1 HOUSE JOINT RESOLUTION

2 WHEREAS, The General Assembly passed legislation and the
3 Governor signed into law major reforms of Illinois' Medical
4 Assistance Programs, including Senate Bill 2840, The Save
5 Medicaid Access and Resources Together (SMART) Act (Public Act
6 97-0689) and House Bill 5429 (Public Act 96-1501) and these new
7 laws intend to "address the significant spending and liability
8 deficit in the medical assistance program budget of the
9 Department of Healthcare and Family Services by implementing
10 changes, improvements, and efficiencies"; and

11 WHEREAS, The reforms require the Illinois Department of
12 Healthcare and Family Services to enroll at least 50% of
13 recipients eligible for comprehensive medical benefits in a
14 care coordination program by January 1, 2015; and

15 WHEREAS, Care coordination programs may be
16 provider-sponsored programs that contract directly with the
17 State or traditional managed care programs; they must operate
18 integrated delivery systems where recipients will receive
19 their care from providers who are responsible for providing or
20 arranging the majority of care, including primary care
21 physician services, referrals from primary care physicians,
22 diagnostic and treatment services, behavioral health services,
23 in-patient and outpatient hospital services, dental services,

1 and rehabilitation and long-term care services; and

2 WHEREAS, The Department must designate or contract for
3 integrated delivery systems that ensure enrollees have a choice
4 of systems and of primary care providers within the systems;
5 and

6 WHEREAS, Payment for coordinated care must be based on
7 arrangements where the State pays for performance related to
8 health care outcomes, the use of evidence-based practices, the
9 use of primary care delivered through comprehensive medical
10 homes, the use of electronic medical records, and the
11 appropriate exchange of health information electronically made
12 either on a capitated basis in which a fixed monthly premium
13 per recipient is paid and full financial risk is assumed for
14 the delivery of services, or through other risk-based payment
15 arrangements; and

16 WHEREAS, Health care providers, including hospitals,
17 physicians and nurses, federally qualified health centers
18 (FQHCs), nursing homes, home health agencies, social service
19 organizations, and pharmacies can assume responsibility for
20 coordinating the care of Medicaid recipients under a direct
21 arrangement with the State that requires the providers to
22 assume increasing risk over a short period of time; and

1 WHEREAS, In order to achieve significant savings needed to
2 cover administrative expenses and generate profits for
3 shareholders, HMOs often prevent beneficiaries from getting
4 the services they need; Medicaid HMOs in Illinois have
5 previously placed barriers to care, and in some instances,
6 either reduced rates to providers or made it very difficult for
7 providers to get approvals to provide the care that people
8 need; major policy reviews of various studies on Medicaid HMO
9 managed care have found little savings from HMOs and that such
10 an approach is unlikely to significantly lower costs; and

11 WHEREAS, HMOs in Illinois have a checkered track record in
12 "managing" Medicaid patients; Illinois failed in its first
13 major attempt to enroll a large number of children into a
14 managed care program, the Healthy Moms/Kids program, which was
15 scrapped in 1995 after having failed to meet performance
16 standards and spending millions in failed computer systems; the
17 State also scrapped the ambitious MediPlan Plus program; and

18 WHEREAS, Even more concern should be given to the 2004
19 federal court ruling in Memisovski v. Maram that HMOs provided
20 less preventive and primary care and poorer quality care to
21 children in the Medicaid program in Cook County than non-HMO,
22 fee-for-service programs; and in 2008, an HMO in Illinois paid
23 $225 million - the largest jury verdict in a false claims case
24 in U.S. history - to settle charges that it deliberately

1 excluded pregnant women and sick people from its program; and

2 WHEREAS, The 50% goal must be achieved by enrolling medical
3 assistance enrollees from each medical assistance enrollment
4 category, including parents, children, seniors, and people
5 with disabilities only to the extent that current State
6 Medicaid payment laws would not limit federal matching funds
7 for the State; and

8 WHEREAS, Moving most or all recipients to full-capitation
9 HMOs will contravene federal rules, cause the State to exceed
10 the federal upper payment limit and thus jeopardize up to $1
11 billion in federal funding under the Hospital Assessment
12 Program; and

13 WHEREAS, The Illinois Department of Healthcare and Family
14 Services has selected only a limited number of
15 provider-sponsored Care Coordination Entities while giving
16 preference to health maintenance organizations; another
17 solicitation of interest could ensure further expansion of care
18 coordination beyond mandatory HMO enrollment; and

19 WHEREAS, The State should thoroughly evaluate its
20 experience with HMOs before substantially increasing mandatory
21 enrollment in these types of plans; hastily moving large
22 portions of the Medicaid population into HMOs (i.e., 1.5

1 million to 2 million) is inherently risky; and

2 WHEREAS, Given that the Department is planning more
3 aggressive use of HMOs, all policymakers should know that there
4 is little evidence to date that the initiatives will contain
5 program costs; Illinois needs to be far more cautious and
6 conservative in estimates of the likely benefits of HMO
7 Medicaid managed care; the State should work with providers to
8 develop innovative partnerships that share risk, rather than
9 abdicate responsibilities to HMOs, which often achieve savings
10 by denying services or reducing payment; and

11 WHEREAS, Hastily moving large numbers of Medicaid
12 recipients to full-capitation HMOs will jeopardize up to $1
13 billion in federal funding under the Hospital Assessment
14 Program; care coordination must be carefully designed so that
15 the State does not jeopardize the funding provided by the
16 Hospital Assessment Program; therefore, be it

17 RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE
18 NINETY-EIGHTH GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, THE
19 SENATE CONCURRING HEREIN, that we urge the Department of
20 Healthcare and Family Services to carefully evaluate and
21 reconsider its actions to quickly move larger numbers of
22 Medicaid beneficiaries into HMOs; and urge that the agency
23 refocus its current preferences and give more favorable

1 consideration to innovative, provider-based care coordination
2 strategies; Accountable Care Entities should be utilized as
3 important and valued alternatives to traditional HMOs; these
4 models bring together a wide variety of entities such as
5 hospitals, physician-led groups, Federally Qualified Health
6 Centers, social service organizations, pharmacies, and
7 behavioral health providers and closely resemble the
8 Accountable Care Organizations (ACOs) that participate in the
9 Medicare Shared Savings Program, under which these entities
10 provide care coordination services to seniors and adults with
11 disabilities who have the most complex physical health and
12 behavioral health conditions by facilitating the delivery of
13 appropriate health care and other services and managing needed
14 transitions in care among providers and community agencies; and
15 be it further

16 RESOLVED, That the General Assembly recommends that the
17 Department of Healthcare and Family Services should more
18 actively pursue provider-sponsored care coordination in the
19 Medicaid program, including application for relevant federal
20 grants and Medicaid waivers; and give provider-sponsored
21 entities a more meaningful and substantive opportunity to
22 succeed, because provider-sponsored care coordination, done at
23 the local level, is best for patients.