligibility category.

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[27] These trend factors were used for purposes of creating a reasonable comparison between different Medicaid managed care approaches and do not represent a precise attempt to estimate future Medicaid expenditure levels. For example, costs and member months were trended from FY2004 to CY2006 as though this were a single year, although there is an 18 month gap between the midpoints of these two periods.

[28] For example, "The Impact of Medicaid Managed Care on Hospitalizations for Ambulatory Care Sensitive Conditions" (Bindman et al, Health Services Research, February 2005) quantified a 33 percent reduction in inpatient admissions for conditions such as asthma, diabetes and hypertension. Extensive data exists documenting significant reductions in average length of hospital stays in the HMO setting. A 2003 Lewin Group study, "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting," quantified a 15 percent savings in PMPM Medicaid pharmacy costs in the capitated setting versus FFS, after taking all rebates in both settings into account.

Table 19. 2006 Medical Cost Impact Factors for Each Model, Disabled Eligibility Category

HMO Model Cost Impact Factors

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Central IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Southern IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Cook County	0.700	1.000	1.000	0.880	1.000	1.000	0.850
Collar Counties	0.700	1.000	1.000	0.880	1.000	1.000	0.850

Note: Pharmacy factors take into account the rebates that Illinois receives in the non-capitated setting.

PCCM & Disease Management Model Cost Impact Factors

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Central IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Southern IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Cook County	0.900	1.000	1.000	0.960	1.000	1.000	0.970
Collar Counties	0.900	1.000	1.000	0.960	1.000	1.000	0.970

Complex Care Coordination Model Cost Impact Factors

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Central IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Southern IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Cook County	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Collar Counties	0.950	1.000	1.000	0.950	1.000	1.000	0.950

PCCM/DM/CCC Model Cost Impact Factors

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.890	1.000	1.000	0.940	1.000	1.000	0.950
Central IL	0.891	1.000	1.000	0.942	1.000	1.000	0.951
Southern IL	0.893	1.000	1.000	0.944	1.000	1.000	0.954
Cook County	0.890	1.000	1.000	0.949	1.000	1.000	0.959
Collar Counties	0.883	1.000	1.000	0.942	1.000	1.000	0.952

D. Administrative Costs and Profit Margins

The Medicaid managed care models being assessed all assume that external contractors will be engaged to implement the selected approaches. While it is possible for some of the approaches to be handled entirely by DPA (e.g., PCCM, DM, and/or CCC), such changes would require large-scale hiring's and system reconfigurations – and would bypass the extensive body of experienced and qualified vendors that are well-equipped to expand their Medicaid managed

care operations and have economies of scale advantages in doing so. Therefore, a contractor model is assumed for all approaches. Note, however, that each of these contractor models will create new staffing requirements and other oversight costs and responsibilities for DPA, and these investments have been included in the modeling effort.

HMO Costs: HMO administrative costs have been estimated to consume six percent of capitation costs for disabled persons and ten percent of capitation costs for the other categories of assistance. Note that the health plans' capitation would likely not include costs for nursing home, other institutional, and waiver services. HMO profit is assumed to be 2.5 percent of capitation revenue. State administrative costs include the enrollment broker contractor, other contractors (e.g., actuarial, external quality review organization, etc.), and direct state costs to modify the eligibility and claims systems to accommodate and oversee program operations, and to hire sufficient oversight staff. PMPM costs estimates for the HMO model are summarized in ***Tables 21 and 22*** for 2006. All PMPM administrative cost estimates are inflated by 5 percent per year.

Note that these figures all assume mandatory enrollment with no direct marketing, and that an extensive array of outreach and education services will be provided to the enrollee population. Pennsylvania's and Arizona's capitated Medicaid programs serve as models, with their overall administrative costs currently averaging 8.0 and 7.6 percent of revenue, respectively.

PCCM, Disease Management and Complex Care Coordination Administrative Costs: Contractor administrative costs for the PCCM component are estimated at $1.50 PMPM. Disease management vendor costs are based on known negotiated costs for the Texas DM program, which average approximately $27.50 per month per targeted individual. These $27.50 cost is added to the PCCM administrative cost according to the proportion of persons in each region and eligibility category who qualify for DM services. Profit margins are assumed to be 20 percent of administrative costs for the PCCM/DM model, in acknowledgement of the expectation that the vendor's administrative fees will be substantially (if not fully) at risk for achieving specified cost and other outcomes and that an "upside" reward should exist to balance this risk. State PMPM administrative costs are assumed to be $1.50 for PCCM/DM model. These costs are much lower than are needed for the HMO model, but the PCCM/DM approach also requires system redesign, program oversight, and actuarial work related to financial reconciliations.

For complex care coordination, vendor administrative costs are assumed to be $175 PMPM for each targeted enrollee, which is translated into a (much smaller) population-wide PMPM cost based on the proportion of the overall population in each region and category of assistance receiving case management services. The profit margin under the CCC model is assumed to be 10 percent of administrative fees, reflecting an assumption that this model will entail less fee risk than the PCCM/DM approach. State administrative costs for CCC services are assumed to be $0.50 PMPM.

PMPM administrative costs for the PCCM/DM/CCC model are higher than in the PCCM/DM model, but not as high as the amount created by adding the separate PCCM/DM and CCC estimates together. This situation results form the overlap of target populations: CCC case management services will be provided to many persons who will otherwise receive DM services, but CCC will also be targeted to some persons who do not need DM interventions.

Table 20 presents the administrative and profit assumptions for the fee-for-service based Medicaid managed care models.

Table 20. Administrative Cost PMPM Estimates For Various Models, CY2006

	Contractor Administration	Contractor Profit	State Administration
Disabled:			
HMO	$43.86 - $51.85	$18.28 - $23.55	$3.00
PCCM/DM	$11.59 - $14.45	$2.32 - $2.89	$1.50
CCC	$14.35 - $19.60	$1.44 - $1.96	$0.50
PCCM/DM/CCC	$17.52 - $19.01	$3.50 - $3.80	$1.75
Family Health:			
HMO	$14.86 - $17.06	$3.72 - $4.26	$3.00
PCCM/DM	$3.26 - $4.08	$0.65 - $0.82	$1.50
CCC	$0.82 - $1.05	$0.08 - $0.10	$0.50
PCCM/CCC	$2.32 - $2.55	$0.46 - $0.51	$1.25

Note: For non-HMO models, projected contractor costs vary by region based on percentage of population targeted for DM services; figures shown depict the range across regions.

E. Overall Cost Estimates

Once the medical cost and administrative estimates are in place, the net cost impacts of each managed care approach can be derived for each year, region, and category of assistance. The net results for the disabled population for 2006 are shown in ***Table 21***; similar information for the family health category of assistance is presented in ***Table 22.*** Detailed summary cost results for each model and year are presented in ***Appendix 5.***

The key findings from the cost modeling are summarized below:

- Nearly all models of Medicaid managed care will create savings. The "Affirmative Choice" model which combines the HMO and PCCM approaches (in a manner where they would function side-by-side in a competitive fashion) was not projected to yield savings in some regions and populations. Also, Disease Management programs targeted at the lower-cost Family Health Plan population were not expected to yield savings.

- The mandatory HMO model creates by far the largest cost savings for the Disabled population group, for each geographic region and year. For the Disabled population, estimated savings from the HMO model were more than double that of the next most cost-effective model, which is a combination of PCCM/DM/CCC.

- For the Family Health population, savings estimates for the mandatory HMO model were higher than all other approaches in some regions (e.g., the Collar Counties). The combination of PCCM/CCC yielded the largest savings in the Southern Region and savings levels closely similar to the HMO approach in the Northwestern and Central regions.

- The difficulties that IGT funding poses for the HMO model in Cook County need to be explicitly resolved for this approach to become advisable. While ***Tables 21*** and ***22*** indicate that Cook County savings from the HMO can exceed $250 million in Year 1 for all payers, Table 6 on page 9 indicates that about $350 million of Federal safety-net funds would be forfeited (before counting any additional impacts from reductions in lump sum payments).

Table 21. Year 1 Savings Summary by Model and Region, Disabled Eligibles

Medicaid Managed Care Model:	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings if Cook County Bureau of Health Services is "Held Harmless"
HMO					
Northwestern	$80.33	10.5%	5.7%	$12,433,940	$12,268,805
Central	$75.48	10.9%	5.9%	$11,381,280	$11,274,807
Southern	$78.41	11.1%	5.9%	$15,938,591	$15,938,302
Cook County	$156.95	16.5%	10.8%	$188,515,727	$117,370,435
Collar Counties	$125.87	11.8%	7.3%	$20,824,261	$19,083,641
PCCM/DM					
Northwestern	$28.54	3.1%	2.0%	$4,418,070	$4,363,031
Central	$25.50	3.2%	2.0%	$3,844,342	$3,808,854
Southern	$26.85	3.3%	2.0%	$5,456,875	$5,456,778
Cook County	$55.61	5.1%	3.8%	$66,791,978	$43,079,252
Collar Counties	$46.06	3.6%	2.7%	$7,620,279	$7,040,131
CCC					
Northwestern	$24.20	3.0%	1.7%	$3,745,724	$3,715,700
Central	$24.19	3.2%	1.9%	$3,647,772	$3,628,413
Southern	$25.47	3.2%	1.9%	$5,176,357	$5,176,304
Cook County	$33.04	3.8%	2.3%	$39,682,102	$27,824,553
Collar Counties	$28.94	2.9%	1.7%	$4,787,903	$4,497,800
HMO/PCCM					
Northwestern	($3.61)	3.4%	(0.3%)	($559,392)	($608,181)
Central	($3.29)	3.5%	(0.3%)	($495,853)	($527,311)
Southern	($3.72)	3.6%	(0.3%)	($756,778)	($756,863)
Cook County	$11.52	5.1%	0.8%	$13,834,529	($6,916,181)
Collar Counties	$5.36	3.7%	0.3%	$886,805	$379,125
PCCM/DM/CCC					
Northwestern	$36.80	4.3%	2.6%	$5,695,513	$5,629,373
Central	$33.40	4.4%	2.6%	$5,036,013	$4,993,756
Southern	$34.11	4.3%	2.6%	$6,932,443	$6,932,331
Cook County	$61.60	5.9%	4.2%	$73,986,093	$47,882,859
Collar Counties	$54.85	4.6%	3.2%	$9,074,049	$8,397,556

Table 22. Year 1 Savings Summary by Model and Region, Family Health Eligibles

Medicaid Managed Care Model:	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings if Cook County Bureau of Health Services is "Held Harmless"
HMO					
Northwestern	$7.96	18.0%	4.7%	$11,625,587	$11,254,938
Central	$7.03	17.8%	4.3%	$9,553,500	$9,333,831
Southern	$4.54	16.0%	2.5%	$6,228,633	$6,228,196
Cook County	$9.12	18.5%	5.2%	$61,660,580	$3,974,530
Collar Counties	$10.94	19.9%	6.7%	$18,996,233	$16,066,858
PCCM/DM					
Northwestern	$2.40	5.1%	1.4%	$3,500,193	$3,376,656
Central	$1.78	5.0%	1.1%	$2,413,860	$2,340,644
Southern	$2.54	4.5%	1.4%	$3,484,346	$3,484,201
Cook County	$4.24	5.5%	2.4%	$28,643,342	$9,416,581
Collar Counties	$3.32	5.7%	2.0%	$5,770,080	$4,793,720
PCCM/CCC					
Northwestern	$7.38	6.9%	4.4%	$10,787,155	$10,652,374
Central	$7.11	6.9%	4.3%	$9,664,481	$9,584,602
Southern	$7.12	6.2%	3.9%	$9,768,970	$9,768,811
Cook County	$7.11	6.5%	4.1%	$48,075,984	$28,847,301
Collar Counties	$7.39	7.2%	4.5%	$12,841,869	$11,865,411
CCC					
Northwestern	$6.66	4.9%	4.0%	$9,730,831	$9,663,441
Central	$6.63	5.0%	4.0%	$9,010,028	$8,970,088
Southern	$6.67	4.5%	3.7%	$9,147,478	$9,147,399
Cook County	$5.79	4.2%	3.3%	$39,133,539	$29,519,197
Collar Counties	$6.47	5.0%	4.0%	$11,239,714	$10,751,485
HMO/PCCM					
Northwestern	($5.95)	5.7%	(3.5%)	($8,690,204)	($8,799,714)
Central	($6.09)	5.7%	(3.7%)	($8,286,888)	($8,351,790)
Southern	($7.45)	5.1%	(4.1%)	($10,227,588)	($10,227,717)
Cook County	($6.21)	5.7%	(3.6%)	($42,023,658)	($58,848,756)
Collar Counties	($5.02)	6.2%	(3.1%)	($8,711,799)	($9,566,200)
PCCM/DM/CCC					
Northwestern	$6.10	7.4%	3.6%	$8,915,328	$8,762,194
Central	$5.31	7.2%	3.2%	$7,217,104	$7,127,285
Southern	$6.41	6.6%	3.6%	$8,790,918	$8,790,736
Cook County	$7.48	7.4%	4.3%	$50,590,730	$27,196,606
Collar Counties	$6.94	8.0%	4.2%	$12,058,825	$10,868,139

F. IGT Funding Impacts

In assessing the Cook County (Region 4) impacts relative to IGT issues, the two right hand columns of ***Tables 21 and 22*** demonstrate the extremes as to how the Cook County Bureau of Health Services would be affected. The figures in the second column from the right demonstrate the savings if nothing were done to preserve the flow of revenues to the Cook County Bureau of Health Services. This approach leads to fairly large-scale savings under each managed care approach, since each admission avoided/averted at the Bureau would produce a large scale savings.

However, there is a broad-based interest in preserving the Bureau's massive role as a safety net provider, and in continuing to rely heavily on Federal funds to achieve this objective. Medicaid revenue reductions at the Bureau will create some marginal cost savings (as the System will not need to provide as much care), but much of "savings" that would occur through reduced volume at the Bureau would simply represent a loss of Federal funds. The State would likely need to find a mechanism to restore much of these lost funds, which could significantly reduce the level of State savings each model is achieving.

The figures in the right-hand column of ***Tables 21 and 22*** indicate the remaining savings if the Bureau's baseline revenue were fully maintained under each model (i.e., if the Bureau was successfully "held harmless" from the inpatient volume and revenue reductions that Medicaid managed care programs create).

The two right-hand columns therefore represent the "bookends" of the lowest managed care savings that would occur (if the Cook County Bureau of Health Services is "held harmless"), and the fullest savings that would be realized if no efforts are made to preserve the Bureau's revenue.

Note that the capitated HMO model particularly threatens the IGT arrangement, as days of care that occur in the capitated setting at the Cook County Bureau of Health Services do not qualify for the enhanced IGT rate. Preservation of the IGT funding therefore requires not expanding use of the HMO model in the Chicago area, or developing a mechanism to preserve the enhanced payments to Cook County Bureau of Health Services within a fully or partially capitated approach.

Table 23 presents results of estimates of the overall reductions in inpatient revenue that each model would create. Inpatient usage is expected to be reduced under all models (to varying degrees) through utilization management efforts encouraging lower-cost services instead of inpatient care, as well as through improved beneficiary health status that eliminates the need for (or severity of) some hospitalizations. Note that the Cook County Bureau of Health Services IGT involves significant dollar volume for both the Disabled and Family Health categories of assistance. The non-HMO models of Medicaid managed care have a much smaller usage-reducing impact on Cook County Bureau of Health Services than does the HMO model.

Table 23. Estimated Cook County Bureau of Health Services Revenue Reductions Through Inpatient Usage Impacts of Each Model, CY2006 ($$ figures in millions)

Population Group & Managed Care Model	Inpatient Reduction in Cook County ($ millions)	Cook County Bureau of Health Services % of Inpatient	Estimated Cook County Inpatient Reduction ($ millions)
Disabled			
HMO	$210	34%	$71
PCCM/DM	$70	34%	$24
CCC	$35	34%	$12
PCCM/DM/CCC	$77	34%	$26
Family Health			
HMO	$170	30%	$52
PCCM/DM	$57	30%	$17
CCC	$28	30%	$9
PCCM/DM/CCC	$69	30%	$21
Family Health & Disabled			
HMO	$387	32%	$123
PCCM/DM	$127	32%	$41
CCC	$63	32%	$21
PCCM/DM/CCC	$146	32%	$47

G. Cash Flow Impacts

The savings estimates presented up to this point depict costs on an accrued basis. Because vendors are paid up-front under most of the Medicaid managed care models, many of the models (particularly capitation and monthly administrative fee approaches) create short-term cash flow disadvantages at the point the program is implemented. ***Table 24*** presents the cash flow and accrued savings impacts associated with transitioning all non-Medicare, non-spend-down persons to a capitated program in a 20 county area (11 counties in the Collar county area and 8 counties in the East St. Louis region. Key assumptions driving these assessments are:

- 1% of incurred FFS claims paid in same month, 5% in month 2, 20% in month 3, 65% in month 4, and the remaining 9% across months 5-10.
- Capitation payments are assumed to be delayed one month (as currently occurs).

Capitation rates assume the savings levels derived in the previous modeling calculations for the capitated HMO approach in each category of eligibility and year. Capitated funds assume that all Medicaid services will be included in the capitation except for nursing home, other institutional, and waiver services.

Table 24 indicates that while significant savings accrue to implementing the capitated model in 19 counties (in the Collar County and the East St. Louis areas), there is a significant initial adverse cash flow impact to this transition. If the target population in these 19 counties were entirely and simultaneously enrolled into capitated health plans, the Medicaid program would realize an accrual gain of $60 million as of the end of the first year of implementation,

increasing to approximately $477 million cumulatively by the end of Year 5. However, an adverse cash flow impact of $117 million would need to be borne during the early stages (especially Months 2 and 3) of Year 1. While the program would be saving money every month on an incurred basis from inception, it would take until Month 30 of implementation for the capitated initiative to realize a cumulative savings on a cash flow basis.

A phased enrollment approach was also modeled, which softens the adverse cash flow impacts by staggering the timeframe through which recipients would be educated about and enrolled in the new program. This phase-in approach enrolls the total 19 county target population evenly across a two-year period. This approach would lower the maximum cumulative cash flow deficit to $87 million, although it also pushes back to Month 37 the point at which the program achieves a cumulative surplus from a cash flow perspective. Under the 24 month phase-in approach, the capitated program continues to achieve accrual savings every month from inception, although these savings are smaller under the phase-in than under the "full transition in Month 1" scenario. The two-year phase-in would achieve accrued savings of only $17 million as of the end of Year 1 (versus $60 million saved under the non-phased approach). A detailed comparison of the cash flow impacts of the non-phase-in and phase-in approaches is presented in ***Appendix 6***.

Another option for softening the adverse short-term cash flow impacts that are created by a transition to capitation involves phasing out the existing voluntary enrollment capitation programs. Moving a given amount of funds from capitation to fee-for-service creates an "equal and opposite" cash flow advantage as compared to the adverse impact of moving the same amount of funding from fee-for-service to capitation. Roughly $20 million per month is spent on capitation currently in the Illinois Medicaid program.

Table 24. Estimated Cash Flow: 19 Counties (Collar & East St. Louis Areas)
All Four Categories of Assistance Combined

Month	Estimated Cum. Enrollment	Estimated Capitation Payments	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	325,242	$0	$748,494	$4,970,936
February	325,242	$72,368,065	($64,638,969)	$9,941,872
March	325,242	$72,368,065	($115,056,559)	$14,912,808
April	325,242	$72,368,065	($116,822,065)	$19,883,744
May	325,242	$72,368,065	($115,593,597)	$24,854,680
June	325,242	$72,368,065	($113,616,635)	$29,825,616
July	325,242	$72,368,065	($110,891,180)	$34,796,552
August	325,242	$72,368,065	($107,417,231)	$39,767,488
September	325,242	$72,368,065	($103,194,789)	$44,738,424
October	325,242	$72,368,065	($98,223,853)	$49,709,360
November	325,242	$72,368,065	($93,252,917)	$54,680,297
December '06	325,242	$72,368,065	($88,281,981)	$59,651,233
December '07	333,893	$78,091,386	($27,734,796)	$134,462,952
December '08	342,932	$84,608,835	$48,480,735	$227,021,115
December '09	352,387	$91,674,869	$143,476,092	$340,024,563
December '10	362,291	$99,621,122	$259,895,429	$476,894,515

H. Enhanced Provider Payments

We have modeled a design feature with regard to the HMO model to ensure that the program's savings accrue predominantly through management of care (rather than further reductions in Medicaid's already low provider payment rates) and which would utilize the HMO model as a vehicle to prop up provider payment rates. This feature would involve a programmatic requirement that all Medicaid health plans contract for physician and inpatient hospital services at, for example, 5 percent above prevailing Medicaid fee-for-service payment rates. (A further feature to encourage network development would be to allow health plans to pay only 90 percent of the Medicaid fee-schedule to out-of-network hospitals and physicians if they have documented at least three attempts to contract with that provider.) We have therefore modeled a 5 percent increase in inpatient and physician fee schedules to assess this approach's impact on the HMO model's savings levels. The results of this are shown in ***Table 25.***

Table 25. Impacts of Incorporating 5 Percent Provider Rate Increase In HMO Model
($ figures in millions)

Region and Category of Assistance	Net Savings, HMO Model With No Provider Rate Increase	Net Savings, HMO Model With 5% Inpatient & Physician Rate Increase	Percentage of Initial Savings If Higher Payment Approach Is Used
11 Collar Counties			
Year 1	$49.5	$34.3	69%
Year 2	$110.7	$89.9	81%
8 E. St. Louis Counties			
Year 1	$13.7	$8.1	59%
Year 2	$35.9	$28.4	79%
Cook County			
Year 1	$129.5	$108.6	84%
Year 2	$211.1	$186.9	89%

Table 25 demonstrates that the HMO model is sufficiently cost-effective that adding a five percent inpatient and physician rate increase mandate to this model would still retain most of the savings that would occur if the HMOs do not enhance payment rates. Year 1 savings under the enhanced fees across the 19 Collar and East St. Louis counties would be $42.4 million, or 67 percent of the $63.2 million Year 1 savings if MCOs match the FFS rate schedule. By Year 5, the percentage would increase to 81 percent.

VI. ASSESSMENT OF OTHER STATES' PROGRAMS

A. National Contracting Environment for Medicaid Managed Care Services

A significant national development related to Illinois' Medicaid managed care options is that an unprecedented "seller's market" clearly exists. States that are implementing Medicaid managed care initiatives are finding that they can essentially stipulate the program design rules however they desire and that a strong array of experienced Medicaid managed care vendors will compete aggressively for the contract(s).

As one example, Georgia is currently procuring contracts for capitated health plans to serve the TANF and TANF-related populations. The state has been divided into six regions and the program involves mandatory enrollment. Interest in the program was so high that the bidder's conferences (three separate conferences took place covering various aspects of the RFP and bid process) were all held in auditoriums.

Another encouraging aspect of the current marketplace is that the interested vendors tend to have strong experience in (and commitment to) serving the Medicaid population. This is important due to the vast differences between Medicaid and "commercial" managed care. In the capitated arena, the health plans that have brought a commercial HMO model to the Medicaid arena have predominantly exited the market and been replaced by an extensive array of organizations that are primarily committed to serving Medicaid (and perhaps Medicare) populations. Most of these organizations are extremely interested in expanding their revenue base, thus any expansion of the capitated model in Illinois would be certain to draw a great deal of attention.

The same situation exists for fee-for-service models of managed care. In the disease management arena, several prospective vendors have extensive Medicaid experience and are willing to accept significant levels of risk related to their administrative fees regarding program savings levels. In Texas, for example, often the disease management contractor (McKesson) fees will be entirely forfeited if the program achieves no savings.

Current procurements for disease management services in Georgia and Missouri are attracting a strong field of potentially interested contractors. Many of the multi-state Medicaid health plans are also interested in entering the "managed fee-for-service" market in States where that is their only contracting opportunity.

The one countervailing factor with regard to this situation is that provider political resistance to the expansion of Medicaid managed care can be difficult to overcome. In Texas, for example, a significant geographic expansion of the mandatory enrollment capitated model for disabled persons may be halted by the state legislature (primarily due to intense opposition from certain provider constituencies). This initiative may switch to a fee-for-service based managed care model, despite the fact that the Medicaid agency has completed extensive procurement activities and received an ample number of bids from Medicaid health plans to move forward with the capitated model in each selected region.

It is a near-certainty that any expansion of the capitated model will be met with strong opposition from the Illinois Hospital Association and the Illinois Primary Health Care Association, for example. Illinois advocacy organizations may also align against such models. However, advocacy organizations might also be supportive of initiatives that (as many states are now doing) mandate a strong array of access, outreach, and oversight features, eliminate direct marketing to the beneficiary population, and permit no lock-in periods.

Because significant investments are needed (both in terms of State resources and prospective bidders' efforts) to implement a procurement process, one lesson from the current Texas situation is to ensure legislative support for an initiative exists before conducting procurement activities.

Notwithstanding potential political challenges, the key message to learn from other states' experience is that there exists an extraordinary opportunity for policymakers to design and implement exactly the form of Medicaid managed care program they would like to have. Some potential features that we believe could readily be included in Illinois if desired:

For capitated contracts:

- prohibitions against direct marketing to Medicaid recipients (beneficiaries would instead be supported in making informed choices from among health plans by a neutral "enrollment broker" contractor separately engaged by DPA)
- minimum requirements regarding the ways new enrollees must be contacted and educated about how the health plan works
- extended hours of direct member services support
- minimum requirements regarding how EPSDT and other preventive services (e.g., prenatal care) must be promoted and tracked
- minimum requirements regarding how special needs populations must be identified and the outreach/education services they must be given
- no lock-in period for enrollment – recipients could be free to choose another health plan effective the first of the month (if notification occurs before, for example, the 15th of the previous month)
- requirements that certain "safety net" providers be offered participation in a health plan's networks
- requirements that certain providers be paid a certain percentage (e.g., 5-10 percent) above Medicaid fee-for-service rates, in tandem with requirements that if a health plan documents three attempts to contract with a provider, and the provider refuses to do so, the health plan may pay the provider a discounted percentage (e.g., 90 percent) of the Medicaid fee schedule for all services that occur out-of-network
- competitive bidding on price (or simply disclosing the price the state is offering to pay) to ensure significant savings
- delay in timing of capitation payments to soften the "cash flow" disadvantage of switching to capitation

- a carefully designed "auto-assignment" process to keep non-choosers aligned with current primary caregivers (assignment algorithm could also disproportionately award auto-assignment to plan achieving strongest overall score in procurement process, best price, strongest network or outreach programs, etc.)

For contracts under fee-for-service design models:

- stipulation of which populations must be targeted for case management, disease management, etc.
- minimum requirements as to the level of outreach and education each targeted beneficiary must be offered, including documentation requirements of these activities
- performance-based payment structures under PCCM, such that participating primary care providers are not evenly rewarded simply for participating, but rather are variably awarded based on the access, cost and/or quality outcomes for their panel of Medicaid patients (this approach can also adjust the overall size of the enhanced payment pool according to how well the primary care physicians have collectively performed)
- competitive bidding on price (or simply disclosing the price the state is offering to pay) to ensure significant savings for DM and CCC services
- stipulation of the terms by which DM and CCC contractor's administrative fees will be at risk for cost, access, and/or clinical outcomes (including detailed stipulation as to how each of these outcomes will be measured)
- requirements as to what services must be provided to support the program's participating primary care physicians (under PCCM model) using enrollment broker to assist in initial PCP selection and change processing, and stipulation of a clear process for assigning non-choosers to an appropriate initial PCP

Clearly, contractors will need to believe they have a reasonable opportunity to operate profitably over the long-term in order to bid for contracts in Illinois. However, the market climate could not be more favorable to the State in terms of there being such a strong field of well-qualified and eager contractors. Many of these organizations face significant pressure to meet internal growth targets (and stockholder expectations), and few new large-scale opportunities present themselves in any given year in the Medicaid arena. Illinois is in a position to implement a large-scale initiative that would attract enormous vendor attention. A significant leveraged opportunity exists to both improve Medicaid for the State's beneficiaries and to achieve large savings.

B. Other States' Experience with Managed Care Models

The states of Florida, Texas, and Washington have considerable experience with one or all of the forms of managed care analyzed in this study. All states operate capitated programs, PCCM and disease management, although the interaction between the models varies from state to state. These states have had enough time with the programs to offer suggestions to states, such as Illinois, who are considering implementation of managed care for Medicaid recipients.

1. Florida

Florida operates multiple managed care models throughout the state, including capitated managed care, PCCM, and disease management. Medicaid recipients are mandated into managed care unless they reside in a nursing facility or have dual eligibility for Medicaid and Medicare. Within the mandatory managed care program, recipients can choose health plans, PCCM or Provider Service Networks (PSN) depending on county of residence.[29]

Capitated Health Plans

Florida has eleven health plans operating throughout the state. Currently, health plans operate in 34 of 67 counties with a maximum of three health plans in any one county. Florida operates its PCCM program in competition with the health plans in all 34 counties.

Assignment. Medicaid recipients are given 30 days for the date that Medicaid eligibility begins to select a managed care option. If they do not select an option, the recipient is automatically assigned with a multi-faceted algorithm. One legislatively mandated component of the algorithm is sixty percent of defaults are to health plans and 40 percent are to PCCM. In addition, the algorithm takes into consideration the number of plans in a county, capacity of plans, and rotation of assignments to plans.

The responsibility for assignment, enrollment and disenrollment lies with the state's Enrollment Broker. The Enrollment Broker is an unbiased source of information for recipients to assist in making an active choice of models and/or plans. Functions of the Enrollment Broker include responsibilities, such as:

- Distribution of materials to new eligibles
- Enrollment (via phone) for active choice
- Default for non-chooser
- Lock in
- Disenrollment
- Call center
- Internet website with information

State officials strongly recommend the use of an Enrollment Broker in a capitated program. The following were deciding factors in Florida's decision to contract for this function:

- Unbiased information for recipients
- One central point for recipients to call
- Alleviates most problems related to health plan marketing
- Immediate expertise of the vendor

[29] Thirty-three counties have at least one HMO and PCCM. Thirty-four counties have only PCCM.

More flexibility than if handled by state staff (hours of operation; turnover is the vendor's issue; creativity in staffing levels, patterns; recruiting of bilingual staff)

Lock in. Recipients who enroll in managed care begin a 12 month lock in period. For the first 90 days, the recipient may disenroll from the health plan for any reason. After 90 days, the recipient must stay in that plan for the next nine (9) months and then begin a yearly cycle of open enrollment. Certain recipients may disenroll at any time.[30]

Marketing. All health plans must submit a marketing strategy and materials to the State for written approval. The health plan contract contains numerous restrictions and limitations on marketing conducted by the health plans. Examples of prohibitions include:

- Activities that could mislead or confuse the recipient
- Solicitation for the purpose of enrollment
- Offering monetary or other items of value for the purpose of enrollment
- Direct or indirect cold call marketing
- Promotional items in excess of $1.00 retail to attract attention
- Gifts to enrollment broker staff or contractors

Marketing violations are considered good cause for disenrollment for the recipient, therefore the recipient may disenroll at any time. The health plans are allowed to inform members ***after*** enrollment of incentives offered by the health plan for participation in certain activities.

Savings. Compared to fee-for-service, the capitated program saves the state between eight to nine percent of medical costs. The medical loss ratio for plans is between 82 to 87 percent. In interviews with state officials, Lewin was told the state is not concerned that the federal actuarial soundness provisions would increase the cost to the program. Instead, the Florida HMOs are concerned actuarial soundness could drive rates down.[31]

Lessons learned. State officials offered a few suggestions for states such as Illinois to consider when considering a capitated managed care program expansion. Suggestions include:

- **Encounter data.** The state of Florida is currently under contract with an IT vendor to assist in designing an encounter data system for the capitated program. Historically, encounter data has been tracked through "homegrown" templates but not within a more global system with ability to manipulate and monitor data. This has been a weakness for the program and an issue the state intends to overcome as the program moves forward. Encounter data is essential for quality monitoring and many states use this data for capitation rates and risk adjustment.
- **Enrollment function.** Eliminate all enrollment functions as a health plan responsibility. Florida has an enrollment broker handling almost all enrollment functions at this time. There has been one last function, movement of a health plan member between counties,

[30] SSI recipients under age 19, foster care children, children in subsidized adoption arrangements, children enrolled in Children's Medical Services, dual eligibles and American Indians can change managed care plans at any time.

[31] Interview with Florida Medicaid officials, April 5, 2005.

which the State has allowed the plans to retain. As the program moves forward, this responsibility will be transferred to the enrollment broker, drawing clear distinctions between enrollment broker and health plan responsibilities for enrollment and disenrollment.

PCCM. Florida's MediPass program is a statewide, state-operated PCCM program. PCPs are responsible for providing and arranging for primary care services and referring to other medically necessary services on a 24-hour basis. In exchange for these responsibilities, the PCP receives a $3 per patient per month fee in addition to the Medicaid reimbursement for services provided.

Recipients must receive prior authorization for covered services. However, prior authorization is not required for emergency services, vision, hearing, family planning, early intervention and dialysis services. Prior authorization for mental health and dental is not required except in service areas with Prepaid Mental Health and Prepaid Dental plans.

Independent evaluations of the MediPass program have shown the program has more providers than needed on a statewide basis.[32] The state is considering establishing a minimum PCP caseload of 50 Medicaid recipients in order to participate in the program as a PCP. It is not cost effective for the state to credential and monitor a PCP who has a Medicaid caseload below 50 patients.

Lessons learned. When discussing the program, Florida officials were candid in the challenges faced in operating a PCCM program and suggestions on areas to address when building a program.

- Data Management Tools. State officials see data management tools as a key to better patient management and physician utilization monitoring. At this time, there is considerable lag time—up to three months—between when a service occurs and data is available. Florida would like to have real-time data to send to physicians to assist them in better managing the care of their patients. The state does request that hospitals contact physicians when a patient is seen in the emergency room or is admitted to the hospital, but for the most part this does not occur. The state would also like to have increased data capacity in order to generate physician profiling and peer comparisons.
- Unique PCP Authorization Numbers. In Florida, the physician authorization number is the physician's Medicaid number. This number does not change. It has been reported that it is not uncommon for specialist offices to have the PCP's provider number available at all times and to use that number without contacting the PCP's office. This makes it almost impossible for a PCP to manage the patient's care. Florida is working to address this issue.

Monthly PCP management fee. Florida would like to consider initiating a performance payment system for PCPs rather than a flat, fixed monthly management fee. However, the data

[32] Interview with Florida Medicaid officials, April 5, 2005.

systems currently used for payment cannot accommodate multiple rates for the same service. Florida suggests that other states consider this option when starting a program.

Disease Management. Florida Medicaid was one of the early adopters of disease management and now has programs for diabetes, asthma, cancer, congestive heart failure, hypertension, and HIV/AIDS. All MediPass (PCCM) members who have the specified diseases are eligible for disease management services. MediPass members enroll in a separate Disease Management Organization (DMO) to receive these services and the PCP has responsibility to coordinate care with the DMO.[33]

Historically, the disease management programs have been available to both TANF and ABD populations, as long as the recipient was in PCCM. As Florida moves forward with disease management, they plan to focus on the ABD population. The TANF population is difficult to manage due to constant fluctuation of eligibility. Disease management programs take a longer focus on changing behaviors and improving disease outcomes, which are more likely to be successful for the ABD population, both in terms of health outcomes and cost savings.

Financial arrangements for DMOs in Florida have varied. Arrangements have included shared savings with an advance fee and settle up, no-risk administrative fees and value added programs with pharmaceutical manufacturers. Both of the pharmaceutical manufacturer programs end this year and the state does not intend to continue the programs. Originally, these arrangements were tied to the Preferred Drug List but the legislature now only allows monetary arrangements in relation to the PDL, rather than service exchange.

Independent evaluations are conducted by an outside vendor for all disease management programs. Across the board savings are estimated at five percent for all programs. Savings in Year 1 varied by disease state, for example diabetes did not yield Year 1 savings but did produce savings in Year 2.

Lessons learned. Based on their experience, Florida officials offer the following recommendations for states considering implementing disease management programs:

- Establish a program as close to the physician and patient as possible. Nurse relationship is the key but it is difficult to have the number of nurses needed for the program.
- Do not use shared savings arrangements. It is better to pay for expected processes and outcomes on a flat rate arrangement. Determine the flat rate based on savings expectations.

Focus on the ABD population. Active, intent management for ABD will yield stronger outcomes and TANF recipients will still see some benefit.

[33] Florida currently has four DMO and has had as many as seven.

2. Texas

Texas operates multiple managed care models throughout the state, including capitated managed care, PCCM and disease management. Texas also continues to operate a fee-for-service program in rural areas. At this time, the state is in the midst of implementing an expansion of PCCM into all rural areas of the state, essentially eliminating fee-for-service for most Medicaid recipients. The state is also considering a capitated managed care expansion although this change may not occur due to legislative concerns.

Capitated Health Plans. The state of Texas contracts with capitated health plans for TANF and ABD populations. In all major metropolitan areas and the contiguous counties, Texas operates the STAR program, which is a mandatory program for pregnant women and children, and a voluntary program for the ABD population. In Houston and surrounding counties, the state also operates the STAR+PLUS program which is a mandatory program for the ABD population and include acute and long-term care services.

Assignment. Medicaid recipients are given 30 days for the date that Medicaid eligibility begins to select a managed care option. For pregnant women, there is an expedited enrollment process which allows 15 days for choice and involves active outreach on the part of the enrollment broker to facilitate active choice. If a recipient does not select an option in the allotted time, automatic assignment is completed through an algorithm which first looks at managed care history, then history with any Medicaid physician. If the recipient has no Medicaid history, the algorithm make an assignment based on physical proximity to an in-network physician. There is no default into the PCCM program unless the recipient has a history with a physician who is only in the PCCM network. The default, enrollment, and disenrollment process is managed by a neutral enrollment broker.

Lock in. Texas does not have a lock in process for managed care recipients. A recipient can move between managed care health plans at any time.

Marketing. In Texas, enrollment decisions are made by members through an outside enrollment broker. The Enrollment Broker has all pertinent information about each plan and can assist the member in selecting a plan that best meets their needs. Marketing provisions in the Texas program are stringent and designed to prohibit the health plan's involvement in enrollment and disenrollment decisions.

The health plan is prohibited from discussing, inducing, or accepting a member's enrollment or disenrollment. The state goes further to say if a health plan approaches an eligible Medicaid recipient who states that she is enrolled in an HMO, the health plan must end the conversation immediately. The health plan is not allowed to stock, reproduce, or handle enrollment forms and is prohibited from assisting Medicaid recipients in filling out an enrollment form or making a decision about a health plan. There are also additional stipulations, for example, health plans cannot market in county welfare agencies or around the county welfare or public assistance offices and cannot conduct surveys for the purpose of soliciting re-enrollment of previous members. All marketing materials must be approved by the State prior to distribution.

Lessons learned. State officials offered a few suggestions for states such as Illinois to consider when designing a managed care expansion. Suggestions include:

- Build an infrastructure to support monitoring and management of the model. This infrastructure may be an in-house, state staff model or through an outsourced vendor. Persons responsible for oversight of a capitated program need to have skills in insurance, contract compliance, health plans, technology systems, financial oversight, auditing and complaints/appeals. These skills are significantly different than the traditional skills needed in a state health agency. This is not a simple process of moving staff into new functions if they do not have the skills or experience.
- Meet with provider groups and advocates prior to procurement. Allowing providers and advocates to assist in designing the program will increase the likelihood of their support during implementation.
- Have supporting contracts in place early on in the development process. This would include contracts such as the enrollment broker, quality monitor and rate setting.
- Consider a provision such as the Texas "experience rebate". This provision requires the health plan and state share profits above a pre-determined amount. Texas allows profits and losses from its three managed care products to be combined for a cumulative profit/loss and allows HMOs in multiple service areas to combine all areas for a cumulative profit/loss. This rebate protects the state from overpayment, particularly in the beginning of a program when rates are more difficult to set appropriately. It also provides incentives for plans to go into areas where losses might occur if they can balance those losses with gains in other areas in order to minimize the amount owed to the state.

PCCM. Texas operates an enhanced PCCM program which is currently expanding to all counties that do not have Medicaid managed care. The state had plans to withdraw PCCM from areas where HMOs operate but this has been placed on hold pending legislative action.

Texas added several enhancements to the traditional PCCM model, including community health services that identify high utilizers, and makes personal contacts, provides client education, manages a 24-hour nurse line, and conducts selective contracting/contract negotiation with hospitals. Recently, Texas reduced utilization management requirements for hospitals by moving to DRG payments for all hospitals. The hospital is required to have prior authorization for the service but there is no need for additional contact with the PCCM administrator. The hospital is managing the care and responsible if a person stays in longer than the payment of the DRG. The Office of Inspector General is responsible for auditing for up coding on the part of hospitals.

Lessons learned. Texas continues to look for ways to hold the contracted PCCM vendor and participating physicians accountable for quality outcomes. Currently, the contracted vendor administers the program for a set fee but has little contractual responsibility for outcomes.[34] Texas is also considering a variable case management fee, rather than the traditional $3 PMPM given to participating physicians.

[34] Texas recently awarded a three year, $86 million dollar contract to its PCCM administrator.

Texas is also looking at ways to integrate its PCCM and DM programs. Disease management was started in non-managed care counties last year but with the expansion of PCCM, both programs will now operate in the same counties. Texas will be meeting with the DM and PCCM vendors to clearly define roles and responsibilities and to determine the best approach for integration.

Disease Management. Texas requires its capitated health plans to provide or arrange for disease management services for its members. The health plan is required to maintain a system to track and monitor all DM participants for clinical, cost and utilization measures. The degree of specificity of diseases to be managed has varied.

Texas also contracts with an outside vendor for disease management services for fee-for-service Medicaid recipients. This program started in September 2004 as of March 2005, 43,500 recipients were in the program. This program covers asthma, coronary arterial disease, congestive heart failure, diabetes, and chronic obstructive pulmonary disease. Prior to signing the disease management vendor contract, the State engaged the services of Lewin to assess the bids received, to negotiate contract terms, and to establish the baseline for which cost savings would be measured. If these targets are not achieved, the DM vendor must forfeit some (and potentially all) of its fees. The program is in its first year of operations, thus savings targets and quality outcomes are yet to be measured.

3. Washington State

Capitated Health Plans. Washington operates Healthy Options, a mandatory capitated managed care program for pregnant women and children (TANF and TANF-related categories) in almost all counties in the state. There are two counties which are excluded entirely from the capitated program and nine which are voluntary. The primary reason for their exclusion is that they are small rural counties with limited health care infrastructure. The remaining 28 counties are in managed care.

Assignment. The State issues enrollment letters to recipients after Medicaid eligibility begins. The letter informs the recipient that they will be enrolled into capitated managed care and they should choose a health plan. Typically, this process takes 60 days to complete from the time of eligibility determination. The state is attempting to decrease the time between eligibility and enrollment by informing recipients that they will be defaulted into an identified managed care plan unless they respond with an active choice. The defaulted choice will be based on plan capacity.

Lock in. Currently, recipients are allowed to change health plans on a monthly basis without cause. The State is considering a lock in period for the program. Historically, they have not seen much movement between plans except for a distinct set of individuals who are typically reacting to being managed more tightly due to concerns of using multiple doctors or multiple pharmacies.

Marketing. Washington's managed care contract contains several provisions related to marketing services, including a prohibition of inducements for enrollment and indirect or direct marketing that would include door-to-door, telephonic or other cold call marketing. All marketing materials must be approved by the State. In discussions with state officials, they do

allow plans to offer items such as school supplies or diapers ***after*** the recipient is enrolled, for example to promote a parent taking their child in for well child visits.

Pilot projects. The State is beginning several pilot managed care projects for the Aged, Blind and Disabled (ABD). In one county, the ABD population can voluntarily enroll into capitated managed care for medical, mental health, substance abuse and long-term care services, including nursing facility. The program began enrolling participants in January 2005 and will include all services starting in October 2005. There is only one health plan involved due to the small size of the program. Another pilot project will begin in May 2005 with a voluntary program for full dual eligibles in a few counties.

PCCM. Washington operates a small PCCM program for approximately 3,000 Native American tribal members.

Disease Management. Washington was one of the first states to adopt a disease management program. The disease management program is operated by two outside vendors focusing on End Stage Renal Disease (ESRD), asthma, congestive heart failure (CHF), and diabetes. Medicaid recipients in fee-for-service (primarily Aged, Blind, and Disabled) and PCCM (primarily Native Americans) are eligible to receive these services. Medicaid managed care recipients are excluded.

Year 1 (April 1, 2002 through March 31, 2003) findings are now available and the results have been mixed, with a general feeling that the program did not meet its targets for Year 1. The University of Washington evaluated the clinical outcomes of the programs and, with significant caveats, concluded there were some positive clinical outcomes for ESRD, asthma, and diabetes. ESRD decreased hospitalizations, emergency department visits, and inpatient days. Asthma and diabetes appeared to decrease hospitalizations and improved process outcomes, such as HgA1c tests and retinal exams. There were no significant benefits confirmed for CHF.[35]

From a financial perspective, ESRD achieved its targeted savings but asthma, diabetes, and CHF did not .[36] For asthma, diabetes, and CHF, there were program savings compared to the expected trend line for program costs. However, when administrative costs were included, overall costs of the program exceeded savings.[37] The state had contractual protections against costs exceeding savings and therefore did not actually incur additional costs.

Lessons learned. The state is now in the process of determining whether to move forward with the disease management program. It appears the program will move forward but with significant programmatic changes to address issues that have emerged. Potential programmatic changes include:

- A more focused effort on higher need cases rather than anyone with the disease
- State will determine who receives services, rather than the vendor

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[35] Christakis, Dimitri et al. Report of Disease Management Evaluation, University of Washington, November 3, 2004.

[36] Milliman, State of Washington Renaissance Disease Management Savings Evaluation, Year 1, March 29, 2005.

[37] Milliman, State of Washington McKesson Disease Management Savings Evaluation, Year 1, revised February 4, 2005.

- State and vendor will agree on trend factor prior to starting the new contract period

New program targeted at individuals with chronic pain.

In discussions with Washington officials, the following suggestions were given for other states for consideration when implementing a disease management program:

- Agree with the vendor ahead of time on how to calculate the trend line. This upfront work will simplify negotiations on the back end
- Know your data. Washington officials found more third party payment than expected, more people moving in and out of the program than expected and state data given to the vendor did not reflect retroactive changes
- Do not assume savings in Year 1

Evaluation of savings should be conducted by an independent evaluator, not the state or the vendor.

VII. RECOMMENDATIONS AND CONCLUSIONS

A. Overview of Key Recommendations

A series of recommendations emerges from our analyses.

1. Immediate development of a mandatory enrollment capitated program in the "extended Collar County" and "extended East St. Louis" areas (collectively encompassing 19 counties) is recommended, in which all non-Medicare and non-spend-down Medicaid recipients would be enrolled.[38] This would involve a competitive procurement for contracts, with no more than three health plans being selected to serve the Collar County area and no more than two health plans selected to serve the East St. Louis area. The State's RFP would define in detail the desired program features and requirements. Such features should include (but would by no means be limited to):

    - Extensive prohibitions on marketing activities (complete elimination of individual marketing is recommended), relying instead on an independent enrollment broker contractor to facilitate beneficiary choice among selected health plans.
    - Clear delineation of the outreach and education activities that are required to promote EPSDT and other preventive services, as well as to facilitate understanding of the HMO's delivery system and promote access to all needed services.
    - Detailed rules about provider network composition and payment terms, to ensure that the program is designed to truly "manage care" and becomes a vehicle to help prop up, rather than drive down, Medicaid payment rates to physicians, hospitals and clinics.
    - Inclusion, if desired, of a premium tax mechanism to replace and restore safety net funds that could be lost by reducing the days that are "countable" for the existing provider assessment program.

    Note that conversion to capitation creates immediate accrued savings but imposes a short-term cash flow cost. We recommend that enrollment of the capitated program be phased-in gradually across at least a 12 month period, and that other mechanisms be deployed as needed to address the cash flow situation. It would be extraordinarily "penny wise and pound foolish" for the State to avoid implementing the capitated model due to the short-term cash flow issue.

[38] The extended Collar County area includes the following 11 counties: Winnebago, Boone, McHenry, Lake, DeKalb, Kane DuPage, Kendall, Grundy, Will and Kankakee. The extended East St. Louis area includes 8 counties: Madison, St. Clair, Monroe, Randolph, Perry, Franklin, Jackson and Williamson.

2. We do not see adequate value in continuing the existing voluntary capitation program in Cook County. We recommend that this program be phased out of existence in conjunction with the immediate creation of a similar-sized (e.g., approximately 150,000 enrollees) mandatory capitation program in selected zip codes within Cook County. These zip codes should be chosen in a manner that minimizes IGT impacts, i.e., where relatively low usage of the Cook County Bureau of Health Services facilities is occurring.[39] Existing health plan contractors would have in-state experience that might provide them an edge in securing contracts under the mandatory enrollment program, but we recommend that competitive procurement of these contracts be open to all willing bidders such that no organization is ensured an award.

3. In the remainder of Cook County, we recommend immediate exploration of options for implementing a mandatory capitated model, focusing on modifying the existing IGT arrangement in ways that are acceptable to CMS and that would permit the most cost-effective model of Medicaid coverage (mandatory capitation) to be used in all of Cook County while preserving the "safety net" role of the Cook County Bureau of Health Services. There are many possible paths to overcoming the IGT barrier, including obtaining a waiver that explicitly channels the Federal funding that is occurring to the Cook County Bureau of Health Services (while allowing a capitated program to occur), carving out inpatient care at the Bureau's facilities from the capitated initiatives (but requiring/encouraging channeling of patient volume to the Bureau), and other options. However, the certainty of any given path being workable cannot be determined without developing the detailed options and engaging in dialogue with CMS.

4. In all other areas of the State (82 counties), we recommend immediate development of a managed FFS program which combines primary care case management and complex care coordination program for the Family Health, SCHIP, and DCFS ward populations. In these same areas for the non-Medicare disabled population, we recommend this same model, but with the addition of disease management.[40] These fee-for-service based models would be administered through a contract with one or more qualified vendors through a carefully designed procurement (again stipulating all the State's desired features regarding access, cost savings, risk-sharing, payment terms, etc.). We further recommend that a strong performance-based payment model be incorporated in the PCCM, disease management, and complex care coordination programs to promote and reward the financial, clinical, and access outcomes the State is seeking to achieve.

5. While this opportunity has not been analyzed in detail or factored into the cost projections, once the PCCM/DM/CCC model is successfully implemented, we encourage the State to pursue a demonstration initiative with CMS to apply this model to the dual eligible population. While our study has predominantly excluded dual

[39] Lewin did not conduct zip code level analyses and thus cannot provide detailed guidance on which zip codes meet these criteria. Several portions of Cook County appear promising in terms of not being near the Bureau's facilities.

[40] The timing of IGT solutions in Cook County should dictate whether managed FFS models are implemented in the portions of Cook County that are not part of the mandatory zip codes. If the State believes there is a clear path to resolving IGT issues within two years, for instance, the managed FFS option should probably not be implemented. If, however, the timeframes are extended, it may be worthwhile to implement managed FFS on an interim basis to maximize managed care savings in the near term.

eligibles from our assessment, this subgroup's Medicare PMPM costs are enormously high and we believe the managed FFS model is very well-suited to addressing the needs of non-institutionalized dually eligible seniors and disabled persons. An arrangement could perhaps be implemented whereby the State would share 50/50 with CMS in the total (Medicare plus Medicaid) net savings the dual eligible program creates.

Collectively, we anticipate that this approach will yield large-scale, efficiency-driven savings and will improve access and health outcomes for the beneficiary population. Savings of nearly $200 million are projected for the first year of full implementation, and these savings increase substantially in each subsequent year as the program matures. The savings can be of great importance in helping State policymakers preserve Medicaid eligibility, benefits, and provider payment rates during "lean years," and can help finance coverage expansions should the overall fiscal climate improve. ***Table 26*** presents the summary savings from implementation of the most cost-effective models in each region.

Table 26. Savings Associated With Implementing Recommended Model In Each Area

	Collar County Area: HMO Model (11 Counties)	**Selected Zip Codes in Cook County: HMO Model***	**Remainder of Cook County:** (FFS Yrs 1-2, HMO Yrs 3-5)*	**East St. Louis Area: HMO Model** (8 Counties)	**Remaining 82 Counties** (Managed FFS)	**Total Savings**
Year 1	$49,476,232	$19,426,345	$73,120,559	$13,721,981	$36,977,406	$192,722,523
Year 2	$61,382,542	$25,065,503	$91,261,447	$17,966,146	$46,202,486	$241,878,124
Year 3	$75,301,316	$31,669,322	$110,082,622	$22,977,462	$57,118,050	$297,148,773
Year 4	$91,585,510	$39,404,835	$142,037,850	$28,896,864	$70,039,224	$371,964,284
Year 5	$110,655,987	$48,470,613	$179,459,494	$35,893,326	$85,343,431	$459,822,852

Note: Figures shown represent all funds—Federal and State payments combined.

* For modeling purposes, we are assuming it will take until Year 3 to resolve the IGT issues and implement the mandatory capitation model in the central Chicago area. Savings will be considerably larger if this model can be implemented sooner than Year 3.

The ***Table 26*** figures are adjusted to hold Cook County Bureau of Health Services harmless from usage reductions (although little use of Cook County Bureau of Health Services among non-Cook County residents occurs). All savings shown in this table would therefore be shared 50% by the State and 50% by the Federal Government. Total savings will be larger if usage reductions at the Cook County Bureau of Health Services occur, although such additional savings would not accrue to the State.

Sufficient resources will need to be allocated to DPA to administer the procurement, and to conduct ongoing program oversight. The costs of ongoing oversight are factored into the above savings estimates. The "development costs" of conducting the procurements and modifying MIS systems to accommodate the new programs are not included in Table 26. These costs are estimated to be less than $5 million.

Regarding timing, realistically it is likely to take until July 1, 2006 to begin implementation of the managed FFS program and the 19 county mandatory HMO model initiative. This would allow approximately one year to develop the detailed design specifications for each initiative,

prepare and release RFPs for competitive bids, select vendors, and allow these vendors time to develop the required systems, staffing and contracts to begin operations in Illinois.

B. Discussion of Recommendations Regarding Each Managed Care Option

In this section, we present recommendations regarding each model we have considered: Affirmative Choice; mandatory HMO-only; and various managed FFS/enhanced PCCM models.

1. Affirmative Choice

Combination models that have capitated HMOs and FFS approaches such as PCCM operating side-by-side for the same population in the same geographic area—the model represented by Affirmative Choice—pose a number of challenges. Given the many drawbacks associated with a combination model that creates competition between a FFS approach and the capitated approach, we do not, in general, recommend use of the Affirmative Choice model anywhere in the State. It is preferable to implement either a mandatory HMO-only model or a managed FFS model (e.g., PCCM/DM or PCCM/DM/CCC) rather than to offer an HMO option and a managed FFS option to the same population within the same region. Challenges of the Affirmative Choice Model include:

- **Provider Preference.** All other things equal, providers will almost always prefer a FFS payer to an HMO. Because HMOs deploy the strongest array of medical cost containment methods (and do so most aggressively given their at-risk status), this model is particularly unattractive to the provider community.

- **Enrollee Preference.** There appears to be little reason for an enrollee to select an HMO option if a FFS alternative is available. In most instances, the HMO option represents the same benefits as FFS, access to the same or fewer providers as FFS, and more restrictions on the enrollees' care-seeking behavior.[41] (On the surface, PCCM poses the same primary care gatekeeper requirements as HMOs, but it is much easier under PCCM for patients to self-refer to other providers than is the case in the HMO setting.) While the Affirmative Choice proposal divides all Family Health Plan recipients between capitated health plans (50 percent) and PCCM (50 percent), recipients will be allowed to make a choice between health plans and PCCM and assignment will take place only for those who do not make a choice. Therefore, there appears to be no guarantee that enrollment will not be skewed toward the PCCM model—which, as our cost modeling has shown, is far less cost-effective than the HMO model.

- **Limited Ability to Capture/Control Market Share.** Given the issues discussed above regarding provider and enrollee preferences, the HMOs are ill-positioned in a simultaneous HMO/PCCM model environment to capture and control market share. For the HMO model to be most effective, it needs this leverage both in contracting with

[41] These factors all make the HMO model a "difficult sell" in a voluntary enrollment setting. Conversely, however, it is important to note that enrollees of capitated Medicaid plans tend to be satisfied with their health plans based on the extensive surveys that are conducted in this setting.

providers and in promoting cost-effective beneficiary and provider behavior within the contracted delivery system.

- **Selection Bias.** The combination model setting also creates capitation rate-setting challenges, as strong potential exists for the HMO enrollee population to have different average health status than the FFS enrollees. Addressing the selection bias issues effectively is not a small challenge, and in many situations (e.g., the national Medicare+Choice program in the Medicare managed care arena) the selection bias has completely eliminated the intended program savings. While it appears that payment rate adjustments that went into effect for Illinois Medicaid HMOs in August 2003 may have addressed the selection bias issue somewhat (e.g., medical loss ratios of the health plans have increased somewhat since that time), no risk adjustment methodology is perfect. Selection bias is likely to remain a significant challenge in any voluntary setting.

- **Marketing Expense.** Even where the HMO-only model is mandatory, some portion of an HMO's administrative budget goes toward promoting the HMO over other health plans that are available to beneficiaries. In the voluntary setting, promotion and marketing expenses are considerably higher; the HMO not only is compelled to extol its virtues compared to competing HMOs, but also to convince beneficiaries of its merits relative to the PCCM system in order to attract enrollees. Certain voluntary program design features can serve to lessen the marketing focus and expense inherent in a voluntary model. For example, use of an enrollment broker will eliminate the direct marketing expenses (and sometimes undesirable marketing tactics) associated with one-on-one marketing by HMOs. In addition, the Affirmative Choice proposal—by virtue of calling for a 50/50 split of recipients between capitated health plans and PCCM—decreases the degree to which HMOs have to "fight" for desired enrollment levels (however, it is unclear as to how or whether such a 50/50 split can be guaranteed). In any event, the portion of an HMO's capitation revenue spent on marketing efforts will almost certainly be greater in the HMO/PCCM vs. HMO-only setting.

Thus, we recommend that the Affirmative Choice model not be implemented anywhere in the State. We further recommend that the existing voluntary capitation program in Cook County and the East St. Louis region be phased out of existence in conjunction with the creation of new models in these areas as summarized previously and discussed further below.

2. *Mandatory HMO-Only Model*

As our cost modeling has shown, the mandatory HMO-only model achieves the largest savings in the following geographic areas and for the indicated populations:

- **"Extended" Collar County Area.** The 11 county Collar County region has all of the characteristics that support a mandatory HMO-only model and very few of the barriers (e.g., IGT issues). We recommend that the mandatory HMO-only model be implemented in this region for all Medicaid beneficiaries with the exception of dual eligibles and spend-down recipients.
  - **Savings Potential.** We estimate that savings of approximately $4 million per month during the initial year of implementation (totaling $49 million in the first

year) will accrue to the Medicaid program through a mandatory enrollment capitated model that would serve this region's non-Medicare, non-spend-down population. These savings are projected to grow to $111 million in the fifth year of implementation. Projected savings from the this model are nearly twice those of the most cost-effective fee-for-service Medicaid managed care model (which involves a combination of complex care coordination and primary care case management for all subgroups, as well as disease management for the disabled population).

- **Large population size.** Approximately 230,000 potential Medicaid HMO enrollees reside in the Collar County area (after adjusting the number of total eligible persons downward for retrospective eligibility and pre-enrollment periods). Collectively, this population is generating more than $600 million annually in Medicaid spending that can be impacted by managed care (disregarding costs for Medicare and spend-down populations, as well as claims for nursing home, other institutional services, and waiver services). This population readily supports a multi-health plan capitated model.
- **Relatively high Medicaid per capita costs.** Disabled PMPM costs in the Collar County region are higher than any other region except for Cook County. Collar County per capita Medicaid costs are above those in Cook County for both the Disabled and Family Health populations when the enhanced payments to Cook County Bureau of Health Services are disregarded.
- **Competitive provider markets.** The Collar Counties are all part of a metropolitan statistical area and the suburban/urban nature of this region is conducive to the capitated model and to the formation of competitive, network-model systems of care. The 11 Collar Counties collectively are "home" to 35 hospitals and more than 5,000 physicians.
- **Minimal IGT concerns or issues.** Very few Medicaid admissions occur at the Cook County Bureau of Health Services from residents of the Collar Counties. The annual revenue loss to Cook County Bureau of Health Services that would occur through a capitated program in the Collar Counties is approximately $3 million.
- **Geographic Expansion Potential.** IGT issues clearly pose a current barrier to use of the mandatory enrollment model in Cook County. While it may take some time to resolve this barrier prior to introducing mandatory enrollment in Cook County, implementing this approach immediately in the Collar Counties does bring this model into existence in the greater Chicago area. Eventual expansion of this model into Cook County itself would be a natural and valuable geographic extension.

  The capitated model in the Collar Counties can be readily extended to other contiguous counties. We have defined the extended "Collar County area" as including Kankakee County to the south, reaching the Wisconsin border to the North, and the Rockford area (Winnebago County) to the northwest.

- **East St. Louis.** The 8 county East St. Louis region also has all of the characteristics that support a mandatory HMO-only model, including 21 hospitals and more than 1, 000 physicians. While more rural overall than the Collar County area, the East St. Louis area

has the added advantage of meaningful existing Medicaid HMO penetration. Savings of roughly $1 million per month are projected in this region during the initial year, growing to approximately $3 million per month by Year 5. In this region, we recommend that a competitive mandatory HMO model be implemented and that two (and no more than two) HMOs be awarded contracts.

- **Cook County.** Cook County generally is an ideal environment for the mandatory HMO model for all non-dual, non-spend-down eligibility categories. However, while the Collar County and East St. Louis areas are largely spared the thorny IGT issues**,** such concerns loom large in Cook County. Until solutions to such issues are created, converting to a mandatory HMO model throughout Cook County during a time of severe budget constraints is not feasible. However, in the absence of IGT arrangements —which are increasingly being challenged at the Federal level and which create barriers to the adoption of truly cost-effective models of care—the mandatory HMO model is far superior to any other model assessed. When designed well, such a model not only is highly cost-effective but also enhances access and quality of care.

  If the IGT challenges did not exist, this study would strongly recommend immediately moving to a mandatory capitated model throughout Cook County for the Medicaid-only disabled, Family Health, DCFS wards, and SCHIP subgroups. The Chicago market area has a tremendous array of attributes that are favorable to this model, including the vast enrollment base, relatively high PMPM costs, and extensive provider capacity to support a model that relies upon competitive networks. The magnitude of the cost savings that could be realized from implementing the mandatory capitated model in Cook County exceeds what can be achieved throughout the rest of the state.

  Although IGT challenges in Cook County do keep us from recommending the immediate creation of a mandatory capitation program throughout the County, portions of the County do appear promising in terms of not being near the Bureau facilities. Thus, we recommend that a mandatory program be created immediately in selected zip codes of Cook County.

  Further, we recommend that the State of Illinois not presume that the IGT barriers are insurmountable or use this barrier as an excuse to avoid serious pursuit and implementation of the capitated model. Rather, we recommend that the State work to develop solutions to the IGT barriers that currently exist as necessary groundwork for future implementation of the mandatory HMO model in the entirety of Cook County.

- **Other Regions.** In the remainder of the state, our cost modeling has demonstrated the following:

  The mandatory HMO-only model appears to achieve smaller initial savings than the strongest managed FFS models for the Family Health population. (In some regions, such as East St. Louis, the mandatory HMO model's savings are close to those of the strongest managed FFS model in the initial years, then surpass the FFS model's savings.)

For the disabled population, the mandatory HMO-only model has been projected to yield significantly greater savings than any other model.

However, the size of the disabled populations in the regions evaluated may not, alone, support a competitive HMO model. (While the disabled population in the Collar County area is no larger than the disabled populations in the other broad regions assessed, the disabled population is more concentrated in the Collar County area and the HMO-only model is also more cost-effective for the Family Health population. Thus, the combined Family Health/disabled population is more than ample to support a competitive HMO-only model.)

Therefore, the primary options we considered in detail for each region were (1) mandatory HMO-only model for both the Family Health and disabled populations, and (2) some form of managed FFS model for both Family Health and disabled populations. The decision is not clear-cut: the HMO-only model appears to yield somewhat greater savings than the strongest managed FFS model (i.e., the incremental savings achieved by the HMO model for the disabled population more than offset the incremental "losses" achieved by this model, compared to the strongest managed FFS model, for the Family Health population). However, the greater savings may not be significant enough to warrant the development effort needed to implement the HMO model. Thus, we recommend implementing managed FFS models in the remaining 82 counties of the state.

Wherever the mandatory HMO-only model is implemented, we recommend that the capitated benefits be quite comprehensive. For example, mental health and pharmacy should not be carved out. On the other hand, we do recommend that long-term care services and recipients residing in institutions be carved out.

3. Managed FFS Models

We recommend that a managed FFS approach be implemented in all areas where the mandatory capitation approach is not being developed. Our assessment of managed FFS models has looked at the PCCM model, disease management model, and complex care coordination model, along with various combinations of the three. Each of these models has something compelling to offer, but none in isolation is as strong as when combined with at least one of the other models.

Given the "medical home" ensured by the PCCM model, we recommend that this serve as the foundation of any managed FFS model that is implemented. We further recommend that a performance-based incentive system be included in the PCCM program that reward participating primary care physicians collectively and individually when established cost, quality and access objectives are met. Broadly, we suggest that the size of the "enhanced payment pool" be determined by the level of savings the program achieves, and that individual primary care providers' share of the available savings be determined by a formula based partially on improvement against the provider's own baseline, and partially on exceeding pre-established benchmarks. In this way, everyone would benefit financially from improving their own performance, and providers would also benefit from "outperforming" normative standards (whether or not they have improved their own performance).

Similarly, we recommend that the disease management and complex care coordination programs have significant performance-based financial incentives, such that the administrative fees paid to these contractors will be significantly reduced when established savings and other targets are not met. The procurement for these contracts can encourage competition over the level of risk being assumed and the savings targets being "committed to."

Our recommendations and rationale as to how the managed FFS model components (PCCM, disease management, and complex care coordination) can best be utilized for each population group are outlined below.

a. Disabled Population

Based on our cost modeling, a combination model that enhances primary care case management with both disease management and complex care coordination creates the greatest cost savings. A significant portion of the disabled population has one or more chronic illnesses (e.g., congestive heart failure, coronary artery disease, diabetes, or chronic obstructive pulmonary disease) that are the focus of many disease management programs. Further, there is considerable stability within the disabled population relative to Medicaid eligibility, making it possible for disease management programs to "keep" their enrollees long enough to have an impact on both cost and quality of life. The disabled population also includes individuals who may not have specific chronic illnesses generally targeted by disease management programs, but who nevertheless consume significant and costly health care resources. Thus, adding a chronic care coordination component further enhances the model. Together, these three managed FFS approaches lead to the greatest number of disabled beneficiaries being "touched" by the program in a way that produces both short-term and long-term cost and health status benefits.

b. Family Health Population

As highlighted by both the Florida experience and our cost modeling, disease management does not produce the most cost-effective results for the Family Health and related (e.g. SCHIP and DCFS Ward) categories whether implemented in combination with PCCM and/or PCCM combined with complex care coordination. First, the numbers of Family Health individuals with chronic illnesses is relatively small. Second, among those with the targeted diseases, the average acuity is much lower in the Family Health population than in the disabled population (as evidenced by large PMPM cost differences). Third and perhaps most importantly, the churning of eligibility within the Family Health population limits the beneficial impacts disease management programs are designed to produce.

A PCCM/complex care coordination combination for the Family Health population, on the other hand, is projected to create significant cost-savings. While the projected savings produced by this combination are only marginally above those achieved by the complex care coordination model alone, we believe that the guaranteed medical home created by the PCCM model does much to enhance access and is a vast improvement over the traditional FFS program. Providing every beneficiary with a medical home is also important in creating opportunity/accountability for enhancing access to EPSDT and in implementing other outreach and education initiatives. Thus, we recommend that wherever the mandatory HMO-only model is not implemented for the Family Health population, the state move quickly to develop a PCCM/CCC program.

4. Unmanaged FFS Model

The unmanaged FFS model simply should not be sustained as the primary Medicaid model in the current cost-sensitive environment. As discussed in ***Section IV***, the FFS model has by far the fewest cost containment attributes. In addition, the issues that contribute to access problems for the Medicaid population cannot be effectively addressed by the FFS model. Thus, we have recommended that the FFS model be replaced by a mandatory HMO-only model or by a managed FFS combination approach wherever these models can positively influence cost, access and quality.

However, there are populations and services where managed care approaches have little or no impact. These include the population dually eligible for Medicaid and Medicare; spend-down populations; long-term care and other institutional services costs; and months of retroactive eligibility. For these beneficiaries and services, we recommend that the traditional FFS program be maintained. While the numbers of beneficiaries comprising the dual eligible and spend-down categories are relatively small, and the service categories unaffected by managed care are few, their associated expenses are disproportionately high. In fact, the models we are evaluating can favorably impact only about 45 percent of Illinois' total Medicaid expenditures. Thus, FFS will unavoidably remain a very significant financing model in the Illinois Medicaid program.

C. Concluding Remarks

Illinois stands in stark contrast to virtually all other large states in the modest degree to which its Medicaid program has adopted managed care techniques. All models of Medicaid managed care have potential shortcomings that must be carefully addressed throughout the program design, implementation, and oversight stages. Nonetheless, an exceptional opportunity exists for Illinois to both improve the coverage its Medicaid beneficiaries receive and to achieve large-scale savings through implementing the recommendations in this study. When done well, Medicaid managed care programs represent "Medicaid at its best" – delivering an array of access enhancement, outreach and education services, providing all recipients with a medical home, achieving financial savings, and creating a meaningful and accountable system of coverage where multiple aspects of the program's performance can be tracked.

APPENDICES

Appendix 1
Medicaid-Eligible Population by County and Category of Eligibility, 2004

(Figures shown represent days of Medicaid eligibility; divide by 365 to yield average number of persons at a given point in time)

Appendix 1: Medicaid-Eligible Days by County and Category of Eligibility, FY2004

(does not include Medicare dual eligibles or spend-down population)

County	Disabled	DCFS wards	Family Health	SCHIP	Statewide Total
Adams	228,888	30,656	2,385,148	137,813	2,782,505
Alexander	137,402	7,781	766,492	32,403	944,078
Bond	56,286	3,659	531,196	44,046	635,187
Boone	54,524	19,679	1,204,258	111,217	1,389,678
Brown	19,818	1,039	120,571	8,106	149,534
Bureau	54,056	11,186	1,023,411	68,241	1,156,894
Calhoun	13,022	2,227	105,513	14,171	134,933
Carroll	37,253	8,784	528,489	36,185	610,711
Cass	39,642	6,694	456,602	57,018	559,956
Champaign	467,657	150,128	5,218,253	316,857	6,152,895
Christian	112,327	27,967	1,311,998	78,303	1,530,595
Clark	49,973	5,977	655,575	52,523	764,048
Clay	60,821	9,600	578,059	40,315	688,795
Clinton	113,768	6,988	651,732	50,285	822,773
Coles	202,984	32,845	1,548,527	119,724	1,904,080
Cook	37,198,836	21,655,312	232,585,592	15,071,113	306,510,853
Crawford	58,214	5,674	731,010	44,529	839,427
Cumberland	31,192	3,951	386,042	25,335	446,520
De Witt	44,711	6,578	582,446	42,972	676,707
Dekalb	113,145	41,577	1,816,952	193,455	2,165,129
Douglas	52,160	3,145	521,270	44,733	621,308
DuPage	1,244,348	121,506	12,582,467	1,193,502	15,141,823
Edgar	83,431	10,185	735,307	53,247	882,170
Effingham	70,355	12,473	1,101,114	84,152	1,268,094
Fayette	88,604	7,475	930,638	74,558	1,101,275
Fdwards	17,420	5,572	186,867	12,852	222,711
Ford	24,013	5,253	349,799	20,276	399,341
Franklin	302,543	22,169	1,886,729	135,751	2,347,192
Fulton	148,290	13,654	1,446,190	99,527	1,707,661
Gallatin	51,940	8,446	287,154	20,664	368,204
Greene	65,284	7,233	580,186	47,267	699,970
Grundy	36,347	5,841	724,844	46,294	813,326
Hamilton	42,654	1,918	316,081	30,414	391,067
Hancock	58,695	9,700	607,046	39,235	714,676
Hardin	38,353	2,598	202,281	12,962	256,194
Henderson	20,752	5,186	283,132	16,525	325,595
Henry	100,357	18,878	1,424,747	82,429	1,626,411
Iroquois	87,801	25,565	950,316	81,374	1,145,056
Jackson	263,880	23,921	2,403,819	137,007	2,828,627
Jasper	31,880	2,745	328,440	25,908	388,973
Jefferson	189,523	38,982	1,834,168	125,602	2,188,275
Jersey	60,005	12,714	537,276	37,447	647,442
Jo Daviess	24,792	2,166	420,567	47,561	495,086
Johnson	46,597	10,954	392,164	39,226	488,941
Kane	845,194	123,583	13,956,066	1,621,365	16,546,208
Kankakee	611,290	74,104	4,439,683	192,083	5,317,160
Kendall	40,023	8,945	802,891	74,347	926,206
Knox	261,285	22,505	2,208,217	120,077	2,612,084
La Salle	245,459	29,164	3,360,569	176,266	3,811,458

County	Disabled	DCFS wards	Family Health	SCHIP	Statewide Total
Lake	1,096,078	189,983	12,712,604	1,471,745	15,470,410
Lawrence	63,759	2,103	518,630	43,804	628,296
Lee	95,052	15,642	866,435	48,977	1,026,106
Livingston	100,330	23,240	1,081,430	73,800	1,278,800
Logan	64,942	20,349	990,667	68,900	1,144,858
Macon	630,196	79,252	4,894,727	241,519	5,845,694
Macoupin	154,190	17,116	1,582,438	117,489	1,871,233
Madison	1,044,357	89,332	8,536,211	462,395	10,132,295
Marion	198,698	25,124	2,093,136	128,253	2,445,211
Marshall	26,812	9,245	402,852	18,993	457,902
Mason	64,271	15,597	712,696	47,071	839,635
Massac	87,051	8,206	706,078	47,167	848,502
McDonough	104,729	7,749	908,711	57,981	1,079,170
McHenry	218,300	47,160	3,551,655	411,643	4,228,758
McLean	232,807	90,465	3,451,493	252,255	4,027,020
Menard	23,337	3,995	345,165	26,960	399,457
Mercer	31,324	4,909	505,182	38,373	579,788
Monroe	19,130	5,341	213,610	12,383	250,464
Montgomery	114,175	17,338	1,139,378	81,553	1,352,444
Morgan	167,604	8,325	1,210,328	66,976	1,453,233
Moultrie	23,259	1,861	359,150	26,710	410,980
Ogle	73,103	18,427	1,302,814	89,519	1,483,863
Peoria	986,260	313,781	7,820,520	348,147	9,468,708
Perry	96,523	6,150	823,837	48,943	975,453
Piatt	23,587	4,559	318,624	29,727	376,497
Pike	64,250	5,630	629,995	47,898	747,773
Pope	28,998	1,733	186,437	13,851	231,019
Pulaski	72,001	6,561	485,148	32,013	595,723
Putnam	4,146	3,331	143,759	3,780	155,016
Randolph	101,244	8,402	1,179,686	82,499	1,371,831
Richland	71,960	6,251	645,542	46,470	770,223
Rock Island	558,699	73,851	5,794,200	290,288	6,717,038
Saline	231,552	13,300	1,276,483	91,998	1,613,333
Sangamon	700,499	107,352	6,879,176	389,470	8,076,497
Schuyler	16,536	4,915	209,304	18,094	248,849
Scott	10,385	2,927	179,516	18,255	211,083
Shelby	54,107	6,872	641,439	58,042	760,460
St. Clair	2,008,393	167,085	11,986,883	523,955	14,686,316
Stark	9,365	1,950	210,781	19,522	241,618
Stephenson	152,808	25,429	1,649,373	80,806	1,908,416
Tazewell	301,586	78,926	3,507,687	215,561	4,103,760
Union	173,836	5,697	809,242	72,293	1,061,068
Vermilion	451,277	65,734	4,184,101	246,339	4,947,451
Wabash	38,844	1,221	449,406	27,835	517,306
Warren	52,785	4,620	661,663	40,654	759,722
Washington	28,751	11,896	281,655	16,982	339,284
Wayne	58,754	6,190	683,764	47,564	796,272
White	78,343	2,744	544,658	34,966	660,711
Whiteside	178,854	19,822	1,957,848	125,449	2,281,973
Will	1,001,610	248,745	10,964,961	841,369	13,056,685
Williamson	312,588	33,790	2,646,321	189,001	3,181,700
Winnebago	1,183,064	207,307	11,034,452	645,909	13,070,732
Woodford	50,674	17,539	680,658	42,488	791,359
Statewide Total	57,983,577	24,839,951	436,540,403	29,761,896	549,125,827

Appendix 2
Managed Care Criteria for All Counties

Appendix 2: Managed Care Criteria for All Counties

County	County Type	Land Area (km2)	Total Population	Population per km2	Physicians	Physicians per 1,000	Hospitals	Hospitals per 1,000
Adams	5	2,219	67,582	30	126	1.86	2	0.03
Alexander	7	612	9,327	15	4	0.43	0	0.00
Bond	1	985	17,941	18	7	0.39	1	0.06
Boone	2	728	46,477	64	33	0.71	2	0.04
Brown	7	792	6,879	9	0	0.00	0	0.00
Bureau	6	2,250	35,221	16	41	1.16	2	0.06
Calhoun	1	657	5,069	8	2	0.39	0	0.00
Carroll	7	1,151	16,242	14	9	0.55	0	0.00
Cass	6	974	13,841	14	5	0.36	0	0.00
Champaign	3	2,582	186,800	72	393	2.10	2	0.01
Christian	6	1,836	35,127	19	31	0.88	2	0.06
Clark	6	1,299	16,998	13	7	0.41	0	0.00
Clay	7	1,215	14,316	12	7	0.49	1	0.07
Clinton	1	1,228	36,135	29	22	0.61	1	0.03
Coles	5	1,316	51,880	39	86	1.66	1	0.02
Cook	1	2,449	5,351,552	2,185	15,095	2.82	63	0.012
Crawford	6	1,149	19,889	17	21	1.06	1	0.05
Cumberland	9	896	11,063	12	2	0.18	0	0.00
De Kalb	1	1,642	94,041	57	102	1.08	3	0.03
De Witt	6	1,030	16,679	16	11	0.66	1	0.06
Douglas	6	1,080	19,923	18	11	0.55	0	0.00
Du Page	1	864	925,188	1,071	2,064	2.23	8	0.01
Edgar	6	1,615	19,396	12	10	0.52	1	0.05
Edwards	9	576	6,850	12	2	0.29	0	0.00
Effingham	7	1,240	34,529	28	72	2.09	1	0.03
Fayette	6	1,856	21,539	12	10	0.46	1	0.05
Ford	3	1,258	14,094	11	12	0.85	1	0.07
Franklin	5	1,067	39,117	37	28	0.72	2	0.05
Fulton	6	2,242	37,658	17	36	0.96	1	0.03
Gallatin	8	838	6,220	7	1	0.16	0	0.00
Greene	6	1,407	14,708	10	8	0.54	1	0.07
Grundy	1	1,088	39,528	36	50	1.26	1	0.03
Hamilton	7	1,127	8,334	7	7	0.84	1	0.12
Hancock	7	2,058	19,393	9	13	0.67	1	0.05
Hardin	9	462	4,711	10	3	0.64	1	0.21
Henderson	9	981	8,073	8	6	0.74	0	0.00
Henry	2	2,132	50,644	24	39	0.77	2	0.04
Iroquois	6	2,892	30,684	11	23	0.75	2	0.07
Jackson	5	1,523	58,976	39	121	2.05	2	0.03
Jasper	7	1,280	9,955	8	1	0.10	0	0.00
Jefferson	7	1,479	40,334	27	54	1.34	2	0.05
Jersey	1	956	22,188	23	16	0.72	1	0.05
Jo Daviess	6	1,557	22,526	14	10	0.44	1	0.04
Johnson	7	893	12,951	15	2	0.15	0	0.00
Kane	1	1,348	457,122	339	561	1.23	4	0.01
Kankakee	3	1,753	105,625	60	172	1.63	2	0.02
Kendall	1	830	66,565	80	16	0.24	0	0.00
Know	4	1,855	54,491	29	80	1.47	2	0.04
Lake	1	1,159	685,019	591	1,157	1.69	7	0.01
La Salle	4	2,939	112,037	38	117	1.04	4	0.04

County	County Type	Land Area (km2)	Total Population	Population per km2	Physicians	Physicians per 1,000	Hospitals	Hospitals per 1,000
Lawrence	7	963	15,287	16	7	0.46	1	0.07
Lee	4	1,879	35,537	19	52	1.46	1	0.03
Livingston	4	2,703	39,208	15	28	0.71	1	0.03
Logan	6	1,601	30,716	19	20	0.65	1	0.03
McDonough	5	1,526	32,852	22	55	1.67	1	0.03
McHenry	1	1,563	286,091	183	238	0.83	3	0.01
McLean	3	3,065	156,879	51	242	1.54	2	0.01
Macon	3	1,504	111,175	74	198	1.78	2	0.02
Macoupin	1	2,237	49,055	22	16	0.33	2	0.04
Madison	1	1,878	261,689	139	325	1.24	6	0.02
Marion	4	1,482	40,751	27	56	1.37	2	0.05
Marshall	2	1,000	13,039	13	8	0.61	0	0.00
Mason	6	1,396	15,884	11	11	0.69	1	0.06
Massac	7	619	15,138	24	8	0.53	1	0.07
Menard	3	814	12,593	15	2	0.16	0	0.00
Mercer	2	1,453	17,003	12	4	0.24	1	0.06
Monroe	1	1,006	29,723	30	14	0.47	0	0.00
Montgomery	6	1,823	30,352	17	17	0.56	2	0.07
Morgan	4	1,473	35,990	24	57	1.58	1	0.03
Moutrie	6	869	14,469	17	8	0.55	0	0.00
Ogle	4	1,965	52,858	27	25	0.47	1	0.02
Peoria	2	1,605	182,335	114	612	3.36	3	0.02
Perry	7	1,142	22,684	20	14	0.62	2	0.09
Piatt	3	1,140	16,426	14	12	0.73	1	0.06
Pike	7	2,150	16,927	8	10	0.59	1	0.06
Pope	9	961	4,261	4	2	0.47	0	0.00
Pulaski	9	520	7,077	14	0	0.00	0	0.00
Putnam	8	414	6,119	15	0	0.00	0	0.00
Randolph	6	1,498	32,244	22	41	1.27	3	0.09
Richland	7	933	15,997	17	34	2.13	1	0.06
Rock Island	2	1,105	147,912	134	255	1.72	3	0.02
St. Clair	1	1,719	258,606	150	400	1.55	4	0.02
Saline	7	993	26,158	26	37	1.41	2	0.08
Sangamon	3	2,249	191,875	85	643	3.35	3	0.02
Schuyler	7	1,133	7,021	6	4	0.57	1	0.14
Scott	9	650	5,505	8	1	0.18	0	0.00
Shelby	6	1,965	22,407	11	8	0.36	1	0.04
Stark	2	746	6,198	8	1	0.16	0	0.00
Stephenson	4	1,461	48,151	33	66	1.37	1	0.02
Tazewell	2	1,681	128,056	76	94	0.73	2	0.02
Union	7	1,078	18,170	17	25	1.38	1	0.06
Vermilion	3	2,329	82,804	36	141	1.70	2	0.02
Wabash	6	579	12,680	22	9	0.71	1	0.08
Warren	7	1,405	18,246	13	14	0.77	1	0.05
Washington	6	1,457	15,179	10	5	0.33	1	0.07
Wayne	7	1,849	16,944	9	10	0.59	1	0.06
White	6	1,282	15,106	12	11	0.73	1	0.07
Whieside	4	1,774	59,886	34	56	0.94	2	0.03
Will	1	2,168	586,706	271	432	0.74	2	0.00
Williamson	5	1,097	62,448	57	104	1.67	2	0.03
Winnebago	2	1,331	284,313	214	619	2.18	3	0.01
Woodford	2	1,367	36,367	27	21	0.58	1	0.03

County Codes from USDA Rural-Urban Continuum

County Code	Description
1	Counties in metro areas of 1 million population or more.
2	Counties in metro areas of 250,000 to 1 million population.
3	Counties in metro areas of fewer than 250,000 population.
4	Urban population of 20,000 or more, adjacent to a metro area.
5	Urban population of 20,000 or more, not adjacent to a metro area.
6	Urban population of 2,500 to 19,999, adjacent to a metro area.
7	Urban population of 2,500 to 19,999, not adjacent to a metro area.
8	Completely rural or less than 2,500 urban population, adjacent to a metro area.
9	Completely rural or less than 2,500 urban population, not adjacent to a metro area.

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Appendix 3
Baseline Cost Estimated by Region and Category of Eligibility, 2006-2010

Appendix 3: Baseline Cost Estimated by Region and Category of Eligibility, 2006-2010

Disabled Population

FFS PMPM, 2006

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	162,925	$247.27	$114.81	$248.64	$326.42	$0.00	$196.48	$274.52	$1,408.14
Central IL	158,720	$229.49	$91.24	$225.12	$316.53	$0.00	$158.86	$263.53	$1,284.77
Southern IL	213,960	$231.41	$62.71	$264.60	$331.96	$0.01	$141.17	$290.91	$1,322.77
Cook County	1,264,370	$552.56	$190.87	$76.12	$271.90	$0.03	$87.47	$277.47	$1,456.41
Collar Counties	174,152	$418.60	$216.35	$331.09	$314.13	$0.00	$177.92	$260.31	$1,718.39
Grand Total	1,974,127	$454.76	$164.94	$145.26	$290.22	$0.02	$116.00	$276.05	$1,447.26

FFS PMPM, 2007

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	166,183	$259.64	$120.55	$261.07	$375.38	$0.00	$206.30	$288.25	$1,511.19
Central IL	161,894	$240.96	$95.80	$236.38	$364.01	$0.00	$166.81	$276.70	$1,380.66
Southern IL	218,239	$242.98	$65.85	$277.83	$381.76	$0.01	$148.23	$305.46	$1,422.11
Cook County	1,289,658	$580.19	$200.41	$79.92	$312.69	$0.03	$91.84	$291.35	$1,556.42
Collar Counties	177,635	$439.53	$227.16	$347.64	$361.24	$0.00	$186.81	$273.33	$1,835.73
Grand Total	2,013,609	$477.50	$173.19	$152.52	$333.76	$0.02	$121.80	$289.85	$1,548.64

FFS PMPM, 2008

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	169,507	$272.62	$126.58	$274.13	$431.69	$0.00	$216.62	$302.66	$1,624.29
Central IL	165,132	$253.01	$100.59	$248.20	$418.61	$0.00	$175.15	$290.54	$1,486.09
Southern IL	222,604	$255.12	$69.14	$291.72	$439.02	$0.01	$155.64	$320.73	$1,531.39
Cook County	1,315,451	$609.20	$210.43	$83.92	$359.59	$0.03	$96.43	$305.91	$1,665.51
Collar Counties	181,188	$461.51	$238.52	$365.03	$415.43	$0.00	$196.15	$286.99	$1,963.64
Grand Total	2,053,881	$501.38	$181.85	$160.14	$383.82	$0.02	$127.89	$304.35	$1,659.45

FFS PMPM, 2009

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	172,897	$286.25	$132.91	$287.83	$496.44	$0.00	$227.45	$317.79	$1,748.67
Central IL	168,434	$265.66	$105.62	$260.61	$481.40	$0.00	$183.90	$305.07	$1,602.26
Southern IL	227,056	$267.88	$72.60	$306.31	$504.87	$0.01	$163.42	$336.77	$1,651.86
Cook County	1,341,760	$639.66	$220.95	$88.11	$413.53	$0.03	$101.25	$321.21	$1,784.75
Collar Counties	184,812	$484.59	$250.45	$383.28	$477.75	$0.00	$205.96	$301.34	$2,103.36
Grand Total	2,094,959	$526.45	$190.94	$168.15	$441.39	$0.02	$134.29	$319.56	$1,780.80

FFS PMPM, 2010

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	176,355	$300.56	$139.55	$302.22	$570.91	$0.00	$238.82	$333.68	$1,885.75
Central IL	171,803	$278.94	$110.90	$273.64	$553.61	$0.00	$193.10	$320.32	$1,730.51
Southern IL	231,597	$281.27	$76.23	$321.62	$580.60	$0.01	$171.59	$353.60	$1,784.94
Cook County	1,368,595	$671.64	$232.00	$92.52	$475.56	$0.03	$106.32	$337.27	$1,915.34
Collar Counties	188,508	$508.82	$262.97	$402.44	$549.41	$0.00	$216.26	$316.41	$2,256.30
Grand Total	2,136,858	$552.77	$200.48	$176.56	$507.60	$0.02	$141.00	$335.54	$1,913.98

Wards of DCFS

FFS PMPM, 2006

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	33,095	$70.80	$0.00	$11.08	$109.63	$0.00	$5.27	$253.30	$450.09
Central IL	28,224	$82.27	$0.16	$6.99	$112.52	$0.00	$21.77	$281.86	$505.56
Southern IL	19,568	$57.77	$0.00	$17.60	$84.76	$0.15	$1.25	$260.02	$421.55
Cook County	740,718	$84.17	$0.43	$11.09	$54.77	$0.15	$3.70	$163.53	$317.84
Collar Counties	28,043	$185.67	$3.89	$8.68	$121.78	$0.04	$7.09	$590.79	$917.94
Grand Total	849,649	$86.33	$0.51	$11.02	$61.73	$0.14	$4.41	$187.28	$351.42

FFS PMPM, 2007

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	33,757	$74.34	$0.00	$11.63	$126.08	$0.00	$5.54	$265.97	$483.55
Central IL	28,788	$86.38	$0.16	$7.34	$129.40	$0.00	$22.85	$295.95	$542.09
Southern IL	19,959	$60.66	$0.00	$18.48	$97.47	$0.16	$1.31	$273.02	$451.10
Cook County	755,533	$88.38	$0.45	$11.64	$62.99	$0.16	$3.88	$171.71	$339.21
Collar Counties	28,604	$194.96	$4.08	$9.11	$140.05	$0.04	$7.45	$620.33	$976.02
Grand Total	866,642	$90.65	$0.54	$11.57	$70.99	$0.15	$4.63	$196.65	$375.17

FFS PMPM, 2008

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	34,432	$78.06	$0.00	$12.21	$144.99	$0.00	$5.81	$279.27	$520.34
Central IL	29,364	$90.70	$0.17	$7.71	$148.81	$0.00	$24.00	$310.75	$582.14
Southern IL	20,359	$63.69	$0.00	$19.40	$112.09	$0.17	$1.37	$286.67	$483.40
Cook County	770,643	$92.80	$0.48	$12.22	$72.43	$0.17	$4.07	$180.29	$362.47
Collar Counties	29,176	$204.70	$4.29	$9.57	$161.06	$0.05	$7.82	$651.35	$1,038.82
Grand Total	883,975	$95.18	$0.56	$12.15	$81.63	$0.16	$4.87	$206.48	$401.02

FFS PMPM, 2009

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	35,121	$81.96	$0.00	$12.82	$166.73	$0.00	$6.11	$293.23	$560.85
Central IL	29,951	$95.23	$0.18	$8.09	$171.13	$0.00	$25.20	$326.29	$626.13
Southern IL	20,766	$66.88	$0.00	$20.37	$128.90	$0.18	$1.44	$301.00	$518.78
Cook County	786,056	$97.44	$0.50	$12.83	$83.30	$0.18	$4.28	$189.31	$387.84
Collar Counties	29,760	$214.94	$4.50	$10.05	$185.21	$0.05	$8.21	$683.91	$1,106.87
Grand Total	901,654	$99.94	$0.59	$12.76	$93.88	$0.16	$5.11	$216.80	$429.24

FFS PMPM, 2010

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	35,823	$86.06	$0.00	$13.46	$191.74	$0.00	$6.41	$307.89	$605.57
Central IL	30,550	$100.00	$0.19	$8.50	$196.80	$0.00	$26.46	$342.60	$674.54
Southern IL	21,181	$70.22	$0.00	$21.39	$148.24	$0.19	$1.51	$316.05	$557.62
Cook County	801,777	$102.31	$0.52	$13.47	$95.79	$0.19	$4.49	$198.77	$415.56
Collar Counties	30,355	$225.69	$4.72	$10.55	$213.00	$0.05	$8.62	$718.11	$1,180.74
Grand Total	919,687	$104.94	$0.62	$13.39	$107.96	$0.17	$5.36	$227.64	$460.09

Family Health Population

FFS PMPM, 2006

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	1,718,960	$52.60	$0.17	$0.28	$37.14	$0.04	$1.91	$75.48	$167.62
Central IL	1,599,772	$46.97	$0.11	$0.14	$38.73	$0.05	$0.63	$77.04	$163.67
Southern IL	1,614,290	$46.34	$0.13	$1.13	$38.41	$16.64	$0.95	$76.71	$180.31
Cook County	7,955,574	$71.20	$0.41	$0.18	$20.80	$25.34	$0.45	$56.57	$174.95
Collar Counties	2,043,237	$60.05	$0.15	$0.20	$28.75	$0.09	$0.57	$73.69	$163.49
Grand Total	14,931,835	$62.25	$0.28	$0.29	$27.59	$15.32	$0.71	$65.46	$171.91

FFS PMPM, 2007

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	1,753,340	$55.23	$0.17	$0.29	$42.72	$0.04	$2.01	$79.26	$179.72
Central IL	1,631,767	$49.32	$0.11	$0.15	$44.54	$0.05	$0.66	$80.89	$175.72
Southern IL	1,646,576	$48.66	$0.14	$1.18	$44.17	$17.64	$1.00	$80.55	$193.34
Cook County	8,114,686	$74.76	$0.43	$0.18	$23.92	$26.86	$0.48	$59.40	$186.03
Collar Counties	2,084,102	$63.05	$0.16	$0.21	$33.06	$0.09	$0.60	$77.38	$174.55
Grand Total	15,230,471	$65.37	$0.30	$0.30	$31.73	$16.24	$0.75	$68.73	$183.42

FFS PMPM, 2008

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	1,788,406	$58.00	$0.18	$0.30	$49.12	$0.04	$2.11	$83.22	$192.98
Central IL	1,664,403	$51.79	$0.12	$0.16	$51.22	$0.05	$0.70	$84.94	$188.96
Southern IL	1,679,508	$51.09	$0.14	$1.24	$50.80	$18.70	$1.05	$84.57	$207.60
Cook County	8,276,979	$78.50	$0.45	$0.19	$27.51	$28.47	$0.50	$62.37	$197.99
Collar Counties	2,125,784	$66.20	$0.17	$0.22	$38.02	$0.10	$0.63	$81.25	$186.58
Grand Total	15,535,081	$68.63	$0.31	$0.32	$36.49	$17.22	$0.78	$72.17	$195.92

FFS PMPM, 2009

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	1,824,175	$60.90	$0.19	$0.32	$56.49	$0.05	$2.21	$87.38	$207.54
Central IL	1,697,691	$54.38	$0.12	$0.16	$58.90	$0.06	$0.73	$89.18	$203.53
Southern IL	1,713,098	$53.65	$0.15	$1.30	$58.42	$19.82	$1.10	$88.80	$223.24
Cook County	8,442,519	$82.43	$0.47	$0.20	$31.63	$30.18	$0.52	$65.49	$210.92
Collar Counties	2,168,300	$69.51	$0.18	$0.23	$43.72	$0.11	$0.66	$85.31	$199.71
Grand Total	15,845,782	$72.06	$0.33	$0.33	$41.97	$18.25	$0.82	$75.78	$209.54

FFS PMPM, 2010

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	1,860,658	$63.94	$0.20	$0.33	$64.97	$0.05	$2.32	$91.75	$223.57
Central IL	1,731,645	$57.10	$0.13	$0.17	$67.73	$0.06	$0.77	$93.64	$219.60
Southern IL	1,747,360	$56.33	$0.16	$1.37	$67.18	$21.01	$1.16	$93.24	$240.45
Cook County	8,611,369	$86.55	$0.49	$0.21	$36.38	$31.99	$0.55	$68.76	$224.93
Collar Counties	2,211,666	$72.99	$0.18	$0.24	$50.28	$0.11	$0.69	$89.57	$214.07
Grand Total	16,162,698	$75.67	$0.34	$0.35	$48.26	$19.34	$0.86	$79.57	$224.40

SCHIP Population

FFS PMPM, 2006

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	117,749	$47.99	$0.11	$0.00	$46.46	$0.03	$0.50	$87.13	$182.22
Central IL	121,150	$37.53	$0.00	$0.00	$52.94	$0.04	$0.10	$82.35	$172.95
Southern IL	112,701	$38.82	$0.00	$0.26	$63.02	$9.42	$0.36	$86.78	$198.66
Cook County	599,541	$97.93	$0.13	$0.17	$29.10	$12.38	$0.20	$108.81	$248.72
Collar Counties	232,811	$133.22	$0.08	$0.00	$32.62	$0.07	$0.33	$116.35	$282.66
Grand Total	1,183,953	$113.64	$0.09	$0.11	$37.18	$7.19	$0.26	$103.33	$261.81
	19,400.93	16,490.79							

FFS PMPM, 2007

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	129,524	$50.39	$0.12	$0.00	$53.42	$0.03	$0.52	$91.49	$195.97
Central IL	133,265	$39.41	$0.00	$0.00	$60.88	$0.04	$0.10	$86.46	$186.90
Southern IL	123,971	$40.76	$0.00	$0.27	$72.47	$9.99	$0.38	$91.12	$214.99
Cook County	659,495	$102.83	$0.13	$0.18	$33.46	$13.12	$0.21	$114.25	$264.19
Collar Counties	256,092	$139.88	$0.08	$0.00	$37.51	$0.07	$0.34	$122.17	$300.05
Grand Total	1,302,348	$119.32	$0.09	$0.12	$42.76	$7.62	$0.27	$108.50	$278.69

FFS PMPM, 2008

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	142,477	$52.91	$0.12	$0.00	$61.44	$0.03	$0.55	$96.06	$211.11
Central IL	146,592	$41.38	$0.00	$0.00	$70.01	$0.04	$0.11	$90.79	$202.33
Southern IL	136,368	$42.80	$0.00	$0.29	$83.34	$10.59	$0.40	$95.68	$233.09
Cook County	725,445	$107.97	$0.14	$0.19	$38.48	$13.91	$0.22	$119.97	$280.87
Collar Counties	281,702	$146.87	$0.08	$0.00	$43.13	$0.08	$0.36	$128.28	$318.81
Grand Total	1,432,583	$125.29	$0.10	$0.12	$49.18	$8.07	$0.29	$113.93	$296.97

FFS PMPM, 2009

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	156,724	$55.55	$0.13	$0.00	$70.65	$0.04	$0.58	$100.87	$227.81
Central IL	161,251	$43.45	$0.00	$0.00	$80.51	$0.05	$0.11	$95.33	$219.45
Southern IL	150,005	$44.94	$0.00	$0.30	$95.84	$11.22	$0.42	$100.46	$253.18
Cook County	797,989	$113.37	$0.15	$0.20	$44.25	$14.74	$0.23	$125.97	$298.90
Collar Counties	309,872	$154.21	$0.09	$0.00	$49.60	$0.08	$0.38	$134.70	$339.06
Grand Total	1,575,841	$131.56	$0.10	$0.13	$56.55	$8.56	$0.30	$119.62	$316.82

FFS PMPM, 2010

Region	Member Months	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other	Total Medical PMPM Cost
Northwestern IL	172,397	$58.33	$0.13	$0.00	$81.25	$0.04	$0.61	$105.91	$246.27
Central IL	177,376	$45.62	$0.00	$0.00	$92.59	$0.05	$0.12	$100.09	$238.47
Southern IL	165,005	$47.18	$0.00	$0.32	$110.22	$11.90	$0.44	$105.48	$275.54
Cook County	877,788	$119.04	$0.15	$0.21	$50.89	$15.63	$0.24	$132.26	$318.42
Collar Counties	340,859	$161.92	$0.09	$0.00	$57.04	$0.09	$0.40	$141.43	$360.97
Grand Total	1,733,425	$138.13	$0.11	$0.13	$65.03	$9.07	$0.31	$125.60	$338.40

Appendix 4
Medical Cost Impact Factors For All Models, 2006-2010

Appendix 4: Medical Cost Impact Factors for All Models, 2006-2010

HMO MODEL COST IMPACT FACTORS - ALL ELIGIBILITY CATEGORIES

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Central IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Southern IL	0.725	1.000	1.000	0.880	1.000	1.000	0.850
Cook County	0.700	1.000	1.000	0.880	1.000	1.000	0.850
Collar Counties	0.700	1.000	1.000	0.880	1.000	1.000	0.850

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.715	1.000	1.000	0.870	1.000	1.000	0.840
Central IL	0.715	1.000	1.000	0.870	1.000	1.000	0.840
Southern IL	0.715	1.000	1.000	0.870	1.000	1.000	0.840
Cook County	0.690	1.000	1.000	0.870	1.000	1.000	0.840
Collar Counties	0.690	1.000	1.000	0.870	1.000	1.000	0.840

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.705	1.000	1.000	0.860	1.000	1.000	0.830
Central IL	0.705	1.000	1.000	0.860	1.000	1.000	0.830
Southern IL	0.705	1.000	1.000	0.860	1.000	1.000	0.830
Cook County	0.680	1.000	1.000	0.860	1.000	1.000	0.830
Collar Counties	0.680	1.000	1.000	0.860	1.000	1.000	0.830

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.695	1.000	1.000	0.850	1.000	1.000	0.820
Central IL	0.695	1.000	1.000	0.850	1.000	1.000	0.820
Southern IL	0.695	1.000	1.000	0.850	1.000	1.000	0.820
Cook County	0.670	1.000	1.000	0.850	1.000	1.000	0.820
Collar Counties	0.670	1.000	1.000	0.850	1.000	1.000	0.820

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.685	1.000	1.000	0.840	1.000	1.000	0.810
Central IL	0.685	1.000	1.000	0.840	1.000	1.000	0.810
Southern IL	0.685	1.000	1.000	0.840	1.000	1.000	0.810
Cook County	0.660	1.000	1.000	0.840	1.000	1.000	0.810
Collar Counties	0.660	1.000	1.000	0.840	1.000	1.000	0.810

PCCM/DM MODEL COST IMPACT FACTORS - ALL ELIGIBILITY CATEGORIES

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Central IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Southern IL	0.908	1.000	1.000	0.960	1.000	1.000	0.970
Cook County	0.900	1.000	1.000	0.960	1.000	1.000	0.970
Collar Counties	0.900	1.000	1.000	0.960	1.000	1.000	0.970

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.905	1.000	1.000	0.957	1.000	1.000	0.968
Central IL	0.905	1.000	1.000	0.957	1.000	1.000	0.968
Southern IL	0.905	1.000	1.000	0.957	1.000	1.000	0.968
Cook County	0.897	1.000	1.000	0.957	1.000	1.000	0.968
Collar Counties	0.897	1.000	1.000	0.957	1.000	1.000	0.968

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.902	1.000	1.000	0.953	1.000	1.000	0.966
Central IL	0.902	1.000	1.000	0.953	1.000	1.000	0.966
Southern IL	0.902	1.000	1.000	0.953	1.000	1.000	0.966
Cook County	0.893	1.000	1.000	0.953	1.000	1.000	0.966
Collar Counties	0.893	1.000	1.000	0.953	1.000	1.000	0.966

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.898	1.000	1.000	0.950	1.000	1.000	0.964
Central IL	0.898	1.000	1.000	0.950	1.000	1.000	0.964
Southern IL	0.898	1.000	1.000	0.950	1.000	1.000	0.964
Cook County	0.890	1.000	1.000	0.950	1.000	1.000	0.964
Collar Counties	0.890	1.000	1.000	0.950	1.000	1.000	0.964

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.895	1.000	1.000	0.947	1.000	1.000	0.962
Central IL	0.895	1.000	1.000	0.947	1.000	1.000	0.962
Southern IL	0.895	1.000	1.000	0.947	1.000	1.000	0.962
Cook County	0.887	1.000	1.000	0.947	1.000	1.000	0.962
Collar Counties	0.887	1.000	1.000	0.947	1.000	1.000	0.962

CCC MODEL COST IMPACT FACTORS - ALL ELIGIBILITY CATEGORIES

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Central IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Southern IL	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Cook County	0.950	1.000	1.000	0.950	1.000	1.000	0.950
Collar Counties	0.950	1.000	1.000	0.950	1.000	1.000	0.950

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.945	1.000	1.000	0.945	1.000	1.000	0.945
Central IL	0.945	1.000	1.000	0.945	1.000	1.000	0.945
Southern IL	0.945	1.000	1.000	0.945	1.000	1.000	0.945
Cook County	0.945	1.000	1.000	0.945	1.000	1.000	0.945
Collar Counties	0.945	1.000	1.000	0.945	1.000	1.000	0.945

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.940	1.000	1.000	0.940	1.000	1.000	0.940
Central IL	0.940	1.000	1.000	0.940	1.000	1.000	0.940
Southern IL	0.940	1.000	1.000	0.940	1.000	1.000	0.940
Cook County	0.940	1.000	1.000	0.940	1.000	1.000	0.940
Collar Counties	0.940	1.000	1.000	0.940	1.000	1.000	0.940

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.935	1.000	1.000	0.935	1.000	1.000	0.935
Central IL	0.935	1.000	1.000	0.935	1.000	1.000	0.935
Southern IL	0.935	1.000	1.000	0.935	1.000	1.000	0.935
Cook County	0.935	1.000	1.000	0.935	1.000	1.000	0.935
Collar Counties	0.935	1.000	1.000	0.935	1.000	1.000	0.935

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.930	1.000	1.000	0.930	1.000	1.000	0.930
Central IL	0.930	1.000	1.000	0.930	1.000	1.000	0.930
Southern IL	0.930	1.000	1.000	0.930	1.000	1.000	0.930
Cook County	0.930	1.000	1.000	0.930	1.000	1.000	0.930
Collar Counties	0.930	1.000	1.000	0.930	1.000	1.000	0.930

COMBINATION HMO-PCCM MODEL COST IMPACT FACTORS - ALL ELIGIBILITY CATEGORIES

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.919	1.000	1.000	0.958	1.000	1.000	0.950
Central IL	0.919	1.000	1.000	0.958	1.000	1.000	0.950
Southern IL	0.919	1.000	1.000	0.958	1.000	1.000	0.950
Cook County	0.913	1.000	1.000	0.958	1.000	1.000	0.950
Collar Counties	0.913	1.000	1.000	0.958	1.000	1.000	0.950

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.914	1.000	1.000	0.953	1.000	1.000	0.945
Central IL	0.914	1.000	1.000	0.953	1.000	1.000	0.945
Southern IL	0.914	1.000	1.000	0.953	1.000	1.000	0.945
Cook County	0.908	1.000	1.000	0.953	1.000	1.000	0.945
Collar Counties	0.908	1.000	1.000	0.953	1.000	1.000	0.945

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.909	1.000	1.000	0.948	1.000	1.000	0.940
Central IL	0.909	1.000	1.000	0.948	1.000	1.000	0.940
Southern IL	0.909	1.000	1.000	0.948	1.000	1.000	0.940
Cook County	0.903	1.000	1.000	0.948	1.000	1.000	0.940
Collar Counties	0.903	1.000	1.000	0.948	1.000	1.000	0.940

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.904	1.000	1.000	0.943	1.000	1.000	0.935
Central IL	0.904	1.000	1.000	0.943	1.000	1.000	0.935
Southern IL	0.904	1.000	1.000	0.943	1.000	1.000	0.935
Cook County	0.898	1.000	1.000	0.943	1.000	1.000	0.935
Collar Counties	0.898	1.000	1.000	0.943	1.000	1.000	0.935

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.899	1.000	1.000	0.938	1.000	1.000	0.930
Central IL	0.899	1.000	1.000	0.938	1.000	1.000	0.930
Southern IL	0.899	1.000	1.000	0.938	1.000	1.000	0.930
Cook County	0.893	1.000	1.000	0.938	1.000	1.000	0.930
Collar Counties	0.893	1.000	1.000	0.938	1.000	1.000	0.930

PCCM/DM/CCC MODEL COST IMPACT FACTORS - DISABLED, DCFS, SCHIP

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.890	1.000	1.000	0.940	1.000	1.000	0.950
Central IL	0.891	1.000	1.000	0.942	1.000	1.000	0.951
Southern IL	0.893	1.000	1.000	0.944	1.000	1.000	0.954
Cook County	0.890	1.000	1.000	0.949	1.000	1.000	0.959
Collar Counties	0.883	1.000	1.000	0.942	1.000	1.000	0.952

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.885	1.000	1.000	0.935	1.000	1.000	0.945
Central IL	0.886	1.000	1.000	0.937	1.000	1.000	0.946
Southern IL	0.888	1.000	1.000	0.939	1.000	1.000	0.949
Cook County	0.885	1.000	1.000	0.944	1.000	1.000	0.954
Collar Counties	0.878	1.000	1.000	0.937	1.000	1.000	0.947

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.880	1.000	1.000	0.930	1.000	1.000	0.940
Central IL	0.881	1.000	1.000	0.932	1.000	1.000	0.941
Southern IL	0.883	1.000	1.000	0.934	1.000	1.000	0.944
Cook County	0.880	1.000	1.000	0.939	1.000	1.000	0.949
Collar Counties	0.873	1.000	1.000	0.932	1.000	1.000	0.942

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.875	1.000	1.000	0.925	1.000	1.000	0.935
Central IL	0.876	1.000	1.000	0.927	1.000	1.000	0.936
Southern IL	0.878	1.000	1.000	0.929	1.000	1.000	0.939
Cook County	0.875	1.000	1.000	0.934	1.000	1.000	0.944
Collar Counties	0.868	1.000	1.000	0.927	1.000	1.000	0.937

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.870	1.000	1.000	0.920	1.000	1.000	0.930
Central IL	0.871	1.000	1.000	0.922	1.000	1.000	0.931
Southern IL	0.873	1.000	1.000	0.924	1.000	1.000	0.934
Cook County	0.870	1.000	1.000	0.929	1.000	1.000	0.939
Collar Counties	0.863	1.000	1.000	0.922	1.000	1.000	0.932

Cost factors for the PCCM/DM/CCC model are slightly different for the Family Health eligibility group due to the lower percentage of high-cost patients (costs > $25,000) in the Family Health disease management population.

PCCM/DM/CCC MODEL COST IMPACT FACTORS - FAMILY HEALTH

2006

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.886	1.000	1.000	0.937	1.000	1.000	0.947
Central IL	0.888	1.000	1.000	0.938	1.000	1.000	0.948
Southern IL	0.885	1.000	1.000	0.936	1.000	1.000	0.946
Cook County	0.878	1.000	1.000	0.937	1.000	1.000	0.947
Collar Counties	0.878	1.000	1.000	0.937	1.000	1.000	0.946

2007

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.881	1.000	1.000	0.932	1.000	1.000	0.942
Central IL	0.883	1.000	1.000	0.933	1.000	1.000	0.943
Southern IL	0.880	1.000	1.000	0.931	1.000	1.000	0.941
Cook County	0.873	1.000	1.000	0.932	1.000	1.000	0.942
Collar Counties	0.873	1.000	1.000	0.932	1.000	1.000	0.941

2008

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.876	1.000	1.000	0.927	1.000	1.000	0.937
Central IL	0.878	1.000	1.000	0.928	1.000	1.000	0.938
Southern IL	0.875	1.000	1.000	0.926	1.000	1.000	0.936
Cook County	0.868	1.000	1.000	0.927	1.000	1.000	0.937
Collar Counties	0.868	1.000	1.000	0.927	1.000	1.000	0.936

2009

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.871	1.000	1.000	0.922	1.000	1.000	0.932
Central IL	0.873	1.000	1.000	0.923	1.000	1.000	0.933
Southern IL	0.870	1.000	1.000	0.921	1.000	1.000	0.931
Cook County	0.863	1.000	1.000	0.922	1.000	1.000	0.932
Collar Counties	0.863	1.000	1.000	0.922	1.000	1.000	0.931

2010

Region	Inpatient	Nursing Home	Other Institutional	Pharmacy	Capitation	Waiver	All Other
Northwestern IL	0.866	1.000	1.000	0.917	1.000	1.000	0.927
Central IL	0.868	1.000	1.000	0.918	1.000	1.000	0.928
Southern IL	0.865	1.000	1.000	0.916	1.000	1.000	0.926
Cook County	0.858	1.000	1.000	0.917	1.000	1.000	0.927
Collar Counties	0.858	1.000	1.000	0.917	1.000	1.000	0.926

Appendix 5
Summary Cost Results for All Models, 2006-2010

Appendix 5: Summary Cost Results for All Models, 2006-2010

HMO Model

HMO PMPM, 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,259.80	$45.89	$19.12	$3.00	$1,328	$148.35	$80.33	10.5%	5.7%	$12,433,940	$12,268,805
Central IL	158,720	$1,144.15	$43.86	$18.28	$3.00	$1,209	$140.62	$75.48	10.9%	5.9%	$11,381,280	$11,274,807
Southern IL	213,960	$1,175.66	$46.37	$19.32	$3.00	$1,244	$147.11	$78.41	11.1%	5.9%	$15,938,591	$15,938,302
Cook County	1,264,370	$1,216.39	$56.52	$23.55	$3.00	$1,299	$240.02	$156.95	16.5%	10.8%	$188,515,727	$117,370,435
Collar Counties	174,152	$1,516.07	$51.85	$21.60	$3.00	$1,593	$202.32	$125.87	11.8%	7.3%	$20,824,261	$19,083,641
Total												$175,935,991

HMO PMPM, 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,342.28	$49.47	$20.61	$3.15	$1,416	$168.92	$95.69	11.2%	6.3%	$15,106,868	$14,923,577
Central IL	161,894	$1,220.39	$47.31	$19.71	$3.15	$1,291	$160.27	$90.10	11.6%	6.5%	$13,857,539	$13,739,359
Southern IL	218,239	$1,254.36	$50.00	$20.83	$3.15	$1,328	$167.75	$93.77	11.8%	6.6%	$19,441,179	$19,440,858
Cook County	1,289,658	$1,289.30	$60.14	$25.06	$3.15	$1,378	$267.12	$178.78	17.2%	11.5%	$219,031,166	$140,294,671
Collar Counties	177,635	$1,608.78	$55.55	$23.15	$3.15	$1,691	$226.95	$145.10	12.4%	7.9%	$24,486,530	$22,560,186
Total												$210,958,652

HMO PMPM, 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,431.98	$53.42	$22.26	$3.31	$1,511	$192.31	$113.33	11.8%	7.0%	$18,248,906	$18,045,713
Central IL	165,132	$1,303.46	$51.12	$21.30	$3.31	$1,379	$182.63	$106.91	12.3%	7.2%	$16,771,864	$16,640,852
Southern IL	222,604	$1,340.14	$54.01	$22.50	$3.31	$1,420	$191.25	$111.43	12.5%	7.3%	$23,564,103	$23,563,747
Cook County	1,315,451	$1,368.22	$64.09	$26.71	$3.31	$1,462	$297.29	$203.18	17.8%	12.2%	$253,913,581	$166,866,577
Collar Counties	181,188	$1,709.00	$59.63	$24.84	$3.31	$1,797	$254.63	$166.85	13.0%	8.5%	$28,720,463	$26,590,797
Total												$251,707,686

HMO PMPM, 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,529.70	$57.80	$24.08	$3.47	$1,615	$218.97	$133.61	12.5%	7.6%	$21,946,267	$21,721,271
Central IL	168,434	$1,394.11	$55.34	$23.06	$3.47	$1,476	$208.15	$126.27	13.0%	7.9%	$20,205,223	$20,060,153
Southern IL	227,056	$1,433.81	$58.46	$24.36	$3.47	$1,520	$218.05	$131.76	13.2%	8.0%	$28,421,967	$28,421,573
Cook County	1,341,760	$1,453.81	$68.43	$28.51	$3.47	$1,554	$330.93	$230.52	18.5%	12.9%	$293,843,066	$197,702,370
Collar Counties	184,812	$1,817.54	$64.12	$26.72	$3.47	$1,912	$285.82	$191.51	13.6%	9.1%	$33,622,797	$31,270,647
Total												$299,176,014

HMO PMPM, 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,636.33	$62.67	$26.11	$3.65	$1,729	$249.42	$156.99	13.2%	8.3%	$26,301,930	$26,053,059
Central IL	171,803	$1,493.21	$60.04	$25.02	$3.65	$1,582	$237.30	$148.61	13.7%	8.6%	$24,254,380	$24,093,915
Southern IL	231,597	$1,536.26	$63.40	$26.42	$3.65	$1,630	$248.68	$155.22	13.9%	8.7%	$34,151,722	$34,151,286
Cook County	1,368,595	$1,546.81	$73.18	$30.49	$3.65	$1,654	$368.53	$261.21	19.2%	13.6%	$339,618,792	$233,531,904
Collar Counties	188,508	$1,935.28	$69.09	$28.79	$3.65	$2,037	$321.02	$219.50	14.2%	9.7%	$39,308,210	$36,712,719
Total												$354,542,884

PCCM/DM Model

PCCM/DM PMPM, 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,364.19	$11.59	$2.32	$1.50	$1,380	$43.96	$28.54	3.1%	2.0%	$4,418,070	$4,363,031
Central IL	158,720	$1,243.17	$12.17	$2.43	$1.50	$1,259	$41.60	$25.50	3.2%	2.0%	$3,844,342	$3,808,854
Southern IL	213,960	$1,279.56	$12.39	$2.48	$1.50	$1,296	$43.21	$26.85	3.3%	2.0%	$5,456,875	$5,456,778
Cook County	1,264,370	$1,381.96	$14.45	$2.89	$1.50	$1,401	$74.45	$55.61	5.1%	3.8%	$66,791,978	$43,079,252
Collar Counties	174,152	$1,656.16	$12.23	$2.45	$1.50	$1,672	$62.23	$46.06	3.6%	2.7%	$7,620,279	$7,040,131
Total												$63,748,046

PCCM/DM PMPM, 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,461.04	$12.17	$2.43	$1.58	$1,477	$50.15	$33.97	3.3%	2.2%	$5,363,019	$5,301,929
Central IL	161,894	$1,333.14	$12.78	$2.56	$1.58	$1,350	$47.52	$30.61	3.4%	2.2%	$4,707,226	$4,667,837
Southern IL	218,239	$1,372.71	$13.01	$2.60	$1.58	$1,390	$49.40	$32.21	3.5%	2.3%	$6,677,946	$6,677,839
Cook County	1,289,658	$1,473.60	$15.18	$3.04	$1.58	$1,493	$82.82	$63.03	5.3%	4.0%	$77,226,551	$50,983,677
Collar Counties	177,635	$1,765.91	$12.84	$2.57	$1.58	$1,783	$69.81	$52.83	3.8%	2.9%	$8,915,990	$8,273,940
Total												$75,905,222

PCCM/DM PMPM, 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,567.05	$12.78	$2.56	$1.65	$1,584	$57.24	$40.25	3.5%	2.5%	$6,481,198	$6,413,474
Central IL	165,132	$1,431.80	$13.42	$2.68	$1.65	$1,450	$54.29	$36.53	3.7%	2.5%	$5,731,186	$5,687,520
Southern IL	222,604	$1,474.91	$13.66	$2.73	$1.65	$1,493	$56.48	$38.43	3.7%	2.5%	$8,126,795	$8,126,676
Cook County	1,315,451	$1,573.36	$15.93	$3.19	$1.65	$1,594	$92.15	$71.38	5.5%	4.3%	$89,202,517	$60,189,751
Collar Counties	181,188	$1,885.27	$13.48	$2.70	$1.65	$1,903	$78.37	$60.54	4.0%	3.1%	$10,420,354	$9,710,536
Total												$90,127,957

PCCM/DM PMPM, 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,683.32	$13.42	$2.68	$1.74	$1,701	$65.36	$47.52	3.7%	2.7%	$7,805,104	$7,730,113
Central IL	168,434	$1,540.20	$14.09	$2.82	$1.74	$1,559	$62.06	$43.41	3.9%	2.7%	$6,946,707	$6,898,356
Southern IL	227,056	$1,587.26	$14.34	$2.87	$1.74	$1,606	$64.60	$45.65	3.9%	2.8%	$9,846,522	$9,846,391
Cook County	1,341,760	$1,682.15	$16.73	$3.35	$1.74	$1,704	$102.59	$80.78	5.7%	4.5%	$102,968,014	$70,924,320
Collar Counties	184,812	$2,015.33	$14.15	$2.83	$1.74	$2,034	$88.03	$69.31	4.2%	3.3%	$12,169,493	$11,385,522
Total												$106,784,700

PCCM/DM PMPM, 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,811.07	$14.09	$2.82	$1.82	$1,830	$74.68	$55.95	4.0%	3.0%	$9,373,523	$9,290,574
Central IL	171,803	$1,659.53	$14.79	$2.96	$1.82	$1,679	$70.98	$51.41	4.1%	3.0%	$8,390,198	$8,336,715
Southern IL	231,597	$1,711.01	$15.06	$3.01	$1.82	$1,731	$73.93	$54.03	4.1%	3.0%	$11,888,601	$11,888,456
Cook County	1,368,595	$1,801.05	$17.57	$3.51	$1.82	$1,824	$114.29	$91.38	6.0%	4.8%	$118,815,101	$83,456,341
Collar Counties	188,508	$2,157.32	$14.86	$2.97	$1.82	$2,177	$98.98	$79.33	4.4%	3.5%	$14,206,228	$13,341,151
Total												$126,313,236

PCCM/CCC Model

PCCM & CCC PMPM, 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,346.84	$17.60	$3.52	$1.25	$1,369	$61.30	$38.93	4.4%	2.8%	$6,025,926	$5,965,876
Central IL	158,720	$1,226.49	$15.85	$3.17	$1.25	$1,247	$58.28	$38.01	4.5%	3.0%	$5,731,575	$5,692,857
Southern IL	213,960	$1,261.85	$16.73	$3.35	$1.25	$1,283	$60.92	$39.60	4.6%	3.0%	$8,049,870	$8,049,765
Cook County	1,264,370	$1,368.25	$21.10	$4.22	$1.25	$1,395	$88.16	$61.59	6.1%	4.2%	$73,982,229	$50,267,132
Collar Counties	174,152	$1,641.53	$19.88	$3.98	$1.25	$1,667	$76.86	$51.76	4.5%	3.0%	$8,564,217	$7,984,010
Total												$77,959,641

PCCM & CCC PMPM, 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,439.92	$18.48	$3.70	$1.31	$1,463	$71.27	$47.78	4.7%	3.2%	$7,543,293	$7,475,765
Central IL	161,894	$1,312.84	$16.64	$3.33	$1.31	$1,334	$67.82	$46.54	4.9%	3.4%	$7,157,292	$7,113,752
Southern IL	218,239	$1,351.16	$17.56	$3.51	$1.31	$1,374	$70.94	$48.56	5.0%	3.4%	$10,067,450	$10,067,332
Cook County	1,289,658	$1,456.03	$22.16	$4.43	$1.31	$1,484	$100.40	$72.50	6.5%	4.7%	$88,821,255	$62,152,442
Collar Counties	177,635	$1,747.45	$20.87	$4.17	$1.31	$1,774	$88.28	$61.92	4.8%	3.4%	$10,449,642	$9,797,171
Total												$96,606,462

PCCM & CCC PMPM, 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,541.61	$19.40	$3.88	$1.38	$1,566	$82.68	$58.02	5.1%	3.6%	$9,342,992	$9,267,225
Central IL	165,132	$1,407.34	$17.47	$3.49	$1.38	$1,430	$78.75	$56.40	5.3%	3.8%	$8,848,431	$8,799,579
Southern IL	222,604	$1,448.96	$18.44	$3.69	$1.38	$1,472	$82.43	$58.92	5.4%	3.8%	$12,460,820	$12,460,687
Cook County	1,315,451	$1,551.38	$23.26	$4.65	$1.38	$1,581	$114.13	$84.84	6.9%	5.1%	$106,023,090	$76,100,682
Collar Counties	181,188	$1,862.42	$21.91	$4.38	$1.38	$1,890	$101.22	$73.55	5.2%	3.7%	$12,659,656	$11,927,583
Total												$118,555,757

PCCM & CCC PMPM, 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,652.90	$20.37	$4.07	$1.45	$1,679	$95.77	$69.88	5.5%	4.0%	$11,477,371	$11,392,536
Central IL	168,434	$1,510.96	$18.35	$3.67	$1.45	$1,534	$91.30	$67.83	5.7%	4.2%	$10,854,299	$10,799,600
Southern IL	227,056	$1,556.25	$19.36	$3.87	$1.45	$1,581	$95.61	$70.93	5.8%	4.3%	$15,299,756	$15,299,607
Cook County	1,341,760	$1,655.16	$24.43	$4.89	$1.45	$1,686	$129.59	$98.83	7.3%	5.5%	$125,977,130	$92,473,554
Collar Counties	184,812	$1,987.44	$23.01	$4.60	$1.45	$2,016	$115.92	$86.87	5.5%	4.1%	$15,251,320	$14,431,632
Total												$144,396,929

PCCM & CCC PMPM, 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,774.95	$21.39	$4.28	$1.52	$1,802	$110.81	$83.62	5.9%	4.4%	$14,008,765	$13,913,956
Central IL	171,803	$1,624.79	$19.27	$3.85	$1.52	$1,649	$105.72	$81.08	6.1%	4.7%	$13,233,624	$13,172,494
Southern IL	231,597	$1,674.18	$20.33	$4.07	$1.52	$1,700	$110.76	$84.85	6.2%	4.8%	$18,667,359	$18,667,193
Cook County	1,368,595	$1,768.33	$25.65	$5.13	$1.52	$1,801	$147.01	$114.71	7.7%	6.0%	$149,141,860	$111,699,429
Collar Counties	188,508	$2,123.65	$24.16	$4.83	$1.52	$2,154	$132.65	$102.14	5.9%	4.5%	$18,292,257	$17,376,202
Total												$174,829,275

Complex Care Coordination Model

COMPLEX CARE COORDINATION PMPM, 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,365.73	$16.10	$1.61	$0.50	$1,384	$42.41	$24.20	3.0%	1.7%	$3,745,724	$3,715,700
Central IL	158,720	$1,244.29	$14.35	$1.44	$0.50	$1,261	$40.48	$24.19	3.2%	1.9%	$3,647,772	$3,628,413
Southern IL	213,960	$1,280.06	$15.23	$1.52	$0.50	$1,297	$42.71	$25.47	3.2%	1.9%	$5,176,357	$5,176,304
Cook County	1,264,370	$1,401.31	$19.60	$1.96	$0.50	$1,423	$55.10	$33.04	3.8%	2.3%	$39,682,102	$27,824,553
Collar Counties	174,152	$1,668.74	$18.38	$1.84	$0.50	$1,689	$49.65	$28.94	2.9%	1.7%	$4,787,903	$4,497,800
Total												$44,842,771

COMPLEX CARE COORDINATION PMPM, 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,460.41	$16.91	$1.69	$0.53	$1,480	$50.78	$31.66	3.4%	2.1%	$4,998,132	$4,962,760
Central IL	161,894	$1,332.17	$15.07	$1.51	$0.53	$1,349	$48.49	$31.39	3.5%	2.3%	$4,828,176	$4,805,369
Southern IL	218,239	$1,370.95	$15.99	$1.60	$0.53	$1,389	$51.16	$33.05	3.6%	2.3%	$6,852,268	$6,852,206
Cook County	1,289,658	$1,491.29	$20.58	$2.06	$0.53	$1,514	$65.13	$41.97	4.2%	2.7%	$51,419,562	$37,450,184
Collar Counties	177,635	$1,776.65	$19.29	$1.93	$0.53	$1,798	$59.08	$37.33	3.2%	2.0%	$6,299,191	$5,957,420
Total												$60,027,939

COMPLEX CARE COORDINATION PMPM, 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,563.87	$17.75	$1.78	$0.55	$1,584	$60.42	$40.34	3.7%	2.5%	$6,496,228	$6,454,901
Central IL	165,132	$1,428.36	$15.82	$1.58	$0.55	$1,446	$57.73	$39.78	3.9%	2.7%	$6,239,740	$6,213,093
Southern IL	222,604	$1,470.50	$16.79	$1.68	$0.55	$1,490	$60.89	$41.88	4.0%	2.7%	$8,855,897	$8,855,825
Cook County	1,315,451	$1,589.03	$21.61	$2.16	$0.55	$1,613	$76.48	$52.16	4.6%	3.1%	$65,184,359	$48,863,046
Collar Counties	181,188	$1,893.80	$20.26	$2.03	$0.55	$1,917	$69.84	$47.00	3.6%	2.4%	$8,090,161	$7,690,848
Total												$78,077,713

COMPLEX CARE COORDINATION PMPM, 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,677.14	$18.64	$1.86	$0.58	$1,698	$71.53	$50.45	4.1%	2.9%	$8,286,676	$8,238,726
Central IL	168,434	$1,533.87	$16.61	$1.66	$0.58	$1,553	$68.39	$49.54	4.3%	3.1%	$7,926,425	$7,895,508
Southern IL	227,056	$1,579.74	$17.62	$1.76	$0.58	$1,600	$72.12	$52.15	4.4%	3.2%	$11,249,487	$11,249,403
Cook County	1,341,760	$1,695.41	$22.69	$2.27	$0.58	$1,721	$89.34	$63.80	5.0%	3.6%	$81,322,127	$62,385,323
Collar Counties	184,812	$2,021.22	$21.27	$2.13	$0.58	$2,045	$82.14	$58.16	3.9%	2.8%	$10,211,516	$9,748,213
Total												$99,517,174

COMPLEX CARE COORDINATION PMPM, 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,801.39	$19.57	$1.96	$0.61	$1,824	$84.36	$62.23	4.5%	3.3%	$10,425,186	$10,369,881
Central IL	171,803	$1,649.81	$17.44	$1.74	$0.61	$1,670	$80.70	$60.91	4.7%	3.5%	$9,940,729	$9,905,070
Southern IL	231,597	$1,699.86	$18.51	$1.85	$0.61	$1,721	$85.08	$64.12	4.8%	3.6%	$14,107,361	$14,107,264
Cook County	1,368,595	$1,811.43	$23.82	$2.38	$0.61	$1,838	$103.91	$77.10	5.4%	4.0%	$100,241,038	$78,399,620
Collar Counties	188,508	$2,160.08	$22.33	$2.23	$0.61	$2,185	$96.22	$71.05	4.3%	3.1%	$12,723,514	$12,189,149
Total												$124,970,984

Affirmative Choice Model

AFFIRMATIVE CHOICE (HMO/PCCM), 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,360.45	$37.48	$11.32	$2.50	$1,412	$47.69	-$3.61	3.4%	-0.3%	-$559,392	-$608,181
Central IL	158,720	$1,239.49	$35.34	$10.72	$2.50	$1,288	$45.27	-$3.29	3.5%	-0.3%	-$495,853	-$527,311
Southern IL	213,960	$1,275.32	$37.35	$11.33	$2.50	$1,326	$47.46	-$3.72	3.6%	-0.3%	-$756,778	-$756,863
Cook County	1,264,370	$1,382.63	$45.88	$13.89	$2.50	$1,445	$73.78	$11.52	5.1%	0.8%	$13,834,529	-$6,916,181
Collar Counties	174,152	$1,655.40	$42.34	$12.79	$2.50	$1,713	$62.99	$5.36	3.7%	0.3%	$886,805	$379,125
Total												-$8,429,412

AFFIRMATIVE CHOICE (HMO/PCCM), 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,455.12	$39.36	$11.89	$2.63	$1,509	$56.08	$2.21	3.7%	0.1%	$348,703	$293,233
Central IL	161,894	$1,327.37	$37.11	$11.26	$2.63	$1,378	$53.29	$2.30	3.9%	0.2%	$353,842	$318,077
Southern IL	218,239	$1,366.22	$39.21	$11.90	$2.63	$1,420	$55.89	$2.15	3.9%	0.2%	$446,262	$446,165
Cook County	1,289,658	$1,471.88	$48.17	$14.58	$2.63	$1,537	$84.54	$19.17	5.4%	1.2%	$23,486,966	-$6,988
Collar Counties	177,635	$1,762.88	$44.46	$13.43	$2.63	$1,823	$72.85	$12.33	4.0%	0.7%	$2,081,357	$1,506,561
Total												$2,557,048

AFFIRMATIVE CHOICE (HMO/PCCM), 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,558.59	$41.32	$12.48	$2.76	$1,615	$65.70	$9.14	4.0%	0.6%	$1,471,354	$1,408,502
Central IL	165,132	$1,423.60	$38.96	$11.82	$2.76	$1,477	$62.50	$8.96	4.2%	0.6%	$1,404,900	$1,364,375
Southern IL	222,604	$1,465.82	$41.17	$12.50	$2.76	$1,522	$65.57	$9.15	4.3%	0.6%	$1,934,516	$1,934,406
Cook County	1,315,451	$1,568.88	$50.58	$15.31	$2.76	$1,638	$96.63	$27.99	5.8%	1.7%	$34,975,478	$8,453,344
Collar Counties	181,188	$1,879.61	$46.68	$14.10	$2.76	$1,943	$84.03	$20.49	4.3%	1.0%	$3,526,226	$2,877,343
Total												$16,037,971

AFFIRMATIVE CHOICE (HMO/PCCM), 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,671.92	$43.39	$13.11	$2.89	$1,731	$76.75	$17.36	4.4%	1.0%	$2,851,857	$2,780,854
Central IL	168,434	$1,529.18	$40.91	$12.41	$2.89	$1,585	$73.08	$16.86	4.6%	1.1%	$2,698,075	$2,652,294
Southern IL	227,056	$1,575.16	$43.23	$13.12	$2.89	$1,634	$76.70	$17.46	4.6%	1.1%	$3,765,665	$3,765,541
Cook County	1,341,760	$1,674.53	$53.11	$16.07	$2.89	$1,747	$110.22	$38.15	6.2%	2.1%	$48,624,646	$18,762,763
Collar Counties	184,812	$2,006.63	$49.02	$14.81	$2.89	$2,073	$96.73	$30.01	4.6%	1.4%	$5,268,838	$4,538,246
Total												$32,499,698

AFFIRMATIVE CHOICE (HMO/PCCM), 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,796.28	$45.56	$13.76	$3.04	$1,859	$89.47	$27.11	4.7%	1.4%	$4,542,115	$4,462,121
Central IL	171,803	$1,645.25	$42.96	$13.03	$3.04	$1,704	$85.27	$26.24	4.9%	1.5%	$4,282,238	$4,230,660
Southern IL	231,597	$1,695.42	$45.39	$13.78	$3.04	$1,758	$89.52	$27.31	5.0%	1.5%	$6,008,877	$6,008,737
Cook County	1,368,595	$1,789.81	$55.76	$16.88	$3.04	$1,865	$125.53	$49.85	6.6%	2.6%	$64,818,793	$31,276,615
Collar Counties	188,508	$2,145.12	$51.47	$15.55	$3.04	$2,215	$111.18	$41.13	4.9%	1.8%	$7,365,740	$6,545,106
Total												$52,523,239

PCCM/DM/CCC Model

PCCM/DM/CCC PMPM, 2006

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	162,925	$1,347.82	$18.15	$3.63	$1.75	$1,371	$60.32	$36.80	4.3%	2.6%	$5,695,513	$5,629,373
Central IL	158,720	$1,228.39	$17.69	$3.54	$1.75	$1,251	$56.38	$33.40	4.4%	2.6%	$5,036,013	$4,993,756
Southern IL	213,960	$1,265.89	$17.52	$3.50	$1.75	$1,289	$56.88	$34.11	4.3%	2.6%	$6,932,443	$6,932,331
Cook County	1,264,370	$1,370.45	$18.84	$3.77	$1.75	$1,395	$85.96	$61.60	5.9%	4.2%	$73,986,093	$47,882,859
Collar Counties	174,152	$1,638.99	$19.01	$3.80	$1.75	$1,664	$79.40	$54.85	4.6%	3.2%	$9,074,049	$8,397,556
Total												$73,835,874

PCCM/DM/CCC PMPM, 2007

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	166,183	$1,441.30	$19.05	$3.81	$1.84	$1,466	$69.90	$45.20	4.6%	3.0%	$7,135,476	$7,061,425
Central IL	161,894	$1,315.20	$18.58	$3.72	$1.84	$1,339	$65.46	$41.33	4.7%	3.0%	$6,356,245	$6,308,914
Southern IL	218,239	$1,355.87	$18.40	$3.68	$1.84	$1,380	$66.24	$42.33	4.7%	3.0%	$8,775,516	$8,775,390
Cook County	1,289,658	$1,458.87	$19.79	$3.96	$1.84	$1,484	$97.56	$71.98	6.3%	4.6%	$88,184,056	$58,957,549
Collar Counties	177,635	$1,745.17	$19.96	$3.99	$1.84	$1,771	$90.56	$64.77	4.9%	3.5%	$10,930,513	$10,174,919
Total												$91,278,197

PCCM/DM/CCC PMPM, 2008

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	169,507	$1,543.44	$20.01	$4.00	$1.93	$1,569	$80.85	$54.91	5.0%	3.4%	$8,842,944	$8,760,192
Central IL	165,132	$1,410.24	$19.51	$3.90	$1.93	$1,436	$75.86	$50.52	5.1%	3.4%	$7,924,704	$7,871,791
Southern IL	222,604	$1,454.43	$19.32	$3.86	$1.93	$1,480	$76.96	$51.85	5.0%	3.4%	$10,965,523	$10,965,382
Cook County	1,315,451	$1,554.96	$20.77	$4.15	$1.93	$1,582	$110.55	$83.69	6.6%	5.0%	$104,588,362	$71,926,664
Collar Counties	181,188	$1,860.47	$20.95	$4.19	$1.93	$1,888	$103.17	$76.10	5.3%	3.9%	$13,098,236	$12,255,719
Total												$111,779,748

PCCM/DM/CCC PMPM, 2009

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	172,897	$1,655.28	$21.01	$4.20	$2.03	$1,683	$93.40	$66.16	5.3%	3.8%	$10,867,596	$10,775,280
Central IL	168,434	$1,514.48	$20.48	$4.10	$2.03	$1,541	$87.78	$61.17	5.5%	3.8%	$9,787,796	$9,728,749
Southern IL	227,056	$1,562.60	$20.28	$4.06	$2.03	$1,589	$89.26	$62.90	5.4%	3.8%	$13,567,345	$13,567,188
Cook County	1,341,760	$1,659.61	$21.81	$4.36	$2.03	$1,688	$125.13	$96.93	7.0%	5.4%	$123,558,102	$87,120,746
Collar Counties	184,812	$1,985.90	$22.00	$4.40	$2.03	$2,014	$117.46	$89.03	5.6%	4.2%	$15,631,385	$14,693,411
Total												$135,885,373

PCCM/DM/CCC PMPM, 2010

Region	Member Months	Total Medical PMPM Cost	Vendor PMPM Admin Costs	Vendor PMPM Profit	State PMPM Admin Cost	Total PMPM Cost	PMPM Medical Savings	Total PMPM Savings (Loss)	Percent Medical Savings	Percent Total Savings (Loss)	Total $$ Savings (Loss)	Adjusted Savings If Cook County Health System Is "Held Harmless"
Northwestern IL	176,355	$1,777.96	$22.06	$4.41	$2.13	$1,807	$107.79	$79.20	5.7%	4.2%	$13,268,632	$13,165,811
Central IL	171,803	$1,629.05	$21.51	$4.30	$2.13	$1,657	$101.47	$73.53	5.9%	4.2%	$12,000,855	$11,935,068
Southern IL	231,597	$1,681.54	$21.30	$4.26	$2.13	$1,709	$103.40	$75.71	5.8%	4.2%	$16,658,346	$16,658,171
Cook County	1,368,595	$1,773.81	$22.90	$4.58	$2.13	$1,803	$141.53	$111.92	7.4%	5.8%	$145,515,987	$104,931,477
Collar Counties	188,508	$2,122.63	$23.10	$4.62	$2.13	$2,152	$133.68	$103.83	5.9%	4.6%	$18,594,142	$17,551,402
Total												$164,241,929

Appendix 6
Estimated Cash Flow for Capitation Program in Collar & East St. Louis Regions, All Eligibility Categories

Appendix 6: Estimated Cash Flow for Capitation Program in Collar & East St. Louis Regions, All Eligibility Categories

Estimated Cash Flow over 12-Month Phase-In Collar & East St. Louis Regions, All Aid Categories				
Month	Estimated Cumulative Enrollment	Estimated Capitation Payments	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	308,689	$0	$748,494	$4,970,936
February	308,689	$69,878,424	($64,638,969)	$9,941,872
March	308,689	$69,878,424	($115,056,559)	$14,912,808
April	308,689	$69,878,424	($116,822,065)	$19,883,744
May	308,689	$69,878,424	($115,593,597)	$24,854,680
June	308,689	$69,878,424	($113,616,635)	$29,825,616
July	308,689	$69,878,424	($110,891,180)	$34,796,552
August	308,689	$69,878,424	($107,417,231)	$39,767,488
September	308,689	$69,878,424	($103,194,789)	$44,738,424
October	308,689	$69,878,424	($98,223,853)	$49,709,360
November	308,689	$69,878,424	($93,252,917)	$54,680,297
December	308,689	$69,878,424	($88,281,981)	$59,651,233
January '07	317,009	$69,878,424	($83,242,976)	$65,885,543
February	317,009	$75,421,940	($83,407,143)	$72,119,852
March	317,009	$75,421,940	($82,209,932)	$78,354,162
April	317,009	$75,421,940	($76,588,242)	$84,588,472
May	317,009	$75,421,940	($70,694,277)	$90,822,782
June	317,009	$75,421,940	($64,732,243)	$97,057,092
July	317,009	$75,421,940	($58,702,139)	$103,291,402
August	317,009	$75,421,940	($52,603,967)	$109,525,712
September	317,009	$75,421,940	($46,437,726)	$115,760,022
October	317,009	$75,421,940	($40,203,416)	$121,994,332
November	317,009	$75,421,940	($33,969,106)	$128,228,642
December	317,009	$75,421,940	($27,734,796)	$134,462,952
January '08	325,710	$75,421,940	($21,422,666)	$142,176,132
February	325,710	$81,725,145	($21,024,635)	$149,889,312
March	325,710	$81,725,145	($19,070,190)	$157,602,493
April	325,710	$81,725,145	($12,057,397)	$165,315,673
May	325,710	$81,725,145	($4,733,320)	$173,028,853
June	325,710	$81,725,145	$2,668,577	$180,742,034
July	325,710	$81,725,145	$10,148,295	$188,455,214
August	325,710	$81,725,145	$17,705,834	$196,168,394
September	325,710	$81,725,145	$25,341,194	$203,881,575
October	325,710	$81,725,145	$33,054,374	$211,594,755
November	325,710	$81,725,145	$40,767,554	$219,307,935
December	325,710	$81,725,145	$48,480,735	$227,021,115
January '09	334,821	$81,725,145	$56,279,278	$236,438,069
February	334,821	$88,557,663	$57,672,118	$245,855,023
March	334,821	$88,557,663	$60,772,216	$255,271,977
April	334,821	$88,557,663	$69,420,904	$264,688,931
May	334,821	$88,557,663	$78,411,043	$274,105,885
June	334,821	$88,557,663	$87,486,545	$283,522,839
July	334,821	$88,557,663	$96,647,411	$292,939,793
August	334,821	$88,557,663	$105,893,639	$302,356,747
September	334,821	$88,557,663	$115,225,230	$311,773,701
October	334,821	$88,557,663	$124,642,184	$321,190,655
November	334,821	$88,557,663	$134,059,138	$330,607,609
December	334,821	$88,557,663	$143,476,092	$340,024,563
January '10	344,373	$88,557,663	$152,989,704	$351,430,393
February	344,373	$96,234,619	$155,309,651	$362,836,222
March	344,373	$96,234,619	$159,562,765	$374,242,051
April	344,373	$96,234,619	$170,098,670	$385,647,880
May	344,373	$96,234,619	$181,021,207	$397,053,710
June	344,373	$96,234,619	$192,040,403	$408,459,539
July	344,373	$96,234,619	$203,156,258	$419,865,368
August	344,373	$96,234,619	$214,368,770	$431,271,198
September	344,373	$96,234,619	$225,677,941	$442,677,027
October	344,373	$96,234,619	$237,083,771	$454,082,856
November	344,373	$96,234,619	$248,489,600	$465,488,685
December '10	344,373	$96,234,619	$259,895,429	$476,894,515

Estimated Cash Flow over 12-Month Phase-In Collar & East St. Louis Regions, Disabled Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	28,234	$850	$239,987		$239,987	$1,919,898	$239,987	$1,919,898
February	28,234	$850	$1,439,923	$22,078,825	($20,638,902)	$1,919,898	($20,398,914)	$3,839,796
March	28,234	$850	$6,239,668	$22,078,825	($15,839,157)	$1,919,898	($36,238,072)	$5,759,694
April	28,234	$850	$21,838,838	$22,078,825	($239,987)	$1,919,898	($36,478,059)	$7,679,591
May	28,234	$850	$22,798,787	$22,078,825	$719,962	$1,919,898	($35,758,097)	$9,599,489
June	28,234	$850	$23,038,774	$22,078,825	$959,949	$1,919,898	($34,798,148)	$11,519,387
July	28,234	$850	$23,278,761	$22,078,825	$1,199,936	$1,919,898	($33,598,212)	$13,439,285
August	28,234	$850	$23,518,748	$22,078,825	$1,439,923	$1,919,898	($32,158,289)	$15,359,183
September	28,234	$850	$23,758,736	$22,078,825	$1,679,911	$1,919,898	($30,478,378)	$17,279,081
October	28,234	$850	$23,998,723	$22,078,825	$1,919,898	$1,919,898	($28,558,480)	$19,198,978
November	28,234	$850	$23,998,723	$22,078,825	$1,919,898	$1,919,898	($26,638,582)	$21,118,876
December	28,234	$850	$23,998,723	$22,078,825	$1,919,898	$1,919,898	($24,718,685)	$23,038,774
January '07	28,798	$900	$24,017,922	$22,078,825	$1,939,097	$2,332,676	($22,779,588)	$25,371,450
February	28,798	$900	$24,113,917	$23,585,945	$527,972	$2,332,676	($22,251,616)	$27,704,126
March	28,798	$900	$24,497,896	$23,585,945	$911,951	$2,332,676	($21,339,664)	$30,036,802
April	28,798	$900	$25,745,830	$23,585,945	$2,159,885	$2,332,676	($19,179,779)	$32,369,477
May	28,798	$900	$25,822,626	$23,585,945	$2,236,681	$2,332,676	($16,943,098)	$34,702,153
June	28,798	$900	$25,841,825	$23,585,945	$2,255,880	$2,332,676	($14,687,218)	$37,034,829
July	28,798	$900	$25,861,024	$23,585,945	$2,275,079	$2,332,676	($12,412,139)	$39,367,505
August	28,798	$900	$25,880,223	$23,585,945	$2,294,278	$2,332,676	($10,117,862)	$41,700,181
September	28,798	$900	$25,899,422	$23,585,945	$2,313,477	$2,332,676	($7,804,385)	$44,032,857
October	28,798	$900	$25,918,621	$23,585,945	$2,332,676	$2,332,676	($5,471,709)	$46,365,533
November	28,798	$900	$25,918,621	$23,585,945	$2,332,676	$2,332,676	($3,139,033)	$48,698,209
December	28,798	$900	$25,918,621	$23,585,945	$2,332,676	$2,332,676	($806,357)	$51,030,884
January '08	29,374	$950	$25,938,492	$23,585,945	$2,352,547	$2,790,572	$1,546,190	$53,821,456
February	29,374	$950	$26,037,846	$25,115,144	$922,703	$2,790,572	$2,468,893	$56,612,027
March	29,374	$950	$26,435,265	$25,115,144	$1,320,122	$2,790,572	$3,789,014	$59,402,599
April	29,374	$950	$27,726,877	$25,115,144	$2,611,733	$2,790,572	$6,400,747	$62,193,170
May	29,374	$950	$27,806,360	$25,115,144	$2,691,217	$2,790,572	$9,091,964	$64,983,742
June	29,374	$950	$27,826,231	$25,115,144	$2,711,088	$2,790,572	$11,803,052	$67,774,313
July	29,374	$950	$27,846,102	$25,115,144	$2,730,959	$2,790,572	$14,534,011	$70,564,885
August	29,374	$950	$27,865,973	$25,115,144	$2,750,830	$2,790,572	$17,284,840	$73,355,456
September	29,374	$950	$27,885,844	$25,115,144	$2,770,701	$2,790,572	$20,055,541	$76,146,028
October	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$22,846,112	$78,936,599
November	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$25,636,684	$81,727,171
December	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$28,427,255	$84,517,742
January '09	29,962	$1,000	$27,926,277	$25,115,144	$2,811,134	$3,295,812	$31,238,389	$87,813,554
February	29,962	$1,000	$28,029,088	$26,666,114	$1,362,974	$3,295,812	$32,601,363	$91,109,366
March	29,962	$1,000	$28,440,330	$26,666,114	$1,774,216	$3,295,812	$34,375,579	$94,405,178
April	29,962	$1,000	$29,776,867	$26,666,114	$3,110,753	$3,295,812	$37,486,332	$97,700,990
May	29,962	$1,000	$29,859,115	$26,666,114	$3,193,001	$3,295,812	$40,679,333	$100,996,801
June	29,962	$1,000	$29,879,677	$26,666,114	$3,213,563	$3,295,812	$43,892,896	$104,292,613
July	29,962	$1,000	$29,900,239	$26,666,114	$3,234,125	$3,295,812	$47,127,022	$107,588,425
August	29,962	$1,000	$29,920,801	$26,666,114	$3,254,688	$3,295,812	$50,381,709	$110,884,237
September	29,962	$1,000	$29,941,363	$26,666,114	$3,275,250	$3,295,812	$53,656,959	$114,180,049
October	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$56,952,771	$117,475,861
November	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$60,248,583	$120,771,672
December	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$63,544,395	$124,067,484
January '10	30,561	$1,050	$29,983,199	$26,666,114	$3,317,085	$3,850,707	$66,861,479	$127,918,191
February	30,561	$1,050	$30,089,563	$28,238,516	$1,851,048	$3,850,707	$68,712,527	$131,768,898
March	30,561	$1,050	$30,515,023	$28,238,516	$2,276,507	$3,850,707	$70,989,034	$135,619,604
April	30,561	$1,050	$31,897,766	$28,238,516	$3,659,250	$3,850,707	$74,648,284	$139,470,311
May	30,561	$1,050	$31,982,857	$28,238,516	$3,744,342	$3,850,707	$78,392,626	$143,321,018
June	30,561	$1,050	$32,004,130	$28,238,516	$3,765,615	$3,850,707	$82,158,241	$147,171,724
July	30,561	$1,050	$32,025,403	$28,238,516	$3,786,888	$3,850,707	$85,945,129	$151,022,431
August	30,561	$1,050	$32,046,676	$28,238,516	$3,808,161	$3,850,707	$89,753,289	$154,873,138
September	30,561	$1,050	$32,067,949	$28,238,516	$3,829,434	$3,850,707	$93,582,723	$158,723,844
October	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$97,433,430	$162,574,551
November	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$101,284,136	$166,425,258
December '10	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$105,134,843	$170,275,964

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 12-Month Phase-In Collar & East St. Louis Regions, DCFS Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	3,629	$898	$32,589		$32,589	$195,532	$32,589	$195,532
February	3,629	$898	$195,532	$3,063,338	($2,867,806)	$195,532	($2,835,217)	$391,064
March	3,629	$898	$847,306	$3,063,338	($2,216,032)	$195,532	($5,051,249)	$586,597
April	3,629	$898	$2,965,572	$3,063,338	($97,766)	$195,532	($5,149,015)	$782,129
May	3,629	$898	$3,095,927	$3,063,338	$32,589	$195,532	($5,116,426)	$977,661
June	3,629	$898	$3,128,515	$3,063,338	$65,177	$195,532	($5,051,249)	$1,173,193
July	3,629	$898	$3,161,104	$3,063,338	$97,766	$195,532	($4,953,482)	$1,368,725
August	3,629	$898	$3,193,693	$3,063,338	$130,355	$195,532	($4,823,128)	$1,564,258
September	3,629	$898	$3,226,281	$3,063,338	$162,944	$195,532	($4,660,184)	$1,759,790
October	3,629	$898	$3,258,870	$3,063,338	$195,532	$195,532	($4,464,652)	$1,955,322
November	3,629	$898	$3,258,870	$3,063,338	$195,532	$195,532	($4,269,120)	$2,150,854
December	3,629	$898	$3,258,870	$3,063,338	$195,532	$195,532	($4,073,588)	$2,346,386
January '07	3,702	$955	$3,261,632	$3,063,338	$198,294	$247,453	($3,875,294)	$2,593,839
February	3,702	$955	$3,275,440	$3,287,587	($12,146)	$247,453	($3,887,440)	$2,841,292
March	3,702	$955	$3,330,674	$3,287,587	$43,087	$247,453	($3,844,353)	$3,088,745
April	3,702	$955	$3,510,184	$3,287,587	$222,598	$247,453	($3,621,755)	$3,336,197
May	3,702	$955	$3,521,231	$3,287,587	$233,644	$247,453	($3,388,111)	$3,583,650
June	3,702	$955	$3,523,993	$3,287,587	$236,406	$247,453	($3,151,705)	$3,831,103
July	3,702	$955	$3,526,754	$3,287,587	$239,168	$247,453	($2,912,537)	$4,078,556
August	3,702	$955	$3,529,516	$3,287,587	$241,929	$247,453	($2,670,608)	$4,326,008
September	3,702	$955	$3,532,278	$3,287,587	$244,691	$247,453	($2,425,917)	$4,573,461
October	3,702	$955	$3,535,039	$3,287,587	$247,453	$247,453	($2,178,464)	$4,820,914
November	3,702	$955	$3,535,039	$3,287,587	$247,453	$247,453	($1,931,011)	$5,068,367
December	3,702	$955	$3,535,039	$3,287,587	$247,453	$247,453	($1,683,558)	$5,315,819
January '08	3,776	$1,017	$3,538,087	$3,287,587	$250,501	$307,186	($1,433,058)	$5,623,006
February	3,776	$1,017	$3,553,327	$3,532,644	$20,683	$307,186	($1,412,375)	$5,930,192
March	3,776	$1,017	$3,614,285	$3,532,644	$81,641	$307,186	($1,330,733)	$6,237,379
April	3,776	$1,017	$3,812,399	$3,532,644	$279,755	$307,186	($1,050,978)	$6,544,565
May	3,776	$1,017	$3,824,591	$3,532,644	$291,947	$307,186	($759,031)	$6,851,752
June	3,776	$1,017	$3,827,638	$3,532,644	$294,995	$307,186	($464,036)	$7,158,938
July	3,776	$1,017	$3,830,686	$3,532,644	$298,043	$307,186	($165,994)	$7,466,124
August	3,776	$1,017	$3,833,734	$3,532,644	$301,091	$307,186	$135,097	$7,773,311
September	3,776	$1,017	$3,836,782	$3,532,644	$304,138	$307,186	$439,235	$8,080,497
October	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	$746,422	$8,387,684
November	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	$1,053,608	$8,694,870
December	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	$1,360,795	$9,002,056
January '09	3,851	$1,084	$3,843,178	$3,532,644	$310,535	$375,719	$1,671,329	$9,377,775
February	3,851	$1,084	$3,859,920	$3,798,935	$60,984	$375,719	$1,732,313	$9,753,494
March	3,851	$1,084	$3,926,884	$3,798,935	$127,949	$375,719	$1,860,262	$10,129,213
April	3,851	$1,084	$4,144,520	$3,798,935	$345,585	$375,719	$2,205,847	$10,504,932
May	3,851	$1,084	$4,157,913	$3,798,935	$358,978	$375,719	$2,564,825	$10,880,651
June	3,851	$1,084	$4,161,261	$3,798,935	$362,326	$375,719	$2,927,151	$11,256,370
July	3,851	$1,084	$4,164,609	$3,798,935	$365,674	$375,719	$3,292,825	$11,632,088
August	3,851	$1,084	$4,167,958	$3,798,935	$369,022	$375,719	$3,661,847	$12,007,807
September	3,851	$1,084	$4,171,306	$3,798,935	$372,371	$375,719	$4,034,218	$12,383,526
October	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$4,409,937	$12,759,245
November	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$4,785,656	$13,134,964
December	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$5,161,375	$13,510,683
January '10	3,928	$1,157	$4,178,357	$3,798,935	$379,421	$454,490	$5,540,796	$13,965,173
February	3,928	$1,157	$4,196,869	$4,090,414	$106,455	$454,490	$5,647,251	$14,419,664
March	3,928	$1,157	$4,270,919	$4,090,414	$180,505	$454,490	$5,827,756	$14,874,154
April	3,928	$1,157	$4,511,582	$4,090,414	$421,168	$454,490	$6,248,924	$15,328,645
May	3,928	$1,157	$4,526,392	$4,090,414	$435,978	$454,490	$6,684,902	$15,783,135
June	3,928	$1,157	$4,530,094	$4,090,414	$439,680	$454,490	$7,124,583	$16,237,626
July	3,928	$1,157	$4,533,797	$4,090,414	$443,383	$454,490	$7,567,966	$16,692,116
August	3,928	$1,157	$4,537,499	$4,090,414	$447,085	$454,490	$8,015,051	$17,146,606
September	3,928	$1,157	$4,541,202	$4,090,414	$450,788	$454,490	$8,465,839	$17,601,097
October	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$8,920,329	$18,055,587
November	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$9,374,820	$18,510,078
December '10	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$9,829,310	$18,964,568

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 12-Month Phase-In Collar & East St. Louis Regions, Family Health Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	250,000	$160	$400,000		$400,000	$2,400,000	$400,000	$2,400,000
February	250,000	$160	$2,400,000	$37,600,000	($35,200,000)	$2,400,000	($34,800,000)	$4,800,000
March	250,000	$160	$10,400,000	$37,600,000	($27,200,000)	$2,400,000	($62,000,000)	$7,200,000
April	250,000	$160	$36,400,000	$37,600,000	($1,200,000)	$2,400,000	($63,200,000)	$9,600,000
May	250,000	$160	$38,000,000	$37,600,000	$400,000	$2,400,000	($62,800,000)	$12,000,000
June	250,000	$160	$38,400,000	$37,600,000	$800,000	$2,400,000	($62,000,000)	$14,400,000
July	250,000	$160	$38,800,000	$37,600,000	$1,200,000	$2,400,000	($60,800,000)	$16,800,000
August	250,000	$160	$39,200,000	$37,600,000	$1,600,000	$2,400,000	($59,200,000)	$19,200,000
September	250,000	$160	$39,600,000	$37,600,000	$2,000,000	$2,400,000	($57,200,000)	$21,600,000
October	250,000	$160	$40,000,000	$37,600,000	$2,400,000	$2,400,000	($54,800,000)	$24,000,000
November	250,000	$160	$40,000,000	$37,600,000	$2,400,000	$2,400,000	($52,400,000)	$26,400,000
December	250,000	$160	$40,000,000	$37,600,000	$2,400,000	$2,400,000	($50,000,000)	$28,800,000
January '07	255,000	$170	$40,033,500	$37,600,000	$2,433,500	$3,034,500	($47,566,500)	$31,834,500
February	255,000	$170	$40,201,000	$40,315,500	($114,500)	$3,034,500	($47,681,000)	$34,869,000
March	255,000	$170	$40,871,000	$40,315,500	$555,500	$3,034,500	($47,125,500)	$37,903,500
April	255,000	$170	$43,048,500	$40,315,500	$2,733,000	$3,034,500	($44,392,500)	$40,938,000
May	255,000	$170	$43,182,500	$40,315,500	$2,867,000	$3,034,500	($41,525,500)	$43,972,500
June	255,000	$170	$43,216,000	$40,315,500	$2,900,500	$3,034,500	($38,625,000)	$47,007,000
July	255,000	$170	$43,249,500	$40,315,500	$2,934,000	$3,034,500	($35,691,000)	$50,041,500
August	255,000	$170	$43,283,000	$40,315,500	$2,967,500	$3,034,500	($32,723,500)	$53,076,000
September	255,000	$170	$43,316,500	$40,315,500	$3,001,000	$3,034,500	($29,722,500)	$56,110,500
October	255,000	$170	$43,350,000	$40,315,500	$3,034,500	$3,034,500	($26,688,000)	$59,145,000
November	255,000	$170	$43,350,000	$40,315,500	$3,034,500	$3,034,500	($23,653,500)	$62,179,500
December	255,000	$170	$43,350,000	$40,315,500	$3,034,500	$3,034,500	($20,619,000)	$65,214,000
January '08	260,100	$182	$43,389,882	$40,315,500	$3,074,382	$3,787,056	($17,544,618)	$69,001,056
February	260,100	$182	$43,589,292	$43,551,144	$38,148	$3,787,056	($17,506,470)	$72,788,112
March	260,100	$182	$44,386,932	$43,551,144	$835,788	$3,787,056	($16,670,682)	$76,575,168
April	260,100	$182	$46,979,262	$43,551,144	$3,428,118	$3,787,056	($13,242,564)	$80,362,224
May	260,100	$182	$47,138,790	$43,551,144	$3,587,646	$3,787,056	($9,654,918)	$84,149,280
June	260,100	$182	$47,178,672	$43,551,144	$3,627,528	$3,787,056	($6,027,390)	$87,936,336
July	260,100	$182	$47,218,554	$43,551,144	$3,667,410	$3,787,056	($2,359,980)	$91,723,392
August	260,100	$182	$47,258,436	$43,551,144	$3,707,292	$3,787,056	$1,347,312	$95,510,448
September	260,100	$182	$47,298,318	$43,551,144	$3,747,174	$3,787,056	$5,094,486	$99,297,504
October	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	$8,881,542	$103,084,560
November	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	$12,668,598	$106,871,616
December	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	$16,455,654	$110,658,672
January '09	265,302	$195	$47,382,157	$43,551,144	$3,831,013	$4,656,050	$20,286,667	$115,314,722
February	265,302	$195	$47,601,941	$47,077,840	$524,102	$4,656,050	$20,810,768	$119,970,772
March	265,302	$195	$48,481,079	$47,077,840	$1,403,240	$4,656,050	$22,214,008	$124,626,822
April	265,302	$195	$51,338,278	$47,077,840	$4,260,438	$4,656,050	$26,474,446	$129,282,872
May	265,302	$195	$51,514,106	$47,077,840	$4,436,266	$4,656,050	$30,910,712	$133,938,923
June	265,302	$195	$51,558,062	$47,077,840	$4,480,223	$4,656,050	$35,390,934	$138,594,973
July	265,302	$195	$51,602,019	$47,077,840	$4,524,179	$4,656,050	$39,915,113	$143,251,023
August	265,302	$195	$51,645,976	$47,077,840	$4,568,136	$4,656,050	$44,483,250	$147,907,073
September	265,302	$195	$51,689,933	$47,077,840	$4,612,093	$4,656,050	$49,095,343	$152,563,123
October	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$53,751,393	$157,219,173
November	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$58,407,443	$161,875,223
December	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$63,063,493	$166,531,273
January '10	270,608	$210	$51,784,828	$47,077,840	$4,706,988	$5,682,769	$67,770,481	$172,214,042
February	270,608	$210	$52,039,518	$51,144,920	$894,598	$5,682,769	$68,665,080	$177,896,811
March	270,608	$210	$53,058,278	$51,144,920	$1,913,358	$5,682,769	$70,578,438	$183,579,580
April	270,608	$210	$56,369,247	$51,144,920	$5,224,327	$5,682,769	$75,802,765	$189,262,349
May	270,608	$210	$56,572,998	$51,144,920	$5,428,079	$5,682,769	$81,230,844	$194,945,117
June	270,608	$210	$56,623,936	$51,144,920	$5,479,017	$5,682,769	$86,709,860	$200,627,886
July	270,608	$210	$56,674,874	$51,144,920	$5,529,955	$5,682,769	$92,239,815	$206,310,655
August	270,608	$210	$56,725,812	$51,144,920	$5,580,893	$5,682,769	$97,820,708	$211,993,424
September	270,608	$210	$56,776,750	$51,144,920	$5,631,831	$5,682,769	$103,452,539	$217,676,193
October	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$109,135,308	$223,358,962
November	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$114,818,077	$229,041,730
December '10	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$120,500,846	$234,724,499

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 12-Month Phase-In Collar & East St. Louis Regions, SCHIP Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	26,826	$283	$75,918		$75,918	$455,506	$75,918	$455,506
February	26,826	$283	$455,506	$7,136,261	($6,680,755)	$455,506	($6,604,837)	$911,012
March	26,826	$283	$1,973,859	$7,136,261	($5,162,401)	$455,506	($11,767,239)	$1,366,518
April	26,826	$283	$6,908,508	$7,136,261	($227,753)	$455,506	($11,994,992)	$1,822,024
May	26,826	$283	$7,212,179	$7,136,261	$75,918	$455,506	($11,919,074)	$2,277,530
June	26,826	$283	$7,288,096	$7,136,261	$151,835	$455,506	($11,767,239)	$2,733,036
July	26,826	$283	$7,364,014	$7,136,261	$227,753	$455,506	($11,539,486)	$3,188,542
August	26,826	$283	$7,439,932	$7,136,261	$303,671	$455,506	($11,235,815)	$3,644,048
September	26,826	$283	$7,515,849	$7,136,261	$379,588	$455,506	($10,856,227)	$4,099,554
October	26,826	$283	$7,591,767	$7,136,261	$455,506	$455,506	($10,400,721)	$4,555,060
November	26,826	$283	$7,591,767	$7,136,261	$455,506	$455,506	($9,945,215)	$5,010,566
December	26,826	$283	$7,591,767	$7,136,261	$455,506	$455,506	($9,489,709)	$5,466,072
January '07	29,509	$300	$7,604,375	$7,136,261	$468,114	$619,681	($9,021,594)	$6,085,753
February	29,509	$300	$7,667,416	$8,232,909	($565,493)	$619,681	($9,587,087)	$6,705,435
March	29,509	$300	$7,919,581	$8,232,909	($313,328)	$619,681	($9,900,415)	$7,325,116
April	29,509	$300	$8,739,116	$8,232,909	$506,207	$619,681	($9,394,208)	$7,944,797
May	29,509	$300	$8,789,549	$8,232,909	$556,640	$619,681	($8,837,568)	$8,564,479
June	29,509	$300	$8,802,157	$8,232,909	$569,248	$619,681	($8,268,319)	$9,184,160
July	29,509	$300	$8,814,766	$8,232,909	$581,857	$619,681	($7,686,463)	$9,803,841
August	29,509	$300	$8,827,374	$8,232,909	$594,465	$619,681	($7,091,998)	$10,423,523
September	29,509	$300	$8,839,982	$8,232,909	$607,073	$619,681	($6,484,925)	$11,043,204
October	29,509	$300	$8,852,590	$8,232,909	$619,681	$619,681	($5,865,243)	$11,662,885
November	29,509	$300	$8,852,590	$8,232,909	$619,681	$619,681	($5,245,562)	$12,282,567
December	29,509	$300	$8,852,590	$8,232,909	$619,681	$619,681	($4,625,881)	$12,902,248
January '08	32,459	$319	$8,867,610	$8,232,909	$634,701	$828,366	($3,991,180)	$13,730,614
February	32,459	$319	$8,942,710	$9,526,213	($583,504)	$828,366	($4,574,683)	$14,558,981
March	32,459	$319	$9,243,108	$9,526,213	($283,106)	$828,366	($4,857,789)	$15,387,347
April	32,459	$319	$10,219,401	$9,526,213	$693,187	$828,366	($4,164,602)	$16,215,714
May	32,459	$319	$10,279,480	$9,526,213	$753,267	$828,366	($3,411,335)	$17,044,080
June	32,459	$319	$10,294,500	$9,526,213	$768,287	$828,366	($2,643,048)	$17,872,446
July	32,459	$319	$10,309,520	$9,526,213	$783,307	$828,366	($1,859,741)	$18,700,813
August	32,459	$319	$10,324,540	$9,526,213	$798,327	$828,366	($1,061,415)	$19,529,179
September	32,459	$319	$10,339,560	$9,526,213	$813,346	$828,366	($248,068)	$20,357,545
October	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	$580,298	$21,185,912
November	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	$1,408,664	$22,014,278
December	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	$2,237,031	$22,842,645
January '09	35,705	$339	$10,372,075	$9,526,213	$845,862	$1,089,373	$3,082,893	$23,932,018
February	35,705	$339	$10,459,554	$11,014,774	($555,220)	$1,089,373	$2,527,673	$25,021,391
March	35,705	$339	$10,809,467	$11,014,774	($205,306)	$1,089,373	$2,322,367	$26,110,764
April	35,705	$339	$11,946,686	$11,014,774	$931,912	$1,089,373	$3,254,279	$27,200,137
May	35,705	$339	$12,016,668	$11,014,774	$1,001,895	$1,089,373	$4,256,174	$28,289,511
June	35,705	$339	$12,034,164	$11,014,774	$1,019,391	$1,089,373	$5,275,564	$29,378,884
July	35,705	$339	$12,051,660	$11,014,774	$1,036,886	$1,089,373	$6,312,451	$30,468,257
August	35,705	$339	$12,069,155	$11,014,774	$1,054,382	$1,089,373	$7,366,832	$31,557,630
September	35,705	$339	$12,086,651	$11,014,774	$1,071,878	$1,089,373	$8,438,710	$32,647,003
October	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$9,528,083	$33,736,377
November	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$10,617,456	$34,825,750
December	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$11,706,830	$35,915,123
January '10	39,276	$361	$12,124,892	$11,014,774	$1,110,118	$1,417,863	$12,816,948	$37,332,986
February	39,276	$361	$12,228,616	$12,760,770	($532,154)	$1,417,863	$12,284,794	$38,750,850
March	39,276	$361	$12,643,513	$12,760,770	($117,257)	$1,417,863	$12,167,537	$40,168,713
April	39,276	$361	$13,991,929	$12,760,770	$1,231,160	$1,417,863	$13,398,697	$41,586,576
May	39,276	$361	$14,074,909	$12,760,770	$1,314,139	$1,417,863	$14,712,836	$43,004,440
June	39,276	$361	$14,095,654	$12,760,770	$1,334,884	$1,417,863	$16,047,719	$44,422,303
July	39,276	$361	$14,116,399	$12,760,770	$1,355,629	$1,417,863	$17,403,348	$45,840,166
August	39,276	$361	$14,137,144	$12,760,770	$1,376,374	$1,417,863	$18,779,722	$47,258,030
September	39,276	$361	$14,157,888	$12,760,770	$1,397,118	$1,417,863	$20,176,840	$48,675,893
October	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$21,594,704	$50,093,756
November	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$23,012,567	$51,511,620
December '10	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$24,430,430	$52,929,483

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 24-Month Phase-In Collar & East St. Louis Regions, All Aid Categories				
Month	Estimated Cumulative Enrollment	Estimated Capitation Payments	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	12,862	$0	$31,187	$207,122
February	25,981	$2,911,601	($2,661,479)	$625,509
March	39,232	$5,881,434	($7,509,050)	$1,257,274
April	52,615	$8,880,965	($12,499,667)	$2,104,550
May	66,132	$11,910,492	($17,489,740)	$3,169,492
June	79,784	$14,970,314	($22,446,827)	$4,454,277
July	93,572	$18,060,734	($27,339,102)	$5,961,103
August	107,498	$21,182,058	($32,134,415)	$7,692,192
September	121,564	$24,334,596	($36,800,300)	$9,649,784
October	135,770	$27,518,659	($41,303,961)	$11,836,147
November	150,119	$30,734,563	($45,643,465)	$14,253,566
December	164,611	$33,982,625	($49,817,171)	$16,904,353
January '07	179,597	$37,263,168	($53,795,918)	$20,434,814
February	194,734	$42,682,827	($59,571,190)	$24,262,940
March	210,022	$46,283,662	($64,861,066)	$28,391,707
April	225,463	$49,920,505	($68,365,776)	$32,824,123
May	241,059	$53,593,717	($71,558,942)	$37,563,224
June	256,810	$57,303,661	($74,508,499)	$42,612,076
July	272,719	$61,050,704	($77,209,146)	$47,973,777
August	288,787	$64,835,218	($79,655,531)	$53,651,456
September	305,016	$68,657,577	($81,842,245)	$59,648,272
October	321,407	$72,518,159	($83,763,827)	$65,967,417
November	337,961	$76,417,347	($85,442,265)	$72,612,114
December	354,682	$80,355,527	($86,875,126)	$79,585,618
January '08	325,710	$84,333,089	($88,122,132)	$87,298,798
February	325,710	$81,725,145	($82,848,159)	$95,011,978
March	325,710	$81,725,145	($74,771,212)	$102,725,159
April	325,710	$81,725,145	($67,527,379)	$110,438,339
May	325,710	$81,725,145	($60,147,179)	$118,151,519
June	325,710	$81,725,145	($52,615,949)	$125,864,700
July	325,710	$81,725,145	($44,975,485)	$133,577,880
August	325,710	$81,725,145	($37,268,003)	$141,291,060
September	325,710	$81,725,145	($29,536,140)	$149,004,240
October	325,710	$81,725,145	($21,822,960)	$156,717,421
November	325,710	$81,725,145	($14,109,780)	$164,430,601
December	325,710	$81,725,145	($6,396,599)	$172,143,781
January '09	334,821	$81,725,145	$1,401,944	$181,560,735
February	334,821	$88,557,663	$2,794,784	$190,977,689
March	334,821	$88,557,663	$5,894,882	$200,394,643
April	334,821	$88,557,663	$14,543,570	$209,811,597
May	334,821	$88,557,663	$23,533,709	$219,228,551
June	334,821	$88,557,663	$32,609,211	$228,645,505
July	334,821	$88,557,663	$41,770,077	$238,062,459
August	334,821	$88,557,663	$51,016,305	$247,479,413
September	334,821	$88,557,663	$60,347,896	$256,896,367
October	334,821	$88,557,663	$69,764,850	$266,313,321
November	334,821	$88,557,663	$79,181,804	$275,730,275
December	334,821	$88,557,663	$88,598,758	$285,147,229
January '10	344,373	$88,557,663	$98,112,370	$296,553,059
February	344,373	$96,234,619	$100,432,317	$307,958,888
March	344,373	$96,234,619	$104,685,431	$319,364,717
April	344,373	$96,234,619	$115,221,336	$330,770,546
May	344,373	$96,234,619	$126,143,873	$342,176,376
June	344,373	$96,234,619	$137,163,069	$353,582,205
July	344,373	$96,234,619	$148,278,924	$364,988,034
August	344,373	$96,234,619	$159,491,436	$376,393,864
September	344,373	$96,234,619	$170,800,607	$387,799,693
October	344,373	$96,234,619	$182,206,436	$399,205,522
November	344,373	$96,234,619	$193,612,266	$410,611,351
December '10	344,373	$96,234,619	$205,018,095	$422,017,181

Estimated Cash Flow over 24-Month Phase-In Collar & East St. Louis Regions, Disabled Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	1,176	$850	$9,999		$9,999	$79,996	$9,999	$79,996
February	2,376	$850	$70,196	$919,951	($849,755)	$161,591	($839,755)	$241,587
March	3,588	$850	$331,484	$1,858,301	($1,526,817)	$244,003	($2,366,572)	$485,590
April	4,812	$850	$1,247,351	$2,806,035	($1,558,684)	$327,239	($3,925,256)	$812,829
May	6,049	$850	$2,218,873	$3,763,246	($1,544,372)	$411,307	($5,469,629)	$1,224,136
June	7,297	$850	$3,210,510	$4,730,029	($1,519,518)	$496,216	($6,989,147)	$1,720,351
July	8,558	$850	$4,222,163	$5,706,479	($1,484,316)	$581,973	($8,473,463)	$2,302,325
August	9,832	$850	$5,254,032	$6,692,695	($1,438,663)	$668,589	($9,912,126)	$2,970,914
September	11,119	$850	$6,306,319	$7,688,772	($1,382,453)	$756,070	($11,294,579)	$3,726,984
October	12,418	$850	$7,379,229	$8,694,811	($1,315,582)	$844,427	($12,610,160)	$4,571,411
November	13,730	$850	$8,462,967	$9,710,909	($1,247,942)	$933,667	($13,858,102)	$5,505,078
December	15,056	$850	$9,557,543	$10,737,169	($1,179,626)	$1,023,799	($15,037,728)	$6,528,877
January '07	16,418	$900	$10,671,476	$11,773,691	($1,102,215)	$1,329,888	($16,139,943)	$7,858,765
February	17,794	$900	$11,831,001	$13,446,641	($1,615,640)	$1,441,353	($17,755,583)	$9,300,118
March	19,184	$900	$13,132,328	$14,573,683	($1,441,354)	$1,553,934	($19,196,937)	$10,854,052
April	20,588	$900	$14,841,331	$15,711,995	($870,664)	$1,667,640	($20,067,601)	$12,521,691
May	22,006	$900	$16,106,859	$16,861,690	($754,831)	$1,782,483	($20,822,432)	$14,304,174
June	23,438	$900	$17,363,041	$18,022,882	($659,841)	$1,898,474	($21,482,272)	$16,202,648
July	24,884	$900	$18,632,593	$19,195,686	($563,093)	$2,015,626	($22,045,365)	$18,218,274
August	26,345	$900	$19,915,648	$20,380,218	($464,570)	$2,133,949	($22,509,935)	$20,352,223
September	27,820	$900	$21,212,342	$21,576,595	($364,253)	$2,253,455	($22,874,189)	$22,605,679
October	29,311	$900	$22,522,810	$22,784,936	($262,126)	$2,374,157	($23,136,315)	$24,979,835
November	30,816	$900	$23,838,781	$24,005,361	($166,580)	$2,496,065	($23,302,895)	$27,475,900
December	32,336	$900	$25,167,910	$25,237,990	($70,080)	$2,619,192	($23,372,975)	$30,095,092
January '08	29,374	$950	$26,484,549	$26,482,945	$1,605	$2,790,572	($23,371,370)	$32,885,664
February	29,374	$950	$27,697,530	$25,115,144	$2,582,386	$2,790,572	($20,788,984)	$35,676,235
March	29,374	$950	$28,467,422	$25,115,144	$3,352,278	$2,790,572	($17,436,705)	$38,466,807
April	29,374	$950	$27,810,870	$25,115,144	$2,695,726	$2,790,572	($14,740,979)	$41,257,378
May	29,374	$950	$27,830,076	$25,115,144	$2,714,932	$2,790,572	($12,026,047)	$44,047,950
June	29,374	$950	$27,872,027	$25,115,144	$2,756,884	$2,790,572	($9,269,163)	$46,838,521
July	29,374	$950	$27,900,701	$25,115,144	$2,785,557	$2,790,572	($6,483,606)	$49,629,093
August	29,374	$950	$27,915,963	$25,115,144	$2,800,819	$2,790,572	($3,682,787)	$52,419,664
September	29,374	$950	$27,917,679	$25,115,144	$2,802,536	$2,790,572	($880,251)	$55,210,236
October	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$1,910,320	$58,000,807
November	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$4,700,892	$60,791,379
December	29,374	$950	$27,905,715	$25,115,144	$2,790,572	$2,790,572	$7,491,463	$63,581,950
January '09	29,962	$1,000	$27,926,277	$25,115,144	$2,811,134	$3,295,812	$10,302,597	$66,877,762
February	29,962	$1,000	$28,029,088	$26,666,114	$1,362,974	$3,295,812	$11,665,571	$70,173,574
March	29,962	$1,000	$28,440,330	$26,666,114	$1,774,216	$3,295,812	$13,439,787	$73,469,386
April	29,962	$1,000	$29,776,867	$26,666,114	$3,110,753	$3,295,812	$16,550,540	$76,765,198
May	29,962	$1,000	$29,859,115	$26,666,114	$3,193,001	$3,295,812	$19,743,541	$80,061,010
June	29,962	$1,000	$29,879,677	$26,666,114	$3,213,563	$3,295,812	$22,957,104	$83,356,821
July	29,962	$1,000	$29,900,239	$26,666,114	$3,234,125	$3,295,812	$26,191,230	$86,652,633
August	29,962	$1,000	$29,920,801	$26,666,114	$3,254,688	$3,295,812	$29,445,917	$89,948,445
September	29,962	$1,000	$29,941,363	$26,666,114	$3,275,250	$3,295,812	$32,721,167	$93,244,257
October	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$36,016,979	$96,540,069
November	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$39,312,791	$99,835,880
December	29,962	$1,000	$29,961,926	$26,666,114	$3,295,812	$3,295,812	$42,608,603	$103,131,692
January '10	30,561	$1,050	$29,983,199	$26,666,114	$3,317,085	$3,850,707	$45,925,687	$106,982,399
February	30,561	$1,050	$30,089,563	$28,238,516	$1,851,048	$3,850,707	$47,776,735	$110,833,106
March	30,561	$1,050	$30,515,023	$28,238,516	$2,276,507	$3,850,707	$50,053,242	$114,683,812
April	30,561	$1,050	$31,897,766	$28,238,516	$3,659,250	$3,850,707	$53,712,492	$118,534,519
May	30,561	$1,050	$31,982,857	$28,238,516	$3,744,342	$3,850,707	$57,456,834	$122,385,226
June	30,561	$1,050	$32,004,130	$28,238,516	$3,765,615	$3,850,707	$61,222,449	$126,235,932
July	30,561	$1,050	$32,025,403	$28,238,516	$3,786,888	$3,850,707	$65,009,337	$130,086,639
August	30,561	$1,050	$32,046,676	$28,238,516	$3,808,161	$3,850,707	$68,817,497	$133,937,346
September	30,561	$1,050	$32,067,949	$28,238,516	$3,829,434	$3,850,707	$72,646,931	$137,788,052
October	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$76,497,638	$141,638,759
November	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$80,348,344	$145,489,466
December '10	30,561	$1,050	$32,089,222	$28,238,516	$3,850,707	$3,850,707	$84,199,051	$149,340,172

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 24-Month Phase-In Collar & East St. Louis Regions, DCFS Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	151	$898	$1,358		$1,358	$8,147	$1,358	$8,147
February	305	$898	$9,532	$127,639	($118,107)	$16,457	($116,749)	$24,604
March	461	$898	$45,013	$257,831	($212,818)	$24,851	($329,567)	$49,455
April	619	$898	$169,382	$389,325	($219,943)	$33,328	($549,509)	$82,783
May	777	$898	$301,308	$522,133	($220,825)	$41,890	($770,334)	$124,672
June	938	$898	$435,966	$656,270	($220,304)	$50,537	($990,638)	$175,209
July	1,100	$898	$573,342	$791,748	($218,406)	$59,271	($1,209,044)	$234,481
August	1,264	$898	$713,463	$928,581	($215,118)	$68,093	($1,424,162)	$302,573
September	1,429	$898	$856,357	$1,066,783	($210,426)	$77,002	($1,634,588)	$379,575
October	1,596	$898	$1,002,051	$1,206,366	($204,315)	$86,001	($1,838,903)	$465,576
November	1,765	$898	$1,149,216	$1,347,345	($198,129)	$95,089	($2,037,032)	$560,665
December	1,935	$898	$1,297,852	$1,489,734	($191,882)	$104,269	($2,228,914)	$664,934
January '07	2,110	$955	$1,449,205	$1,633,547	($184,342)	$141,076	($2,413,256)	$806,010
February	2,287	$955	$1,607,109	$1,874,294	($267,185)	$152,900	($2,680,441)	$958,910
March	2,466	$955	$1,785,628	$2,031,390	($245,762)	$164,843	($2,926,202)	$1,123,753
April	2,646	$955	$2,023,621	$2,190,056	($166,435)	$176,905	($3,092,638)	$1,300,658
May	2,829	$955	$2,196,499	$2,350,309	($153,811)	$189,088	($3,246,448)	$1,489,746
June	3,013	$955	$2,367,879	$2,512,165	($144,286)	$201,392	($3,390,734)	$1,691,138
July	3,199	$955	$2,541,089	$2,675,639	($134,550)	$213,820	($3,525,284)	$1,904,958
August	3,386	$955	$2,716,148	$2,840,748	($124,600)	$226,372	($3,649,884)	$2,131,330
September	3,576	$955	$2,893,074	$3,007,508	($114,434)	$239,049	($3,764,319)	$2,370,379
October	3,767	$955	$3,071,885	$3,175,936	($104,051)	$251,853	($3,868,370)	$2,622,232
November	3,961	$955	$3,251,370	$3,346,048	($94,678)	$264,785	($3,963,047)	$2,887,017
December	4,156	$955	$3,432,650	$3,517,861	($85,211)	$277,847	($4,048,259)	$3,164,864
January '08	3,776	$1,017	$3,612,564	$3,691,392	($78,828)	$307,186	($4,127,087)	$3,472,050
February	3,776	$1,017	$3,779,691	$3,532,644	$247,047	$307,186	($3,880,040)	$3,779,236
March	3,776	$1,017	$3,891,451	$3,532,644	$358,807	$307,186	($3,521,233)	$4,086,423
April	3,776	$1,017	$3,823,855	$3,532,644	$291,211	$307,186	($3,230,021)	$4,393,609
May	3,776	$1,017	$3,827,825	$3,532,644	$295,181	$307,186	($2,934,840)	$4,700,796
June	3,776	$1,017	$3,833,885	$3,532,644	$301,241	$307,186	($2,633,599)	$5,007,982
July	3,776	$1,017	$3,838,133	$3,532,644	$305,489	$307,186	($2,328,110)	$5,315,168
August	3,776	$1,017	$3,840,552	$3,532,644	$307,909	$307,186	($2,020,201)	$5,622,355
September	3,776	$1,017	$3,841,124	$3,532,644	$308,480	$307,186	($1,711,721)	$5,929,541
October	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	($1,404,534)	$6,236,728
November	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	($1,097,348)	$6,543,914
December	3,776	$1,017	$3,839,830	$3,532,644	$307,186	$307,186	($790,161)	$6,851,100
January '09	3,851	$1,084	$3,843,178	$3,532,644	$310,535	$375,719	($479,627)	$7,226,819
February	3,851	$1,084	$3,859,920	$3,798,935	$60,984	$375,719	($418,643)	$7,602,538
March	3,851	$1,084	$3,926,884	$3,798,935	$127,949	$375,719	($290,694)	$7,978,257
April	3,851	$1,084	$4,144,520	$3,798,935	$345,585	$375,719	$54,891	$8,353,976
May	3,851	$1,084	$4,157,913	$3,798,935	$358,978	$375,719	$413,869	$8,729,695
June	3,851	$1,084	$4,161,261	$3,798,935	$362,326	$375,719	$776,195	$9,105,414
July	3,851	$1,084	$4,164,609	$3,798,935	$365,674	$375,719	$1,141,869	$9,481,133
August	3,851	$1,084	$4,167,958	$3,798,935	$369,022	$375,719	$1,510,891	$9,856,851
September	3,851	$1,084	$4,171,306	$3,798,935	$372,371	$375,719	$1,883,262	$10,232,570
October	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$2,258,981	$10,608,289
November	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$2,634,700	$10,984,008
December	3,851	$1,084	$4,174,654	$3,798,935	$375,719	$375,719	$3,010,419	$11,359,727
January '10	3,928	$1,157	$4,178,357	$3,798,935	$379,421	$454,490	$3,389,840	$11,814,217
February	3,928	$1,157	$4,196,869	$4,090,414	$106,455	$454,490	$3,496,295	$12,268,708
March	3,928	$1,157	$4,270,919	$4,090,414	$180,505	$454,490	$3,676,800	$12,723,198
April	3,928	$1,157	$4,511,582	$4,090,414	$421,168	$454,490	$4,097,968	$13,177,689
May	3,928	$1,157	$4,526,392	$4,090,414	$435,978	$454,490	$4,533,946	$13,632,179
June	3,928	$1,157	$4,530,094	$4,090,414	$439,680	$454,490	$4,973,627	$14,086,670
July	3,928	$1,157	$4,533,797	$4,090,414	$443,383	$454,490	$5,417,010	$14,541,160
August	3,928	$1,157	$4,537,499	$4,090,414	$447,085	$454,490	$5,864,095	$14,995,650
September	3,928	$1,157	$4,541,202	$4,090,414	$450,788	$454,490	$6,314,883	$15,450,141
October	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$6,769,373	$15,904,631
November	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$7,223,864	$16,359,122
December '10	3,928	$1,157	$4,544,904	$4,090,414	$454,490	$454,490	$7,678,354	$16,813,612

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 24-Month Phase-In Collar & East St. Louis Regions, Family Health Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	10,417	$160	$16,667		$16,667	$100,000	$16,667	$100,000
February	21,042	$160	$117,000	$1,566,667	($1,449,667)	$202,000	($1,433,000)	$302,000
March	31,773	$160	$552,503	$3,164,667	($2,612,163)	$305,020	($4,045,163)	$607,020
April	42,611	$160	$2,079,028	$4,778,647	($2,699,618)	$409,070	($6,744,782)	$1,016,090
May	53,558	$160	$3,698,319	$6,408,766	($2,710,448)	$514,161	($9,455,229)	$1,530,251
June	64,615	$160	$5,351,135	$8,055,187	($2,704,052)	$620,303	($12,159,282)	$2,150,554
July	75,782	$160	$7,037,313	$9,718,073	($2,680,759)	$727,506	($14,840,041)	$2,878,059
August	87,060	$160	$8,757,186	$11,397,587	($2,640,400)	$835,781	($17,480,442)	$3,713,840
September	98,452	$160	$10,511,092	$13,093,896	($2,582,804)	$945,138	($20,063,246)	$4,658,978
October	109,957	$160	$12,299,369	$14,807,168	($2,507,799)	$1,055,590	($22,571,045)	$5,714,568
November	121,578	$160	$14,105,696	$16,537,573	($2,431,877)	$1,167,146	($25,002,922)	$6,881,714
December	133,314	$160	$15,930,086	$18,285,282	($2,355,196)	$1,279,817	($27,358,118)	$8,161,531
January '07	145,379	$170	$17,787,595	$20,050,468	($2,262,873)	$1,730,006	($29,620,992)	$9,891,537
February	157,564	$170	$19,724,587	$22,984,369	($3,259,782)	$1,875,008	($32,880,774)	$11,766,545
March	169,871	$170	$21,911,116	$24,910,823	($2,999,708)	$2,021,460	($35,880,481)	$13,788,005
April	182,301	$170	$24,817,059	$26,856,542	($2,039,483)	$2,169,377	($37,919,964)	$15,957,382
May	194,855	$170	$26,936,352	$28,821,718	($1,885,366)	$2,318,772	($39,805,330)	$18,276,154
June	207,535	$170	$29,037,854	$30,806,546	($1,768,692)	$2,469,662	($41,574,022)	$20,745,816
July	220,341	$170	$31,161,780	$32,811,222	($1,649,442)	$2,622,060	($43,223,463)	$23,367,877
August	233,276	$170	$33,308,356	$34,835,945	($1,527,589)	$2,775,983	($44,751,052)	$26,143,859
September	246,340	$170	$35,477,807	$36,880,915	($1,403,108)	$2,931,445	($46,154,160)	$29,075,304
October	259,535	$170	$37,670,362	$38,946,335	($1,275,973)	$3,088,461	($47,430,133)	$32,163,765
November	272,861	$170	$39,871,378	$41,032,409	($1,161,030)	$3,247,047	($48,591,163)	$35,410,812
December	286,321	$170	$42,094,405	$43,139,343	($1,044,939)	$3,407,220	($49,636,102)	$38,818,032
January '08	260,100	$182	$44,303,187	$45,267,348	($964,161)	$3,787,056	($50,600,263)	$42,605,088
February	260,100	$182	$46,365,183	$43,551,144	$2,814,039	$3,787,056	($47,786,224)	$46,392,144
March	260,100	$182	$47,785,801	$43,551,144	$4,234,657	$3,787,056	($43,551,567)	$50,179,200
April	260,100	$182	$47,119,744	$43,551,144	$3,568,600	$3,787,056	($39,982,967)	$53,966,256
May	260,100	$182	$47,178,455	$43,551,144	$3,627,311	$3,787,056	($36,355,656)	$57,753,312
June	260,100	$182	$47,255,268	$43,551,144	$3,704,124	$3,787,056	($32,651,532)	$61,540,368
July	260,100	$182	$47,309,872	$43,551,144	$3,758,728	$3,787,056	($28,892,803)	$65,327,424
August	260,100	$182	$47,342,046	$43,551,144	$3,790,902	$3,787,056	($25,101,902)	$69,114,480
September	260,100	$182	$47,351,564	$43,551,144	$3,800,420	$3,787,056	($21,301,482)	$72,901,536
October	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	($17,514,426)	$76,688,592
November	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	($13,727,370)	$80,475,648
December	260,100	$182	$47,338,200	$43,551,144	$3,787,056	$3,787,056	($9,940,314)	$84,262,704
January '09	265,302	$195	$47,382,157	$43,551,144	$3,831,013	$4,656,050	($6,109,301)	$88,918,754
February	265,302	$195	$47,601,941	$47,077,840	$524,102	$4,656,050	($5,585,200)	$93,574,804
March	265,302	$195	$48,481,079	$47,077,840	$1,403,240	$4,656,050	($4,181,960)	$98,230,854
April	265,302	$195	$51,338,278	$47,077,840	$4,260,438	$4,656,050	$78,478	$102,886,904
May	265,302	$195	$51,514,106	$47,077,840	$4,436,266	$4,656,050	$4,514,743	$107,542,954
June	265,302	$195	$51,558,062	$47,077,840	$4,480,223	$4,656,050	$8,994,966	$112,199,004
July	265,302	$195	$51,602,019	$47,077,840	$4,524,179	$4,656,050	$13,519,145	$116,855,055
August	265,302	$195	$51,645,976	$47,077,840	$4,568,136	$4,656,050	$18,087,282	$121,511,105
September	265,302	$195	$51,689,933	$47,077,840	$4,612,093	$4,656,050	$22,699,375	$126,167,155
October	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$27,355,425	$130,823,205
November	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$32,011,475	$135,479,255
December	265,302	$195	$51,733,890	$47,077,840	$4,656,050	$4,656,050	$36,667,525	$140,135,305
January '10	270,608	$210	$51,784,828	$47,077,840	$4,706,988	$5,682,769	$41,374,513	$145,818,074
February	270,608	$210	$52,039,518	$51,144,920	$894,598	$5,682,769	$42,269,111	$151,500,843
March	270,608	$210	$53,058,278	$51,144,920	$1,913,358	$5,682,769	$44,182,470	$157,183,612
April	270,608	$210	$56,369,247	$51,144,920	$5,224,327	$5,682,769	$49,406,797	$162,866,380
May	270,608	$210	$56,572,998	$51,144,920	$5,428,079	$5,682,769	$54,834,875	$168,549,149
June	270,608	$210	$56,623,936	$51,144,920	$5,479,017	$5,682,769	$60,313,892	$174,231,918
July	270,608	$210	$56,674,874	$51,144,920	$5,529,955	$5,682,769	$65,843,847	$179,914,687
August	270,608	$210	$56,725,812	$51,144,920	$5,580,893	$5,682,769	$71,424,740	$185,597,456
September	270,608	$210	$56,776,750	$51,144,920	$5,631,831	$5,682,769	$77,056,571	$191,280,225
October	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$82,739,340	$196,962,993
November	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$88,422,109	$202,645,762
December '10	270,608	$210	$56,827,688	$51,144,920	$5,682,769	$5,682,769	$94,104,877	$208,328,531

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.

Estimated Cash Flow over 24-Month Phase-In Collar & East St. Louis Regions, SCHIP Eligibility Category								
Month	Estimated Cumulative Enrollment	Estimated Fee-for-Service PMPM Cost (a)	Estimated FFS Raw Dollar Payments (b)	Estimated Capitation Payments (c)	Estimated Cash Flow Difference (d)	Accrued Managed Care Savings	Cumulative Cash Flow Impact	Cumulative Accrued Savings
January '06	1,118	$283	$3,163		$3,163	$18,979	$3,163	$18,979
February	2,258	$283	$22,206	$297,344	($275,138)	$38,338	($271,975)	$57,318
March	3,409	$283	$104,862	$600,635	($495,773)	$57,891	($767,748)	$115,209
April	4,572	$283	$394,587	$906,959	($512,372)	$77,639	($1,280,120)	$192,848
May	5,747	$283	$701,919	$1,216,347	($514,427)	$97,585	($1,794,547)	$290,433
June	6,933	$283	$1,015,614	$1,528,828	($513,213)	$117,730	($2,307,761)	$408,163
July	8,132	$283	$1,335,641	$1,844,434	($508,793)	$138,076	($2,816,553)	$546,239
August	9,342	$283	$1,662,063	$2,163,196	($501,133)	$158,626	($3,317,686)	$704,865
September	10,564	$283	$1,994,944	$2,485,145	($490,201)	$179,382	($3,807,887)	$884,247
October	11,799	$283	$2,334,349	$2,810,314	($475,966)	$200,345	($4,283,853)	$1,084,592
November	13,046	$283	$2,677,179	$3,138,735	($461,556)	$221,517	($4,745,409)	$1,306,109
December	14,305	$283	$3,023,438	$3,470,440	($447,002)	$242,902	($5,192,411)	$1,549,011
January '07	15,690	$300	$3,376,146	$3,805,462	($429,316)	$329,491	($5,621,728)	$1,878,502
February	17,089	$300	$3,744,858	$4,377,523	($632,664)	$358,864	($6,254,392)	$2,237,366
March	18,501	$300	$4,164,713	$4,767,766	($603,053)	$388,531	($6,857,445)	$2,625,897
April	19,928	$300	$4,733,785	$5,161,912	($428,128)	$418,495	($7,285,573)	$3,044,392
May	21,369	$300	$5,160,841	$5,560,000	($399,159)	$448,758	($7,684,732)	$3,493,149
June	22,825	$300	$5,585,329	$5,962,068	($376,738)	$479,324	($8,061,470)	$3,972,473
July	24,295	$300	$6,014,594	$6,368,157	($353,563)	$510,195	($8,415,034)	$4,482,668
August	25,780	$300	$6,448,681	$6,778,307	($329,626)	$541,375	($8,744,659)	$5,024,044
September	27,279	$300	$6,887,640	$7,192,558	($304,918)	$572,867	($9,049,577)	$5,596,911
October	28,794	$300	$7,331,519	$7,610,952	($279,433)	$604,674	($9,329,010)	$6,201,585
November	30,324	$300	$7,777,381	$8,033,530	($256,149)	$636,799	($9,585,159)	$6,838,384
December	31,869	$300	$8,227,701	$8,460,333	($232,632)	$669,246	($9,817,791)	$7,507,630
January '08	32,459	$319	$8,685,782	$8,891,405	($205,622)	$828,366	($10,023,413)	$8,335,996
February	32,459	$319	$9,156,715	$9,526,213	($369,499)	$828,366	($10,392,912)	$9,164,363
March	32,459	$319	$9,657,418	$9,526,213	$131,205	$828,366	($10,261,707)	$9,992,729
April	32,459	$319	$10,214,510	$9,526,213	$688,296	$828,366	($9,573,411)	$10,821,096
May	32,459	$319	$10,268,988	$9,526,213	$742,775	$828,366	($8,830,636)	$11,649,462
June	32,459	$319	$10,295,195	$9,526,213	$768,981	$828,366	($8,061,655)	$12,477,828
July	32,459	$319	$10,316,902	$9,526,213	$790,689	$828,366	($7,270,966)	$13,306,195
August	32,459	$319	$10,334,066	$9,526,213	$807,853	$828,366	($6,463,113)	$14,134,561
September	32,459	$319	$10,346,641	$9,526,213	$820,427	$828,366	($5,642,686)	$14,962,927
October	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	($4,814,320)	$15,791,294
November	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	($3,985,954)	$16,619,660
December	32,459	$319	$10,354,580	$9,526,213	$828,366	$828,366	($3,157,587)	$17,448,027
January '09	35,705	$339	$10,372,075	$9,526,213	$845,862	$1,089,373	($2,311,725)	$18,537,400
February	35,705	$339	$10,459,554	$11,014,774	($555,220)	$1,089,373	($2,866,945)	$19,626,773
March	35,705	$339	$10,809,467	$11,014,774	($205,306)	$1,089,373	($3,072,251)	$20,716,146
April	35,705	$339	$11,946,686	$11,014,774	$931,912	$1,089,373	($2,140,339)	$21,805,519
May	35,705	$339	$12,016,668	$11,014,774	$1,001,895	$1,089,373	($1,138,444)	$22,894,893
June	35,705	$339	$12,034,164	$11,014,774	$1,019,391	$1,089,373	($119,054)	$23,984,266
July	35,705	$339	$12,051,660	$11,014,774	$1,036,886	$1,089,373	$917,833	$25,073,639
August	35,705	$339	$12,069,155	$11,014,774	$1,054,382	$1,089,373	$1,972,214	$26,163,012
September	35,705	$339	$12,086,651	$11,014,774	$1,071,878	$1,089,373	$3,044,092	$27,252,385
October	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$4,133,465	$28,341,759
November	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$5,222,838	$29,431,132
December	35,705	$339	$12,104,147	$11,014,774	$1,089,373	$1,089,373	$6,312,212	$30,520,505
January '10	39,276	$361	$12,124,892	$11,014,774	$1,110,118	$1,417,863	$7,422,330	$31,938,368
February	39,276	$361	$12,228,616	$12,760,770	($532,154)	$1,417,863	$6,890,176	$33,356,232
March	39,276	$361	$12,643,513	$12,760,770	($117,257)	$1,417,863	$6,772,919	$34,774,095
April	39,276	$361	$13,991,929	$12,760,770	$1,231,160	$1,417,863	$8,004,079	$36,191,958
May	39,276	$361	$14,074,909	$12,760,770	$1,314,139	$1,417,863	$9,318,218	$37,609,822
June	39,276	$361	$14,095,654	$12,760,770	$1,334,884	$1,417,863	$10,653,101	$39,027,685
July	39,276	$361	$14,116,399	$12,760,770	$1,355,629	$1,417,863	$12,008,730	$40,445,548
August	39,276	$361	$14,137,144	$12,760,770	$1,376,374	$1,417,863	$13,385,104	$41,863,412
September	39,276	$361	$14,157,888	$12,760,770	$1,397,118	$1,417,863	$14,782,222	$43,281,275
October	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$16,200,085	$44,699,138
November	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$17,617,949	$46,117,002
December '10	39,276	$361	$14,178,633	$12,760,770	$1,417,863	$1,417,863	$19,035,812	$47,534,865

(a) Costs exclude services that would not be included in capitation (nursing home, other institutional, waiver)
(b) Assumes 15% of incurred FFS claims paid in same month, 15% in month 2, 15% in month 3, 45% in month 4, remaining 10% across months 5-10
(c) Assumed to be made on 1st of the following month, at 93.3% of FFS in 2006, dropping to 89.3% of FFS in 2010.
(d) Numbers in parentheses indicate a negative cash flow.