CRITICAL ISSUES

ILLINOIS' MANAGED CARE "RE-BOOT"

Health & Medicine
POLICY RESEARCH GROUP

Introduction

In February 2017, the Rauner administration announced a re-bid of Illinois' Medicaid managed care contracts in order to align the State's managed care program, inherited from the Quinn administration, with the goals of the HHS Transformation—to create a health care system that prioritizes prevention and population health, pays for value, quality and outcomes, corrects the institutional bias in long-term services and supports, achieves data integration and uses predictive analytics, and facilitates Medicaid member education and self-sufficiency.

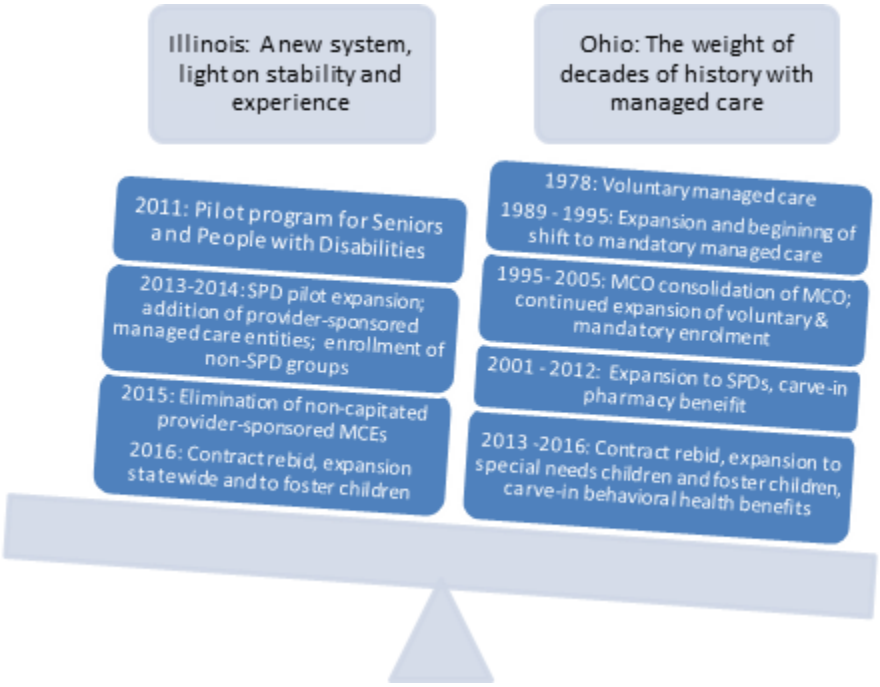
Following the lead of other states like Ohio and Arizona, the Illinois "re-boot" will consolidate Medicaid managed care, reducing the number of contracted Managed Care Organizations (MCO) from thirteen--some specializing in specific populations of Medicaid enrollees, such as Seniors and People with Disabilities (SPD)--to a maximum of seven MCOs with comprehensive contracts with the only specialized contract being for youth in the care of the Department of Children and Family Services (DCFS).

Three Critical Issues

This Critical Issues Policy Brief raises three questions for the Medicaid managed care re-boot and calls on State policy makers to work with stakeholders, including MCOs, Medicaid providers, and Medicaid members to address these issues to set a stronger foundation for a new managed care program in Illinois:

(1) Timeline: Illinois is in the midst of an unprecedented budget crisis that is placing enormous financial strain on government contractors, including Medicaid providers and MCOs who are owed millions of dollars in State payments. At the same time, vast changes contemplated for the Medicaid system in the State's 1115 waiver and related State Plan Amendments, which have not yet been approved by the federal Center for Medicare and Medicaid Services (CMS), creating significant uncertainty regarding the payment and delivery system landscape in which MCOs would be doing business. Despite these challenges and the relative immaturity of capitated managed care in Illinois compared to the states it is emulating, the Administration plans to implement this ambitious restructuring of managed care with less than one year between the release of the RFP and the implementation of new contracts.

Compare this timeline to managed care rollout and reform in Ohio, which with 86% of all Medicaid enrollees in five statewide MCOs is a model for Illinois' re-boot. Illinois is proposing to accomplish in a matter of months the same goals--consolidation, geographic expansion, and enrollment of new populations--that took Ohio decades. Perhaps the best lesson we can learn from Ohio is to slow down and take these goals one step at a time.



(2) Assurances for seniors and people with disabilities: Most Medicaid enrollees are children or non-elderly adults without disabilities. However, 20% of the Illinois Medicaid population are seniors or people with disabilities, or SPDs. Illinois has operated a specialized SPD managed care program, the Integrated Care Program (ICP) since 2011. The ICP currently operates in 29 counties, serving approximately 113,000 members. The State's Request for Proposals requires MCOs to cover *all* populations statewide (except those bidders who are eligible to bid for contracts serving Cook County only). While universality is an important principle in health care reform, the merging of SPDs into a general Medicaid managed care program raises questions about how the State will monitor and ensure access and quality for SPDs in a comprehensive program in which systemic disparities impacting older adults and people with disabilities could be lost in the overall data.

The current state of quality monitoring and reporting for SPDs is still in need of improvement. At a November 2016 Medicaid Advisory Committee's (MAC) Quality Care Subcommittee, Department of Healthcare and Family Services revealed a Medicaid Plan Report Card for consumers and an MCO Performance Dashboard for internal monitoring.

At that meeting, MAC members and other stakeholders raised pointed questions about the methodology and presentation of data in both reports:

Gaps in Quality Monitoring and Reporting in Medicaid Managed Care

- Data is not broken down by, or adjusted for, disability or age, making it impossible for consumers to compare performance based on their most important needs or for the State to monitor disparities in services for older adults and people with disabilities
- There are no measures of plan performance on long-term services and supports
- With so many plans scoring "average" on many measures on the Report Card, the comparison tool is not as useful as it could be. This may indicate that the standard deviation cut-off (1.96) does not differentiate the plans well
- There are no national benchmarks that would allow the State to identify system-wide problems (if every plan is performing badly compared to national benchmarks) and address emerging quality issues
- Key terms in the Performance Dashboard are not defined. Grievance and prior authorization procedures, for example, differ from plan to plan. In the first two years of the Integrated Care Program Pilot, an independent evaluation conducted by UIC's Institute on Disability and Human Development found that plans reporting on responses to grievances and prior authorization requests were sometimes defining terms differently. A great deal of the work of that evaluation consisted of cleaning data and following up with MCOs and the State to clarify uncertainties in the data and correct for such mistakes

(3) Oversight of managed care contracts for DCFS Youth: The State's managed care RFP includes children and youth in the care of DCFS. This is a challenging population for whom to coordinate services:

- Many foster children have complex mental and physical health needs, often unassessed and unmanaged
- Frequent changes in placement and caregivers makes care coordination especially difficult
- Provider shortages, especially for behavioral health and trauma-informed care, impact access and quality of care
- The presence of trauma and shortage of providers are two factors that contribute to the overuse of psychotropic drugs
- Funding and services are fragmented, leading to redundancies, errors, and miscommunication among various agencies and providers involved in the child welfare system

The recent resignation of DCFS Director John Sheldon amid high-profile coverage of the Department's failure to protect children in its care might appear to be a strong argument

for outsourcing management of services to an MCO. However, a major source of the problems in the child welfare system is an inadequate network of therapeutic foster homes for children transitioning from DCFS residential centers. Contracting with an MCO to manage a network that does not fully exist is unlikely to do much more than shift the blame for future catastrophes from the State agency to its contractor.

The structural problems facing Illinois' child welfare system will not be resolved by new leadership alone. We risk setting the next director up for failure, the consequences of which will be borne by the children in DCFS care not by leadership, if we add a vast new responsibility to oversee a managed care contractor when the Department struggles in its oversight role already.

Illinois could build on the strengths it has, for example in monitoring psychotropic drug utilization among DCFS Youth and fostering interagency collaboration. A 2013 State Policy Advocacy and Reform Center (SPARC) report highlighted Illinois' achievements in improving data-sharing between Medicaid and child welfare agencies to monitor prescriptions, and when necessary intervene, to reduce inappropriate use of psychotropic medications in foster children. As with geographic expansion of Medicaid, the goal of enrolling DCFS Youth into managed care will be achieved more decisively and completely if it is done carefully, with deliberate attention to monitoring and improving each step along the way.

Conclusion

Since the launch of mandatory managed care in 2011, Health & Medicine has been collaborating with diverse stakeholders--from the Older Adult Services Advisory Committee and the Medicaid Advisory Committee to physicians and social workers serving Medicaid members to researchers, public health experts, and housing providers--in an effort to understand and advocate for improvements to Medicaid managed care.

We believe the three critical issues we raise here deserve more attention and more public deliberation. There are many other concerns about the managed care reboot, especially in the context of the ongoing budget impasse. All of the issues described above, and many others, put people in Illinois at risk, and each of those risks, and many others, is made more dangerous by the failure of the State to enact a budget and pay for services that protect and strengthen our communities.