Illinois Medicaid

ILLINOIS: BUDGET CUTS LEAD TO PROVIDER COMPLAINTS

"Despite the tax cut they were given, hospitals throughout Illinois are up in arms about the state's handling of its Medicaid mess." They are also concerned about a pending cut in payments for caring for the poor (see AHL 5/30) and some are "upset" about the two-year extension of the hospital tax (see AHL 5/24). In addition, hospitals "are skeptical of promises that the state will pay its bills more quickly." The Edgar administration has said that the payment lag for Medicaid services will be reduced to 20 days from the current 90 days.

A TAXING ISSUE: In addition to lowering the hospital tax and extending it until 6/30/97, the state is also cutting disproportionate share payments from $400 million to $66 million and has frozen overall payment rates. The tax on hospital revenue, which was imposed by Gov. Jim Edgar (R) in 1991, will raise about $727M for the Medicaid program "this year when combined with federal matching funds." The Illinois Hospital and Health Systems Association believes the lower tax rate "could force as many as 40 hospitals out of business, mostly in Chicago and East St. Louis." The association is threatening to sue the state over the lower payment rates. Peoria JOURNAL STAR: "It would argue that the actions violate a federal law that requires adequate reimbursements for Medicaid services, said spokeswoman Bettina French."

IN DEFENSE OF THE CUTS: State Rep. David Leitch (R) said there are hospitals with low occupancy rates that should close. Leitch: "The market should decide which hospitals stay open, not the General Assembly." JOURNAL STAR reports that in order to alter the perception it is "hurting the hospital industry," the administration is pointing to a report that shows Illinois hospitals had profits of $754 million last year. Edgar "also noted that Medicaid payment rates have grown" 64% in the past five years (Eckert, 6/12).

MENTAL HEALTH CONCERNS: Chicago's $2.17M mental health grant was the "only program cut" from the IL Department of Mental Health last month as GOP lawmakers "sought to reduce a $1.3 billion backlog of Medicaid bills" (see AHL 5/10). The grant represents about 16% of the city's $12 million mental health budget, but City Health Commissioner Sister Sheila Lyne "vowed ... to avoid any service cuts" (Novak, CHICAGO SUN-TIMES, 6/14).

fax to
Bruce Vladeck 690-6262
John Monahan 690-8572
From Diana Fortuna

****
*** ACTIVITY REPORT ***
****

TRANSMISSION OK

TX/RX NO.	8192
CONNECTION TEL	96906262
CONNECTION ID	
START TIME	06/27 12:33
USAGE TIME	00'42
PAGES	1
RESULT	OK

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*** ACTIVITY REPORT ***
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TRANSMISSION OK

TX/RX NO.	8191
CONNECTION TEL	96905672
CONNECTION ID	
START TIME	06/27 12:30
USAGE TIME	01'19
PAGES	2
RESULT	OK

PAUL SIMON
ILLINOIS

Illinois Medicaid

COMMITTEES:
LABOR AND HUMAN RESOURCES
JUDICIARY
FOREIGN RELATIONS
BUDGET
INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510-1302

March 31, 1995

HCFA/OEO #9504055082
ORD: ACTION
cc: OLIGA
DIRECT REPLY DUE 4/24

The Honorable William J. Clinton
The White House
Washington, D.C.

Dear President Clinton:

We are writing to express our concern with a request submitted by the State of Illinois for an 1115 Medicaid waiver to implement MediPlan Plus, a Medicaid managed care program.

A number of important questions have been raised regarding the potential impact this program will have on access to health care for thousands of our constituents. These concerns have taken on a new urgency in the wake of recent state budget proposals that would cut Medicaid substantially. These cuts, which include the elimination of adjustments to providers that disproportionately serve the poor, freezes on Medicaid hospital and nursing home rates and a provider tax further erode a floundering Medicaid system that currently is running a $1.4 billion deficit. Launching MediPlan Plus on a crumbling financial foundation will jeopardize access to quality health care for 1.5 million Illinois citizens.

We share the Administration's commitment to granting the states the flexibility needed to implement legitimate efforts to improve access to health care for the poor while infusing much needed cost-control measures. However, modifications to the Medicaid program should not serve solely as a solution to state fiscal problems.

In addition to the recent state budget initiatives that impact the Medicaid waiver, there are several components of the waiver that are of concern to us and that we believe require significant review. These issues include: access to care; payments to providers; client education/HMO marketing; quality of care/quality assurance; and financing.

Managed care may increase more efficient and appropriate use of the medical system, infuse more preventive care, and, in some instances, save money. We support these goals. However, the flexibility provided to the state via the requested Medicaid waiver, could lead to cost saving measures that cause reductions in access and quality care for beneficiaries.

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ROOM 115-B
CARBONDALE, IL 62901
618/457-3653

In closing, we urge the Administration to review closely the issues raised in this letter and consider the impact on the waiver posed by recent State budget decisions.

Cordially,

Paul Simon
U.S. Senator

Glenn Poshard
U.S. Representative

cc: The Honorable Secretary Shalala
Bruce Vladeck, Administrator, HCFA

Sunday Sun-Times

Pages 2, 75 APRIL 2, 1995

TOP OF THE NEWS

Ill. Health Plan Waiver 'Likely'

Panetta Sees OK of Medicaid Reform Program

BY LYNN SWEET
SUN-TIMES WASHINGTON BUREAU

WASHINGTON—Despite reservations about Gov. Edgar's ability to transform Illinois' Medicaid system, approval to waive federal rules for a new program is likely, White House Chief of Staff Leon Panetta said.

"It's still got a few more hoops to go through," Panetta said in an interview Thursday. "But I think . . . the chances are pretty good that that waiver will be provided."

With rising Medicaid costs, Illinois is asking the Health and Human Services Department to allow the state to transfer Medicaid recipients to managed care programs as a way to keep expenses down.

MediPlan Plus is Edgar's proposal to take advantage of cost savings that come from enrolling people in managed care health programs such as health maintenance organizations, as opposed to paying fees for services provided by doctors and hospitals.

Controversy surrounds the Illinois waiver application.

For the White House, the waiver presents a political dilemma. Nationally, President Clinton is moving toward granting the waiver in a pragmatic move to demonstrate his commitment to give governors flexibility in running programs. Republican congressional leaders are gaining political ground with proposals to shift many federal programs to the states, and the White House does not want to hand Republicans a political issue by denying a waiver.


Leon Panetta

If the Clinton administration approves the waiver, however, the president may anger Illinois Democrats who have been urging the White House to go slow, casting doubts about the viability of the Republican governor's plan.

"There is strong evidence to question Illinois' capacity to administer the proposed MediPlan Plus," Illinois House Minority Leader Michael J. Madigan (D-Chicago) wrote in a March 16 letter to Clinton.

HHS officials reviewing the application also have not been convinced that MediPlan Plus will save the state money, and they are hesitant to sign off on the application.

"Projected managed care savings appear high," said an HHS memo obtained by the Sun-Times.

HHS has raised questions about the state's ability to manage the complex plan, especially after the failure of Edgar's intended showcase "Healthy Moms/Healthy Kids" program to enroll as many people as projected.

In a few months, the state will owe $1.3 billion in unpaid Medicaid bills to hospitals and other health providers, also a concern to federal health professionals.

"The anticipated short term savings [of MediPlan Plus] seem unclear and the long-term savings that can be expected from a chronically underfunded program may be overstated," said U.S. Democratic Representatives Cardiss Collins, Richard J. Durbin, Luis V. Gutierrez and Lane Evans in a letter to Clinton last January.

Clinton and HHS Secretary Donna Shalala, in a March 9 letter from U.S. Senators Carol Moseley-Braun and Paul Simon, were asked to include in a waiver certain protections for community health centers.

"They have stepped in to provide care when no other entity would," the Democratic senators wrote.

The centers, which provide primary health care for people who would be targeted under MediPlan Plus, have raised questions about patient access to their services and their fiscal ability to survive under the Edgar plan.

Bruce Vladeck, head of the HHS Health Care Financing Administration, said in December: "You just want to be especially sure [Illinois] is not getting itself to do something it can't do."

Originally, Illinois wanted to launch MediPlan Plus on Saturday. Even if a waiver were granted in the next few weeks, however, the launch of a program is months away.

Once a waiver is granted, the state must win further approvals from HHS before it can contract with HMOs and people can enroll in programs.

Medicaid is the federal-state partnership covering health costs for the uninsured poor, disabled and aged. Under a federal formula, Illinois pays half the costs.

Total federal-state Medicaid costs have climbed from $2.5 billion in fiscal 1991 to $5.7 billion in fiscal 1995, according to the Illinois Department of Public Aid.

Illinois Medicaid

Jll, MA W

ILLINOIS PRIMARY HEALTH CARE ASSOCIATION

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201 East Adams, Suite 250
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FAX: 217/525-4098

March 16, 1995

Ms. Diana Fortuna
Senior Policy Analyst
Domestic Policy Council
Old Executive Office Building, Room 224A
Washington, D.C. 20500

Dear Ms. Fortuna:

Thank you very much for meeting with representatives of the Illinois Primary Health Care Association (***IPHCA***) when they were in Washington on February 28th. Our Association members greatly enjoyed meeting you and Barbara Wooley and the opportunity to share their concerns about the Illinois section 1115 waiver application.

We hope our delegation was able to convey the importance and the urgency of the Department of Health and Human Service's assistance to assure the viability of Illinois' comprehensive Community Health Centers as providers under Medicaid managed care. ***IPHCA*** members are very sincere about their commitment to the President and are convinced about the need for thorough Department review and terms and conditions to assure that important constituencies are protected. I am enclosing letters members of the Illinois Congressional delegation have sent to Secretary Shalala advocating special protections for Federally Qualified Health Centers.

After reflecting on our discussion, our Community Health Centers would like to invite the President to visit one of our comprehensive Community, Migrant or Homeless Health Centers in either urban or rural Illinois. We feel a visit would be mutually beneficial and provide an opportunity for the President to demonstrate his attention to this essential resource that serves his natural constituency.

Moreover, as part of this visit, we would enjoy the opportunity to engage the President in a policy discussion about his approach to granting state Medicaid waivers. As a President interested in policy he might appreciate a discussion that supports his overall commitment to state flexibility but identifies certain key federal commitments that his Administration wants to maintain. Such as the important federal role that protects the safety net health care infrastructure.

Thank you, again for continuing interest and concern for our issues. Bruce Johnson will call your office to discuss these ideas with you further. I look forward to meeting with you again, soon.

Sincerely,

Lon Berkeley

Lon Berkeley
Executive Director

95031602

PAUL SIMON
ILLINOIS

COMMITTEES
LABOR AND HUMAN RESOURCES
JUDICIARY
FOREIGN RELATIONS
BUDGET
INDIAN AFFAIRS

United States Senate

WASHINGTON, DC 20510-1302

March 9, 1995

The Honorable Donna Shalala, Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Madam Secretary:

We are writing to apprise you of concerns we have regarding the state of Illinois' request for a Medicaid waiver.

We appreciate your comprehensive and thorough review of the Illinois waiver application. We understand that many problematic issues have been resolved in on-going discussions you have had with Illinois officials. For us, and many of our constituents, the continued confusion over how Federally Qualified Health Centers (FQHCs) will be handled is disturbing.

FQHCs have been an essential health care provider in medically underserved areas where individuals are usually at high risk of serious illness and medical conditions. They have stepped in to provide care when no other entity would. Currently, there are over 300,000 Illinois Medicaid recipients who receive their medical care through FQHCs. We feel strongly that FQHCs must be part of Illinois' Medicaid managed care system and that any waiver must address the differences between other managed care providers and FQHCs. Those currently receiving health care at FQHCs must not have their medical care disrupted. All Medicaid recipients must be well educated on the choices available to them; enrollment procedures must be fair and equitable. And, HCFA and the state must develop a reimbursement policy that addresses some of the unique financial problems faced by FQHCs.

We believe that Illinois can develop a managed care system that both preserves the best of the state's current delivery system and allows the state to achieve its goal of controlling costs. We are confident that you will ensure these concerns are fully addressed before allowing Illinois to proceed with its program.

Cordially,

Carol Mosely Braun
U.S. Senator

Paul Simon
U.S. Senator

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Congress of the United States

Washington, DC 20515

March 3, 1995

The Honorable Donna Shalala
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Shalala:

We want to commend you for your Department's thorough review of Illinois' request for a Subsection 1115 waiver to establish the Illinois MediPlan Plus program.

Unfortunately, the state's response to the questions HCFA posed last year does not fully alleviate our concerns about access to care and viability of Federally Qualified Health Centers (FQHCs). We believe the revised program may violate basic client rights and lead to the disruption of care and diminished access to high quality care for more than 300,000 Medicaid beneficiaries who now receive care at FQHCs. If the state's current waiver request is granted a significant number of these essential community health care providers may be forced to close.

We hope that you will require Illinois to provide specific language guaranteeing eligible individuals continued access to FQHCs. These provisions should include: (1) protections for FQHCs as managed care subcontractors, (2) assurances of FQHC financial viability through cost-based payment options, (3) assurances of fair and appropriate marketing practices, (4) guarantees of continued access to mandatory FQHC services, and (5) the establishment of equitable enrollment and assignment policies for clients for whom English is not their first language.

We continue to support efforts to reform the health care delivery system and save money without compromising access to or quality of care. With the inclusion of the aforementioned provisions, we hope that the Illinois' plan could accomplish these important criteria.

Thank you again for your assistance.

Sincerely,

LANE EVANS, MC

LUIS GUTIERREZ, MC

BOBBY RUSH, MC

CARDISS COLLINS, MC

Congress of the United States
Washington, DC 20515

March 1, 1995

Honorable Donna E. Shalala
Secretary
Department of Health and
Human Services
200 Independence Ave., SW
Washington, DC 20201

Dear Secretary Shalala:

We want to commend you, again, for your Department's thorough review of Illinois' request for a Subsection 1115 waiver to establish the Illinois MediPlan Plus program.

However, we still have concerns about access to care and the viability of Federally Qualified Health Centers (FQHCs). It is possible the revised program will violate basic client rights and lead to the disruption of care and diminished access to high quality care for more than three hundred thousand Medicaid beneficiaries who now receive care at FQHCs. This 1115 waiver program, as currently proposed, could lead to the closing of several of these most essential community providers, such as ones that are crucial in meeting the health care needs in Southern and Southwestern Illinois.

We hope as your Department continues to negotiate with Illinois, that you will require specific provisions to assure continued access to these high quality services. Specifically the waiver should:

- Provide necessary protections for FQHCs as managed care subcontractors;
- Preserve FQHC financial viability through cost-based payment options;
- Guarantee client rights to mandatory FQHC services;
- Assure fair and appropriate marketing practices; and
- Establish fair enrollment and assignment policies that preserve continuity of care for all clients.

Thank you for your continuing efforts to resolve the problems with the Illinois application. We believe these provisions will assure that the final demonstration program preserves the best of the current delivery capacity while helping the State achieve its important cost control goals. Please do not hesitate to let either of us know if we may answer any questions about these issues.

Sincerely,

JERRY F. COSTELLO
Member of Congress

GLENN POSHARD
Member of Congress

RICHARD J. DURBIN
20TH DISTRICT, ILLINOIS

AT-LARGE WHIP

COMMITTEE ON APPROPRIATIONS
SUBCOMMITTEE ON AGRICULTURE AND RURAL DEVELOPMENT
SUBCOMMITTEE ON TRANSPORTATION
SUBCOMMITTEE ON THE DISTRICT OF COLUMBIA

Congress of the United States
House of Representatives
Washington, DC 20515-1320

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EDWARDSVILLE, IL 62025
(618) 692-1062

221 EAST BROADWAY, SUITE #108
CENTRALIA, IL 62801
(618) 532-4265

March 8, 1995

The Honorable Donna E. Shalala
Secretary
Department of Health and Human Services
Room 615 F
200 Independence Avenue
Washington, D.C. 20201

Dear Madam Secretary:

I would like to commend you for your department's thorough review of the request by the state of Illinois for a Subsection 1115 waiver to establish the Illinois MediPlan Plus program.

I continue to have concerns about the proposed program, especially with regard to the issues of access to care and the continued viability of Federally Qualified Health Centers (FQHCs). FQHCs serve more than 300,000 Medicaid beneficiaries. These community-based providers are often the only place low-income people can turn to receive needed, high-quality health care services. The state's waiver request could cause a significant number of these essential community providers to close, resulting in diminished access to care for many Medicaid recipients.

As your department continues to work with the state of Illinois, I hope that you will require, as a condition of any waiver, that the state fulfill specific terms and conditions regarding the treatment of FQHCs, to assure that eligible individuals have continued access to the high-quality services FQHCs provide. Among the issues that must be addressed are: (1) protections for FQHCs as managed care subcontractors; (2) FQHC financial viability under the revised payment system; (3) assurances that eligible individuals will continue to have access to FQHC services; (4) fair and appropriate marketing practices; and (5) fair enrollment and assignment policies that preserve continuity of care for all persons.

These provisions are essential if the waiver is to achieve its purposes without compromising access to and quality of care. The important role of FQHCs must not be overlooked in the move to cut Medicaid costs.

Thank you again for your work on this important issue.

Sincerely,

Richard J. Durbin
Member of Congress

SIDNEY R. YATES
9TH DISTRICT, ILLINOIS

COMMITTEE
APPROPRIATIONS

RANKING MEMBER INTERIOR AND
RELATED AGENCIES

FOREIGN OPERATIONS

Congress of the United States
House of Representatives
Washington, DC 20515-1309

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2100 RIDGE AVENUE
EVANSTON, IL 60201
(708) 328-2610

March 14, 1995

The Honorable Donna E. Shalala
Secretary
Department of Health and Human
Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Madam Secretary:

I would like to commend you for your Department's thorough review of the request by the state of Illinois for a Subsection 1115 waiver to establish the Illinois Mediplan Plus program.

I continue to have concerns about the proposed program, especially with regard to the issues of access to care and the continued viability of Federally Qualified Health Centers (FQHCs). FQHCs serve more than 300,000 Medicaid beneficiaries. These community-based providers are often the only place low-income people can turn to receive needed, high-quality health care services. The state's waiver request could cause a significant number of these essential community providers to close, resulting in diminished access to care for many Medicaid recipients.

As your Department continues to work with the state of Illinois, I hope that you will require, as a condition of any waiver, that the state fulfill specific terms and conditions regarding the treatment of FQHCs, to assure that eligible individuals have continued access to the high-quality services FQHCs provide. Among the issues that must be addressed are: protection for FQHCs as managed care subcontractors; FQHC financial viability under the revised payment system; assurances that eligible individuals will continue to have access to FQHC services; fair and appropriate marketing practices and finally, fair enrollment and assignment policies that preserve continuity of care for all persons.

These provisions are essential if the waiver is to achieve its purposes without compromising access and quality of care. The important role of FQHCs must not be overlooked in the move to cut Medicaid costs.

With kindest regards,

Sincerely yours,

Sidney R. Yates

SIDNEY R. YATES
Member of Congress

DONALD A. MANZULLO
16TH DISTRICT, ILLINOIS
506 CANNON BUILDING
WASHINGTON, DC 20515
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SMALL BUSINESS
RURAL ENTERPRISES, EXPORTS, AND THE ENVIRONMENT

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ECONOMIC POLICY, TRADE AND ENVIRONMENT
INTERNATIONAL OPERATIONS

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March 1, 1995

The Honorable Donna Shalala
Secretary of Health and Human Services
Department of Health and Human Services
200 Independence Ave., S.W.
Washington, D.C. 20201

Dear Secretary Shalala:

I have been contacted by Mr. John Frana, a constituent from Rockford, who is concerned about your Department's review of Illinois' request for a Section 1115 waiver to establish the Illinois Mediplan Plus program.

Mr. Frana is the executive director of Crusaders Central Clinic Association. Crusaders Clinic is a Federally Qualified Health Center in my district which provides essential primary care services for thousands of Rockford-area residents. He has serious concerns about the state's proposed managed care demonstration program especially as it affects access to high quality primary care offered by this important community resource.

I have enclosed a copy of the original letter, and as your Department proceeds with its review, I hope you will strongly consider his recommendations. Also, I would appreciate it if you could provide Mr. Frana with a response that fully answers the concerns raised.

Thank you for your consideration of this matter.

Sincerely,

Donald A. Manzullo

Donald A. Manzullo
Member of Congress

169264

Congressman Manzullo-

Dear ~~Illinois Congressional Delegation~~:

We urgently seek your assistance to preserve access to high quality primary care services provided by Federally Qualified Health Centers. Illinois request for a Subsection 1115 waiver to initiate the MediPlan Plus program will lead to health center closures and diminish overall access to high quality primary care for low-income Illinois residents.

After reviewing the state's response to HCFA's questions and further discussions with state officials, we believe specific provisions are necessary to protect client rights and the financial viability of Illinois' FQHCs. Specifically, we need federal assurances that:

- Provide basic protections for FQHCs as managed care subcontractors;
- Preserve FQHC financial viability through cost-based payment options;
- Guarantee client rights to mandatory FQHC services;
- Assure fair and appropriate marketing practices; and
- Establish fair enrollment and assignment policies that preserve continuity of care and protects clients for whom English is not their native language.

The Secretary has placed Terms and Conditions on other states' waivers to assure that clients and essential community providers are protected. Please ask Secretary Shalala immediately to incorporate our prepared Terms and Conditions into the waiver for Illinois if one is granted. ***HCFAs deadline to develop terms and conditions for Illinois is March 17, 1995.***

We believe that these provisions will assure that the Illinois managed care program preserves the best of the current delivery capacity while helping the state achieve its important cost control goals.

Thank you for your continuing attention and support during this waiver review process.

Sincerely,

JOHN FRANA
(Name)

120 TAY STREET
(Street Address)

ROCKFORD, IL 61102
(City, State & Zip)

COMMUNITY HEALTH CARE OF ILLINOIS
600 SOUTH FEDERAL, SUITE 501
CHICAGO, ILLINOIS 60605
312-922-2424 FAX 312-922-2549

February 23, 1995

Ms. Barbara Cooper
Acting Director
Office of Research and Demonstration
Health Care Financing Administration
U.S. Dept. of Health and Human Resources
Oak Meadows Building, Room 220
6240 Security Blvd.
Baltimore, Maryland 21207

Dear Ms. Cooper:

The Illinois Department of Public Aid has submitted to your office its response to questions posed by HCFA concerning the Illinois request for a section 1115 waiver for its Mediplan Plus Program. The Community Health Care of Illinois, Inc. (***CHCI***) has carefully reviewed this additional information.

Currently, ***CHCI*** and the Illinois Department are discussing the possibility of ***CHCI*** submitting a proposal in response to the Department's Mediplan Plus RFP as a FQHC Managed Care Community Network (MCCN). The Department has made no commitments to ***CHCI*** and is unlikely to do so prior to an actual evaluation of a response to the RFP. While these discussions are friendly and cooperative there is no assurance by the Illinois Department that a FQHC MCCN is an important element to the Mediplan Plus Program. The MCCN concept, particularly the possibility of having a FQHC MCCN is the only experimental aspect of the Illinois 1115 waiver request. ***CHCI*** is the only not-for-profit corporation wholly owned by FQHCs in Illinois preparing to respond to the Illinois Department's waiver.

While ***CHCI*** recognizes improvements that are occurring in the waiver request, ***CHCI*** is requesting that both HCFA and the Illinois Department realize the need for certain terms and conditions essential for the participation of a FQHC MCCN. Attached is a proposed set of terms and conditions which ***CHCI*** has developed for your consideration as HCFA reviews the Illinois waiver request. These terms and conditions fall into three categories:

- *FQHC MCCN Gradual Compliance Conditions*. -- ***CHCI*** will need some temporary exemptions from the initial screening and ranking requirements. Risk adjustments or stop/loss provisions will be essential to ***CHCI*** since the Illinois Department has provided very little Medicaid experience data for evaluation. Once ***CHCI*** establishes itself for a reasonable period of time this exemption will not be necessary.

- *FQHC MCCN(s) Expansion Guarantees During Waiver Period* – ***CHCI*** is a statewide not-for-profit corporation. While ***CHCI*** is prepared to participate as a FQHC MCCN in some parts of the State initially, it will not initially submit a proposal for all areas of the state. However, ***CHCI*** does wish to gradually expand into all areas of the state and does not want to be locked out in the future.

- *FQHC MCCN/State Partnerships and Demonstration Projects* – ***CHCI*** is willing to enter into partnerships and demonstration projects with the Illinois Department to assist in the expansion of the Mediplan Plus Program in Illinois. There will be a number of both rural and urban areas of the state where no proposals will be submitted. However, many of these rural and urban areas will have established FQHCs prepared to participate through ***CHCI*** if a partnership or demonstration project could be established.

On behalf of CHCI, I thank you and your staff, once again for your attention to these very important issues. I will be pleased to provide you any additional information you may need concerning these proposed terms and conditions.

Sincerely,

Patsy K. Crawford

Executive Director

attachment: Proposed Terms and Conditions for proposed Illinois 1115 Waiver

cc: Rhoda Abrams, Bureau of Primary Health Care, PHS
Rodney Armstead, Office of Managed Care, HCFA
David DuPre, Associate Regional Administrator, HCFA
A. George Hovanec, Administrator, Medical Assistance Programs, IDPA
Sally Richardson, Medicaid Bureau, HCFA

95020901

Community Health Care of Illinois

Proposed Terms and Conditions for proposed Illinois 1115 Waiver

Federally Qualified Health Center MCCN (s) Gradual Compliance

a. The State shall grant temporary exemptions from any RFP requirements as requested in any responses to the RFP which is submitted by a not-for-profit corporation which is wholly owned and controlled by a FQHC(s) (FQHC MCCN). The purpose of these exemptions is to allow for the gradual compliance of a FQHC MCCN(s) over the entire life of the waiver. The State shall not grant any temporary exemption for a period beyond the life of the waiver:

1. When a FQHC MCCN submits a proposal it must specifically identify those criteria for which it is requesting a temporary exemption. The FQHC MCCN must state precisely when and how it anticipates to come into full compliance for each temporary exemption requested.

2. Temporary exemptions shall be granted from any of the initial screening and ranking criteria where the State and the FQHC MCCN enter into a compliance agreements which establishes a detailed plan of achieving compliance. Compliance agreements shall be negotiated and finalized at least 60 days after the submission of a proposal by a FQHC MCCN. Such plans shall be submitted to HCFA for review and approval in writing.

b. Once a FQHC MCCN completes the screening and ranking process as provided above, it shall be eligible to participate in the MCE bidding process. The MCE contract between the State and the FQHC MCCN shall establish a capitated (risk) rate. However, a FQHC MCCN may request that the contract be less than full risk or that a stop/loss provision be included. If such a request is made the State shall enter into negotiations with the FQHC MCCN to include such provisions. Such contracts shall be submitted to HCFA.

c. A FQHC MCCN, regardless of the any temporary exemptions, shall have the same rights and privileges of any other MCE participating in the State's Mediplan Plus.

FQHC MCCN(s) Expansion Guarantees During Waiver Period

a. The State shall accept a response to the RFP submitted by a FQHC MCCN any time during the life of the waiver.

b. A FQHC MCCN(s) shall not be precluded from contracting in any contracting service area of the state where it is able to demonstrate adequate capacity at any time during the life of the waiver.

FQHC MCCN/State Partnerships and Demonstration Projects

a. If there is only one bidder in any contracting service region in the state, the State shall determine if an FQHC MCCN desires develop an MCCN in that particular contracting service area. If a FQHC MCCN indicates it desires to develop a MCCN in that particular contracting service area, the State and the FQHC MCCN shall enter into a technical assistance partnership specifically for the purpose of developing the FQHC MCCN. The State shall provide technical assistance on system development, quality assurance, solvency, and any other issue which may be identified by the State and the FQHC MCCN. Such technical assistance may include State grants or loans. All agreements concerning such partnerships shall be submitted to HCFA for review and approval.

b. In contracting service areas of the State where there are no bidders, the State shall establish a demonstration project specifically to develop a FQHC MCCN. Since this is likely to be in rural areas of the state, the demonstration project shall include the development of additional FQHC sites and emphasize access to health care. All planning and implementation agreements and documents concerning this demonstration shall be submitted to HCFA for review and approval.

95012601

ILLINOIS PRIMARY HEALTH CARE ASSOCIATION

600 South Federal, Suite 700
Chicago, Illinois 60605-1842
Telephone: 312/939-5556
FAX: 312/939-5557

201 East Adams, Suite 250
Springfield, Illinois 62701-1122
Telephone: 217/525-6702
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February 17, 1995

Ms. Barbara Cooper
Acting Director, Office of Research and Demonstration
Health Care Financing Administration, U.S. Dept. of Health and Human Resources
Oak Meadows Building, Room 220, 6240 Security Blvd.
Baltimore, Maryland 21207

Dear Ms. Cooper:

We urgently seek your assistance to assure that if a section 1115 waiver is granted to Illinois that the Mediplan Plus Program does not jeopardize access to high quality primary care services currently provided by the State's Federally Qualified Health Centers and does not diminish overall access to and quality of care available to Medicaid beneficiaries.

After reviewing additional State responses to HCFA's questions and discussions with State officials, we believe specific provisions are necessary to protect client rights and the financial viability of Illinois' FQHCs. Our proposed terms and conditions:

- ***Provide essential protections for FQHCs as managed care subcontractors.***
- ***Preserve FQHC financial viability through cost-based payment options.***
- ***Guarantee client rights to mandatory FQHC services.***
- ***Assure fair and appropriate marketing practices.***
- ***Establish equitable enrollment and assignment policies that preserves continuity of care and protects clients for whom English is not their native language.***

Thank you, again, for your continuing attention and support during this waiver review process. We will be pleased to discuss these issues with you or your staff or provide additional information at your convenience.

Sincerely,

Len Sharber

Len Sharber
President
Illinois Primary Health Care Association

attachment: Proposed Terms and Conditions for proposed Illinois 1115 Waiver

cc: Rhoda Abrams, Bureau of Primary Health Care, PHS
Rodney Armstead, Office of Managed Care, HCFA
David DuPre, Associate Regional Administrator, HCFA
A. George Hovanec, Administrator, Medical Assistance Programs, IDPA
Sally Richardson, Medicaid Bureau, HCFA

Illinois Primary Health Care Association

Proposed Terms and Conditions for proposed Illinois 1115 Waiver

Federally Qualified Health Centers (FQHCs) as MCE Subcontractors

a. The State shall require managed care entities (MCEs) to contract with FQHCs as required by State law [305 ILCS 5/5-16.3 (d) (1)]. The State shall assure that any terms and conditions established by a MCE(s) under Illinois law shall be applied in a non-discriminatory manner and such terms and conditions shall not operate generally to preclude acceptance by the MCE(s) of a FQHC(s).

b. If an MCE intends either to terminate or deny inclusion of a FQHC(s) into the panel of physicians of the MCE as provided for in State law, the State shall demonstrate to HCFA that the MCE has adequate capacity and will provide an appropriate range of services for vulnerable populations without contracting with the FQHC(s) in its service area, prior to the MCE terminating or denying inclusion.

c. No MCE shall terminate or deny inclusion of a FQHC(s) as provided above in paragraph (b), unless the State has submitted to HCFA a report with the following information at least 60 days prior to the termination or denial for the Regional Office (RO) approval and thereafter HCFA concurs in writing with such action. The report submitted by the State shall include:

1. The names of the FQHC(s) in the MCE's service area, and a description of the demonstration populations served and the services provided by the FQHC(s) prior to the demonstration.

2. An analysis demonstrating that the MCE has sufficient provider capacity to serve the demonstration populations currently receiving services at the FQHC. The analysis shall include, but not be limited to, a listing of providers signed with the MCE, capacity of each provider to serve Medicaid patients, geographic location of providers and description of accessibility for Medicaid patients to these providers. The MCE must inform the State if any of this information or data changes over the course of the demonstration.

3. An analysis demonstrating that the MCE will provide a comparable level of Medicaid services as the FQHC (as covered in the approved State plan), including covered outreach, social support services, transpiration and the availability of culturally sensitive services, such as translators and training for medical and administrative staff. The analysis shall describe the proximity of providers, and range of services as it relates to FQHC patients.

FQHC Reimbursement Options

a. The MCE shall pay the FQHC(s) on either a capitated (risk) basis (with appropriate adjustments for adverse selection factors) or on a 100% reasonable cost-based basis. Appropriate adjustments factors for adverse selection shall include, but not be limited to, age, gender, location, eligibility category and prior utilization of health services. A description of the payment methodology shall be provided by the State for the Regional Office (RO) approval in writing prior to the awarding by the State of any contracts to any MCE(s):

1. Where a MCE contracts with a FQHC(s) on a 100% reasonable cost basis and the MCE pays directly to the FQHC such payments, State payments to the MCE shall reflect 100% reasonable costs as stated in section 1902 (a) (13) (E) of the Social Security Act. A MCE has the right to elect to be paid at these 100% reasonable cost based rates for services

described in section 1905 (a) (2) (C) of the Social Security Act, as long as the MCE is paying these rates directly to the FQHC(s).

2. Where a MCE contracts with a FQHC(s) on a capitated (risk) basis (with appropriate adjustments for adverse selection factors), State payments to the MCE shall reflect this capitated basis. FQHC capitated rates shall be at least as favorable as those offered by the MCE to other primary care providers. A FQHC receiving such a capitated rate shall have the right to elect to be paid adjustment payments from the State to reconcile the difference between the total capitated rate payments and what would have been the 100% reasonable cost-based rate payments as stated in section 1902 (a) (13) (E) of the Social Security Act. The State shall provide a description of this adjustment payment methodology to HCFA for review and approval at least 30 days prior to the implementation of the waiver.

b. If a FQHC has entered into a contract with a MCE on a capitated (risk) basis, it may voluntarily waive its right to be paid adjustment payments from the State if the FQHC chooses to enter into a shared saving plan, such as a set-aside pool, % withhold, etc., with a MCE. The waiving of the right by a FQHC(s) to adjustment payments from the State to reconcile the difference between the capitated rate and what would have been the 100% reasonable cost-based rate, can not be a condition for entering into a contract with a MCE(s).

c. If during the demonstration, the MCE changes its payment methodology in any way to a FQHC(s), the changes shall be submitted by the State to HCFA for review and approval in writing prior to making the changes.

Access to FQHC Services (Out-of Plan)

a. Any RFP the State releases shall specifically list FQHC services as one of the mandatory covered services which must be provided by a successful bidder which desires to become a MCE.

b. When a recipient who, either voluntarily or by assignment, is enrolled with a MCE seeks FQHC services at a FQHC which does not have a contract with that recipient's MCE (Out-of Plan FQHC Services Visit), the FQHC providing those FQHC services shall be entitled to 100% reasonable cost-based reimbursement. The FQHC shall bill the State directly for such out-of-plan FQHC services visits.

c. To avoid double payment for Out-of-Plan FQHC Services Visits, the State shall develop a methodology for recouping pre-paid payments to the recipient's MCE which is responsible for providing FQHC services. Such methodology shall be submitted to HCFA for review and approval 60 days prior to the implementation of the Mediplan Plus Program. Such methodology shall include the immediate dis-enrollment of the recipient from the MCE and the re-assignment of the recipient to that FQHC EMCP where FQHC service were provided if the recipient has no objection to the re-assignment.

Marketing Materials

a. The State shall submit all State marketing materials for enrollment into Mediplan Plus to the Regional Office (RO) for review and approval 60 days prior to disseminating these material. Additionally, HCFA shall review and approve marketing materials used by any individual participating Mediplan MCE or Enrolled Managed Care Provider (EMCP).

b. The State will thoroughly report to HCFA immediately any marketing problems, such as but not limited to, written complaints, it identifies or changes intended to be made to any marketing materials or programs.

Enrollment and Assignment

a. To preserve continuity of care, the State shall provide that any Mediplan Plus enrollee already enrolled with a FQHC (under the Health Moms/Healthy Kids Program) who does not affirmatively select another participating MCE or EMCP provider shall be assigned to that same FQHC.

1. The State's education and enrollment program shall include an on-site enrollment process as provided by Section 1902 (a) (55) of the Social Security Act. Employees of a FQHC(s) shall be trained and certified by the State as outstation eligibility workers authorized to accept a Medicaid application and to assist applicants with the application. Such assistance shall include selection of a Mediplan Plus MCE or EMCP provider.

2. The State's education and enrollment program is prohibited from authorizing the placement of MCE employees or representatives in local public aid offices for marketing purposes.

3. The State's education and enrollment program shall prohibit MCE(s) and EMCP(s) from soliciting recipients door to door or at any other enrolled provider's place of business.

b. The State shall establish an education and enrollment program that shall allow for the assignment (default) to MCEs and EMCPs of eligible Mediplan Plus recipients who do not voluntarily make a choice of medical providers on a proportional basis based upon available capacity at all MCE(s) and EMCP(s) in a given service area.

c. The State, for purposes of assigning Mediplan Plus recipients who do not make a choice of medical providers on a proportional basis based upon capacity to all MCE(s) and EMCP(s) in a given service area, shall submit to HCFA for review and approval the methodology for determining capacity at least 60 days prior to the implementation of the waiver.

1. The methodology shall be based upon the availability of providers a MCE or EMCP has identified as being available to provide preventative and primary health care services.

2. The methodology shall provide a higher capacity capability for MCE(s) and EMCP(s) that provide medical services through physician/mid-level nurse practitioner teams.

3. The methodology shall include a provision that assures that recipients for whom English is not their primary language, will be assigned to a MCE or EMCP that offers translation services for that recipient's primary language.

95012403

THE WHITE HOUSE

WASHINGTON

MEMORANDUM TO: The First Lady

FROM: Diana Fortuna
Domestic Policy Council

SUBJECT: Status of Illinois Medicaid Waiver in Preparation for Chicago trip

DATE: February 14, 1995

The purpose of this memo is to brief you on the status of Illinois's request for a Medicaid waiver in advance of your trip to Chicago.

The state submitted a waiver request to HHS and the Health Care Financing Administration on September 15, 1994. The 120th day was January 13. The plan, entitled "Medi-Plan Plus," would require most Medicaid recipients to join managed care plans. Negotiations on the waiver are nearing conclusion, and approval should be announced in the next two to three weeks. Secretary Shalala called the Governor last Friday to reassure him that the process is going very well, although she did not indicate that approval was a certainty.

Governor Edgar has been very anxious to secure approval, in large part because his budget assumes savings from the implementation of managed care. Also, the state's bond rating was recently downgraded, and the rating agency pointed to problems in the Medicaid program as part of the rationale.

Illinois has a very troubled Medicaid program. In the past, it has tried to cope with cash shortfalls by simply not paying bills for months at a time. There is also a long history of quality problems in the program. As a result, many are skeptical that the state can successfully mount such an ambitious managed care program.

Sister Sheila Lyne, head of the city of Chicago's health department, has written HHS to express her concern that the waiver could hurt quality of and access to care because of the state's poor track record. She is also concerned that clinics run by the city could be hurt in the changeover. HHS officials are meeting with her next week. The Illinois Primary Care Association, which represents federally qualified health centers, strongly opposes the waiver because of concerns about whether FQHCs can compete in managed care. (In most states where we have approved Medicaid waivers, the FQHC association has opposed it on these grounds, and the National Association of Community Health Centers is suing us on this issue.) They are also concerned that

the state will direct most of the business to the Chicago HMO, which has strong Republican ties.

Illinois' plan differs from other major Medicaid waivers we have approved in that the expansion of Medicaid coverage to new populations is very small (only a few thousand people). However, HCFA was ultimately persuaded that the State's fiscal problems are such that a coverage expansion was not affordable. HCFA also argued that the state should have applied for a 1915(b) waiver rather than an 1115 waiver, since enrollment in managed care can be accomplished through the former, and the only advantage of an 1115 waiver is to avoid the tougher quality standards in an 1915(b) waiver. The state ultimately compromised and agreed to meet the more stringent 1915(b) quality standards for clients outside of Cook County.

At the beginning of the process there was significant tension between the State and HCFA over the ambitious timeline the State wanted to follow. When the state submitted its proposal, it was about to issue a request for proposals to identify likely providers in time for an April start-up, but HCFA instructed the state to wait for Federal approval before doing so. This exchange was covered extensively by the press at the time. The initial stories were critical of the Federal government's delay of the program, but the coverage shifted within a week or two and then criticized Governor Edgar for trying to move too fast. There were editorials favorable to HCFA in the Chicago Tribune and in the Sun-Times. More recently, the Governor has again criticized HCFA for delays, but the coverage has again suggested that Federal caution is prudent.

cc: Carol Rasco

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

19-Jan-1995 10:42am

TO: Jeremy D. Benami
TO: Diana M. Fortuna

FROM: Carol H. Rasco
Economic and Domestic Policy

SUBJECT: Illinois

Yesterday I played phone tag with Terri Moreland, Director of Illinois' Governor's DC office, and Governor Edgar's Chief of Staff, Gene Reincke. I have now spoken to Terri. The Governor had asked them to call her as a follow up to his meeting with me as yes, they did have their session with HCFA last week but are getting nowhere in obtaining anything in writing, even about the 1915 pieces that were discussed with them. Is there anything that can be done to appease him (he's nervous as his legislature comes in next week, budget figures are screwed if they can't begin to show some of this waiver stuff) short of a letter or call promising the full waiver since Mayor Daly wants a delay, etc.etc. Terri would like a call back by tomorrow if possible. Diana, why don't you check this out and then let's talk....

Welcome to the White House side of waivers.

JMon - Time to decide Daley
(1115 m c/2)
Today — need to Wed early March
Kevin O'Keefe

Talked out of by mtg this wk
Roff Wright
- conf call on data,
then mtg

If Greenlight; but late next wk. impl plan Quickest is Wed.

Mon - hold off
met last week; Tues said yes
Next; bri + crappy progr; discuss impl plan
Want list; new impl plan; then they'll comment/do timeline

easy w/ loan expansion

vet by

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JAN 5 1995

DIANA
FYI +
for the
files

MEMO TO: Carol Rasco
Assistant to the President
Domestic Policy Council

FROM: Bruce C. Vladeck
Administrator

THROUGH: Kevin Thurm, CoS

SUBJECT: Illinois' 1115 Demonstration Proposal

I understand that you will be meeting with Governor Edgar of Illinois on Friday, January 6. This note summarizes our major issues with the State of Illinois' section 1115 demonstration proposal, and how we intend to resolve them. You should be aware that HCFA is meeting with the State of Illinois to continue negotiations on their waiver on January 11.

Background: Illinois submitted its demonstration proposal, MediPlan Plus, on September 14, 1994. The stated goal of the proposed demonstration is to increase access and quality of care for Medicaid eligible clients and limit rising costs through the increased use of managed care. The State claims it will save $1.1 billion over the course of the demonstration, alleviating its significant budget problems.

MediPlan Plus will serve two population groups which are not categorically eligible for Medicaid. One group is currently receiving less comprehensive health care services in a State-only funded program. The other group was part of a State-only funded program which ended in March of last year. In addition, the proposal will expand coverage of family planning services from the current 60 day period to 12 months after childbirth for adults with incomes below 133% of the federal poverty level.

Illinois intends to use a mix of HMOs, managed care community networks (MCCNs) developed around hospitals or federally qualified health centers, traditional insurance, and a more narrowly contained fee-for-service system. The state will have Mandatory MediPlan Plus areas, Voluntary MediPlan Plus Areas, and Traditional Medicaid areas where HMOs and MCCNs are not available for services. A large number of services will be carved out of capitation contracts and will continue to be provided on a fee-for-service basis, e.g. mental health services, skilled nursing services, and alcohol and substance abuse services.

Reasons for concern:

- Illinois has a history of poor management of its Medicaid program. Some examples of this are:
  - For eight straight years, the State has not paid providers in a timely fashion and has failed to meet the timely claims payment standard of its annual Systems Performance Review.
  - Illinois' managed care program known as the Partnership Program was seriously criticized by GAO, which noted widespread client dissatisfaction, marketing abuses, and other managed care deficiencies.
  - Illinois' Healthy Moms/Healthy Kids program was approved in January '93 but to date has enrolled only 20-25% of its targeted population. There have also been difficulties retaining providers because of late payments by the State.
  - Last year, the Chicago Tribune ran an eight-part series describing in detail numerous program deficiencies in the Illinois Medicaid program.
- There is little which is particularly innovative in Illinois' 1115 demonstration proposal. We believe that the State wishes to use the 1115 authority primarily to circumvent quality standards established under the current Freedom of Choice waiver statute. We feel strongly that this is not the proper use of the 1115 authority.
- We have previously been willing to provide more flexibility on managed care quality assurance for states which were expanding eligibility and which have a proven record of their commitment to quality.
- Illinois could develop managed care arrangements for Medicaid beneficiaries using a 1915(b) freedom of choice program waiver.
- The state has set an unrealistic timeline for implementation of the proposal (e.g. start-up on 8/1/95), and particularly for contracting with managed care organizations.
- We could be sued by interest groups for waiving quality standards in a program run by a State with quality problems.
- We question the State's estimate of savings, particularly as their existing 1915(b) program, Healthy Moms/Health Kids, has failed to bring about the savings envisioned (see attachment A).

The State's position:

- The State is asking for flexibility already granted to other states in their 1115 demonstrations.
- The State claims its financial situation is such that it cannot afford an eligibility expansion or a slower implementation timeframe.

Our position: While we are concerned with Illinois' track record in implementing broad changes in Medicaid, the State's proposal has two elements which necessitate use of Section 1115 waiver authority and are truly innovative: The first is the development of managed-care community systems built around hospitals, in urban areas initially, and in rural areas in later years. The second is the development of urban and rural managed-care community networks using federally qualified health centers in the delivery system.

At the January 11 meeting, we will agree in concept to an 1115 demonstration focused on the elements of the proposal that are innovative. We will require and offer assistance in the creation of a more realistic timeframe for implementation to assure that adequate quality assurance, program management, and health care system elements are in place. Since the State will be concerned about the proposal of a slower implementation, we intend to offer the State a 1915(b) managed care waiver for the interim period, to achieve some cost savings in the short-run. The benefits of doing this are:

- The State could put its beneficiaries into managed care and achieve cost savings. We believe the State is likely to save a comparable amount of money under a section 1915(b) waiver as it would under an 1115 demonstration.
- HCFA would be better able to assure quality under a 1915(b) program.
- 1915(b) waivers have a shorter, more simple review process. This should appeal to the State.
- This arrangement would allow the State to keep its promise to Illinois hospitals that they would be involved in the new system.
- This arrangement could result in a program that is a legitimate test of a health care system innovation.

Also attached, for your information, are examples of recent editorials from Illinois papers which are sympathetic to the concerns we have expressed to the State (Attachment B). Please call me if you have any questions.

ATTACHMENT A

Chicago Tribune, Friday, June 24, 1994

State's health plan for poor comes up short

Healthy Moms, Healthy Kids

Costing more, signing up few

By Eric Krol
Tribune Staff Writer

SPRINGFIELD—When Gov. Jim Edgar proposed a new program in 1992 to help reduce the state's high infant-mortality rate it also was supposed to end the medical tribulations of poverty-stricken women and their children.

Under Healthy Moms/Healthy Kids, poor pregnant women were supposed to receive better prenatal care. Their children were supposed to be immunized on schedule.

And whenever a mother or child became sick, physicians were supposed to be available, ending the hodgepodge of emergency room waits and storefront clinic visits that for years have marked health care for the poor.

On top of all that, the state was supposed to save money. Families would stop making costly emergency room visits and preventive care would head off many serious illnesses, reducing the number of lengthy hospital stays.

"This initiative will be more than paying for itself within two years," Edgar predicted in his April 1992 budget address.

But after a little more than a year of operation, the much-hyped program has failed to live up to expectations and is beset by numerous problems:

■ The Illinois Department of Public Aid, which oversees the program, initially promised to sign up 400,000 mothers and children in the Chicago area by the end of last month, but only about 40,000 have been enrolled.

■ Due to a budget cut, the state allocated $57 million this year to enroll 164,000 participants. But when the budget year ends Thursday, the state expects to have spent $70 million to enroll only the 40,000.

■ Instead of simplifying health care for the poor, the new program has complicated it. The computer system at the heart of the program doesn't work properly. The system can't track patients and has often assigned them to clinics miles away from their homes. One patient from Downstate Alton was assigned to a clinic 300 miles away in Chicago.

The failures of Healthy Moms/Healthy Kids serve as a warning to Edgar as he tries to persuade lawmakers to overhaul the entire state Medicaid health-care system to control the skyrocketing cost of treating the poor. Edgar would shift all 1.1 million Illinois Medicaid patients to a similar HMO-style managed health-care system in less than a year.

"How can we expect to move ahead with the governor's plan when there are so many obvious problems with Healthy Moms?" said Rep. Barbara Flynn Currie, a Chicago lawmaker and House Democrat negotiator on Medicaid reform.

The program was the inspiration of former Public Aid Director Phil Bradley and his Medicaid chief, Terry Stoica, before both left state government to take jobs in the health-care industry.

To ensure that families maintained regular access to their physicians and received the proper care, the state gave money to local community organizations, such as the Chicago Urban League, to hire case managers.

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To entice physicians to sign up for the program, the Department of Public Aid offered higher reimbursements and quick payments.

And to operate the entire system—which Edgar billed as "the largest comprehensive case management system in the nation"—the state hired First Health Services Corp. of Virginia under a $25 million, two-year contract.

But despite all of the effort and spending, the new program has left many mothers and children in a holding pattern.

Rather than signing up existing Medicaid families with children, the Department of Public Aid limited the program only to pregnant women when it began running out of money and the computer system malfunctioned.

The department also spent $40 million on administrative overhead as it rushed to set up a complicated program in just 14 months.

Robert Wright, the state's current public aid director, defended the administrative spending, saying, "If you're going to have a system at all, you need all these things in place."

But Delores Morales, who runs clinics on Chicago's North Side and in Des Plaines that are enrolled in the program, says her problems typify the complaints against the Healthy Moms/Healthy Kids program.

When a Department of Public Aid representative came to pitch the program in February 1993, Morales said she was promised 1,500 patients per physician per month. But because of the enrollment slowdown ordered by the department, Morales' clinics have seen nowhere near that many patients.

In fact, four months ago, Morales said, her clinics were mysteriously removed from the program. All 125 of her clients were assigned to other clinics. After Morales complained to lawmakers in Springfield, she said, her clinics were suddenly assigned 300 patients—some of them new, some of them old—the following week.

"I have been tossed around like a Ping-Pong ball," Morales said.

In addition, Morales said, the assignment process for patients often has no rhyme or reason. One mother who signed up for the program lived in south suburban Calumet City but was supposed to travel all the way to Morales' North Side clinic to get medical care for herself and her children.

Public Aid officials declined to discuss the specifics of Morales' problems, but they blame such mistakes on computer errors by First Health Services Corp.

First Health was supposed to set up a computer network linking its office with the 21 Public Aid offices in Chicago and with the case managers at community organizations. The whole system was supposed to be in place by May 1994.

But when case managers began working with the computers, the complaints started rolling in. Last fall, Wright formed a task force to address the problems.

The task force drafted its recommendations in November, but changes did not occur until officials from a federal agency that oversees the cost effectiveness of Healthy Moms/Healthy Kids toured one of the offices where case managers work.

In a February letter to the Department of Public Aid, the U.S. Health Care Financing Administration said it found case managers using computer programs so slow that only a few clients could be handled each day.

In addition, computer programs generated inappropriate health-care plans and data for patients, the federal agency said.

First Health also was supposed to produce reports to show that patients were getting appropriate care. But when First Health tried to generate the reports, it crashed the entire computer system, federal officials said.

Until recently, First Health didn't even have a list of where its staff and computers were assigned.

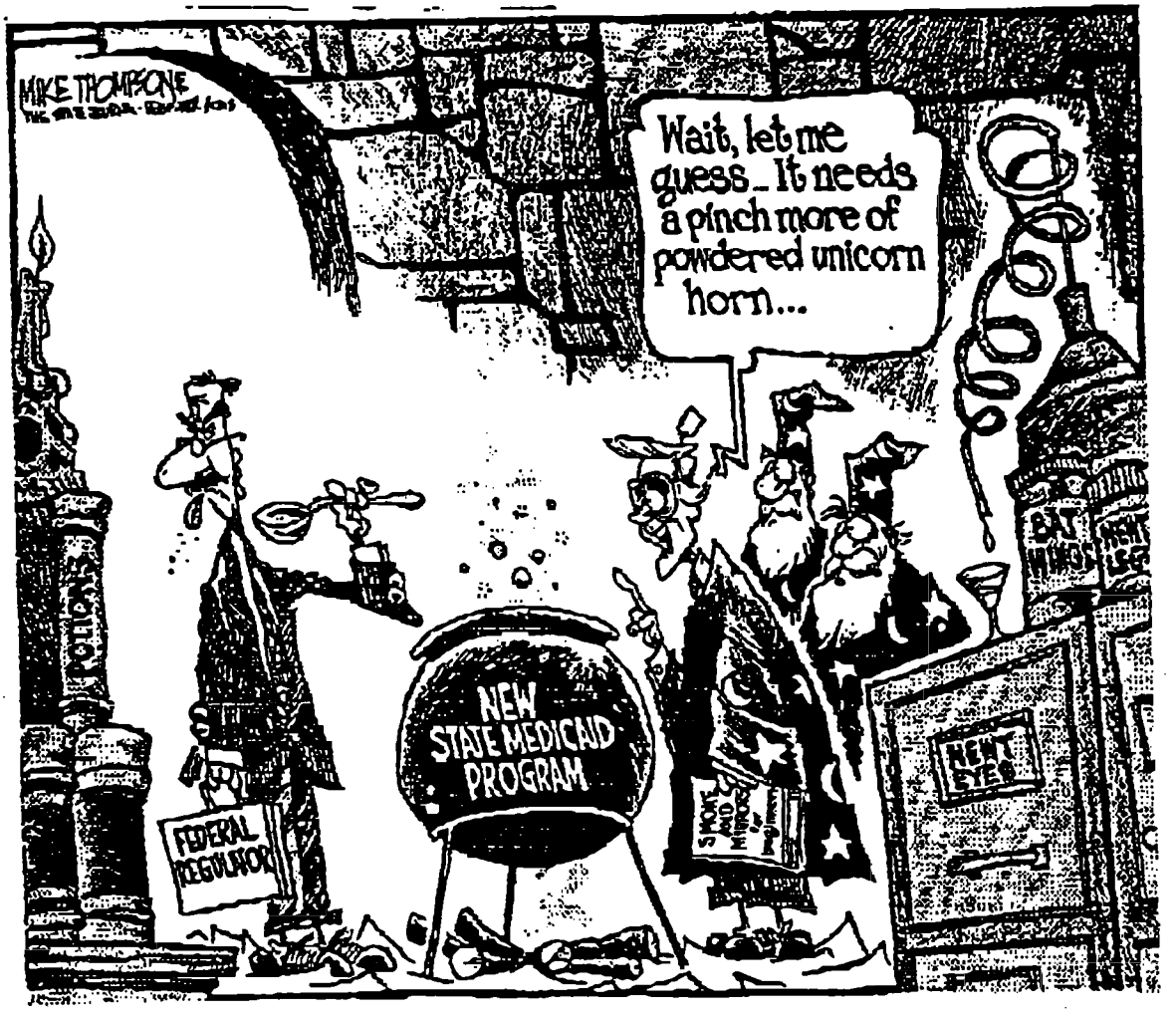
"I don't think First Health entirely appreciated what would be involved with this program," Wright said.

Following a bidding process, the state awarded First Health the contract for Healthy Moms/Healthy Kids because the company had done Medicaid work in other states. But Wright acknowledged that the company's earlier work was nothing on the scope of the Healthy Moms/Healthy Kids program.

(2)

(2)

ATTACHMENT B



State Journal Register December 10

Chicago Business
Crain's

RANCE CRAIN, Editor-in-chief GLORIA SCOBY, VP, publisher

DAVID SNYDER, Editor JAY McCORMICK, Managing editor

Is Edgar's Medicaid mess just the start?

It was just three months ago, in the heat of the gubernatorial campaign, that the arrogance and unwarranted optimism of the Edgar administration was displayed for all to see.

At issue was Gov. Jim Edgar's plan to transfer the state's 1.1 million Medicaid recipients into an HMO-style managed care system. The effort was critical to the state's tenuous financial health: The so-called MediPlan Plus program was designed to save $2 billion in spiraling Medicaid costs over a five-year period beginning this July 1.

No dice, said a parade of outside health care experts. A timetable for enrolling Medicaid patients into MediPlan—and the resulting cost savings—were too ambitious. In a letter to state public aid officials, the U.S. Department of Health and Human Services (HHS) agreed.

Candidate Edgar dismissed the HHS warning as "a letter from a bureaucrat." Today, the re-election victory under his belt, the governor is singing a different tune.

His administration now concedes that the launch of MediPlan Plus will be delayed by months. And those costs savings? They will be delayed, too.

Despite reassurances in October, the truth ultimately came to light in December. The postponement, administration officials say, will cost Illinois taxpayers an estimated $31 million. But don't hold your breath that that's all we'll lose. Those estimates are from the same folks who said the managed care plan was on a workable timetable.

Perhaps more troubling are other assurances made by candidate Edgar that no longer seem to carry the same weight. Is the state's budget as sound as we'd been assured? Or will there be a funding panic when the General Assembly reconvenes this spring? And what about his campaign mantra that he had "no plan to raise taxes?"

Don't hold your breath.

Gov. Edgar made a lot of bold promises while he was seeking re-election. There was skepticism then, and there's skepticism now. In his second term as governor—which begins next week—one can only hope that Mr. Edgar offers a more pragmatic assessment of the state's finances than he did when he was campaigning to be re-elected.

Take Politics Out of Medicaid

Nobody, least of all Gov. Edgar, should be surprised to learn that the state's managed-care system for Medicaid patients won't be up and running by April 1.

Edgar's claim that it was possible to herd 1.1 million Medicaid recipients into managed care in 11 months' time sounded too good to be true when he first announced it last spring. It was. Nonetheless, the ruse achieved its goal: It delayed discussion of the $5 billion Medicaid problem until after the election.

Tuesday, the feds called his bluff. The Health Care Financing Administration questioned Illinois' time line for implementing its new program. The federal agency, which must approve changes in state-run Medicaid programs, is concerned about the lack of time for training staff, developing systems, educating patients and recruiting doctors.

The election is over. Edgar's job is secure for another four years. It's time to step back from the politics and start talking about people. If managed care is going to save taxpayers money, the system must be carefully planned and cautiously implemented.

Managed care remains the best option for controlling medical costs in the future, but savings will be realized only if the system works. It's time for the governor stop playing politics with Medicaid and openly pay attention to details.

Sun Times December 2

Sister Shula
10 bookcases
Can we pull it?

City of Chicago
Richard M. Daley, Mayor

Department of Health

Sheila Lynn, RSM
Commissioner

333 South State Street
Chicago, Illinois 60604
(312) 747-9884
(312) 747-9885 (24 hours)
(312) 744-2960 (TT/TDD)

November 23, 1994

Barbara Cooper, Acting Director
Office of Research and Demonstrations
Health Care Financing Administration
Oak Meadows Building, Room 220
6340 Security Blvd.
Baltimore, MD 21207

Dear Ms. Cooper:

As the public health authority for Chicago's nearly 3 million residents, including over 600,000 Medicaid recipients, and as a major health care provider for the City's poor, the Chicago Department of Health has a great stake in the design and implementation of the State's Medicaid program. After reviewing the Illinois Department of Public Aid's (IDPA) waiver application for Illinois MediPlan Plus, we submit the following comments for your consideration:

The State's Waiver Request was Submitted Under the Wrong Statute

The State of Illinois has submitted a waiver request that seeks to implement the Illinois MediPlan Plus Demonstration Project. The state's request was submitted under section 1115 of the 1965 Social Security Act. That Act authorizes "research and demonstration" waivers, which are intended to encourage the testing of innovative ideas that could be adopted nationwide.

The section 1115 request should be rejected because the Illinois waiver request should have been made in accordance with a different statutory scheme. An appropriate request would have invoked section 1915 of the Social Security Act. Section 1915 waivers are known as "program waivers" because they allow states to experiment with Medicaid service delivery systems and costs. Program waivers may include requirements that Medicaid recipients obtain medical services from specified providers.

Since the Illinois waiver proposal is basically a managed care plan that would require recipients to use traditional health maintenance organizations, there is no basis for proceeding in accordance with section 1115. The waiver request should have been made in accordance with section 1915 of the Social Security Act, which is designed to allow experimentation with service delivery.

The Illinois waiver request should be rejected. The state should be required to submit an appropriate request in accordance with section 1915.

State's Ability to Implement the Demonstrations Project

The September 27, 1994 *Federal Register* included policies and procedures used to guide the review of Section 1115 waivers. The *Policies and Procedures* state that HHS will "consider, as criterion for approval, a State's ability to implement the research or demonstration project." We believe that IDPA's experience to date in managed care indicates a profound inability to effectively implement MediPlan Plus.

A 1990 GAO study of HMO's found significant short comings in IDPA's managed care program. Many of the issues have never been addressed by IDPA, including massive client dissatisfaction and disenrollment and lack of adequate quality assurance standards. Our experience as a public provider has also show that large numbers of managed care enrollees, because of dissatisfaction with their managed care providers, seek care at public clinics and federally-funded community health centers that cannot deny care. None of these serious concerns are addressed in Illinois' waiver request.

IDPA's experience with Healthy Moms Healthy Kids, a managed care program requiring a 1915 (b) waiver also gives some indication of IDPA's inability to rapidly implement a new program. After seventeen months of implementation, IDPA had only enrolled approximately 10% of 580,000 families in Healthy Mom Healthy Kids' target population, at a per-case cost far exceeding the budget's projections.

Specific concerns regarding the State's ability to implement MediPlan Plus:

1. Given the state's experience with managed care and the supply of managed care providers, the goal of enrolling 70%-90% of Cook County's nearly 700,000 eligible clients within one year is totally unrealistic. IDPA has stated that only slightly more than 100,000 Medicaid clients are currently enrolled with a HMO, with an additional 150,000 slots currently available. It is unrealistic to expect sufficient additional HMO and Managed Care Community Network (MCCN) capacity to develop so that over triple the current capacity will be available within a year. The requirements for MCCNs are going to thwart or at least slow down their development, further adding to the capacity problem. IDPA has had trouble attracting most Illinois HMOs to the Medicaid program, and preliminary evidence does not suggest that task will be made any easier through MediPlan Plus.

More time is also needed to allow sufficient opportunity for client and public education regarding MediPlan Plus, particularly client enrollment and patient grievance procedures.

2. The timetable is not workable and poorly sequenced. We had been concerned that IDPA was planning on putting virtually the entire program in place before your agency has approved the waiver. We were pleased by HCFA's September 29th letter that advised IDPA to stop the preliminary implementation steps they were about to embark upon. Encouraging the development of MCCNs; developing procedures for client education and provider selection; sending out client notices regarding the changes; and setting up all the other administrative structures for a program that may not be approved is expensive, confusing to patients, and bad public policy.

3. IDPA does not have an adequate plan for developing and assessing provider capacity. Assessing individual provider capacity is essential for proper patient enrollment and quality monitoring. IDPA has only addressed ways to assess Medicaid capacity, but IDPA can only determine provider's Medicaid capacity by first evaluating their total capacity. Without collecting data on Medicaid-certified providers, including office locations, total patient volume, etc., IDPA will be unable to make a serious attempt at assessing provider capacity and therefore unable to responsibly assign patients to providers or impose sufficient quality controls.

Specifically, we recommend that IDPA establish guidelines for the maximum allowable number of patients per physician and require providers to report the numbers of physicians per health care site and the amount each participating physician will commit to Medicaid practice. The waiver indicates that IDPA will only require compliance with HCFA publication *A Health Care Quality Improvement System for Medicaid Managed Care*: A Guide for States, which does not set specific standards for ratios of physicians to patients. HCFA should consider requiring that standards published by the U.S. Public Health Service concerning physician-to-population ratios and provider productivity be adopted by IDPA.

4. The monitoring mechanisms described are severely deficient. IDPA has allocated insufficient staff to monitor and evaluate program effectiveness, and there is no evidence that adequate data processing and management information systems have been - or will be - put into place to properly monitor and administer such a large and complex program as MediPlan Plus.

IDPA must be required to develop a comprehensive information system that will have the capacity to generate reports on key quality and access indicators. These reports must, on a routine basis, be made available to the General Assembly and the public to enable advocacy groups and other interested citizens to monitor the impact of MediPlan Plus on clients.

As part of the monitoring function, IDPA must establish more stringent requirements for marketing. Current Medicaid managed care marketing practices, including door-to-door marketing, marketing in local IDPA offices, and use of financial or material incentives must be prohibited. Additionally, IDPA should review all marketing materials prior to their use.

Cost Neutrality

Another criterion established in the *Policies and Procedures* is the cost neutrality of a proposal. We have several concerns in this regard:

IDPA's cost analysis is based on a reduction of its costs by 8% for managed care discounts. The state posits this is based partially on "relatively high utilization under the Illinois Medicaid program" currently. However, there is no documentation to support this. In fact, according to IDPA's own analysis, there are many Medicaid recipients who currently are not utilizing any services. This puts into question the underlying cost assumptions.

Assigning all eligible Medicaid participants a primary care provider will undoubtedly lead to an increase in demand for services. Although the waiver proposal estimates program growth during the five years of the demonstration project, it is unclear how much of the growth is projected to be associated with newly-eligible participants, natural growth of the APDC population, or anticipated increased demand of the existing population. Therefore, it cannot be determined whether the projections sufficiently account for increased demand.

Demand which exceeds program budget could have a serious detrimental effect on the quality of care for MediPlan Plus participants, as managed care providers could feel pressure to "cut corners" in their service delivery.

Evaluation

The recent DHHS *Policies and Procedures* place an emphasis on evaluation. We are concerned that the program design is not consistent with the stated goals, making it difficult to determine what precisely should be evaluated. One of the goals is to "test the efficacy of three models of managed health care", HMO's, MCCN's, and Gatekeeper Providers. Given the built-in disincentives for Gatekeepers (such as required co-payments, no "default" assignments when patients don't choose a provider, prohibition of outstationing while allowing HMO's to station workers in IDPA offices), MediPlan Plus does not provide a level playing field upon which to fairly judge the relative efficacy of the three models. This inequity will make it impossible for IDPA to fairly evaluate the three models.

The following issues, while not explicitly noted in the new DHHS *Policies and Procedures*, are of great concern to us:

Quality of Care

1. Continuity of care will be greatly compromised under IDPA's intent to swiftly implement MediPlan Plus. Despite IDPA's claims that MediPlan Plus should cause minimum disruption of the patient-provider relationship, to meet managed care enrollment deadlines, most Medicaid recipients will be steered to providers different than their current ones, disrupting care for patients and causing confusion and financial difficulties for community-based providers.

2. Key quality assurance and monitoring methods continue to be described only in vague terms. No additional monitoring systems have been sufficiently described in the waiver proposal to indicate that MediPlan Plus will be more stringently monitored than the currently-existing Medicaid system has been. Due to persistent concerns that many of us in Illinois have had regarding the quality of care offered by some of currently participating HMO's and private providers, it is imperative that any Medicaid restructuring proposal explicitly delineate quality assurance and monitoring mechanisms that go beyond existing systems.

3. Although not explicitly addressed in the waiver application, the October 14, 1994 draft Rules propose that to qualify as a participating "primary care physician", a physician only has to be licensed to practice medicine in Illinois. There are no requirements for board certification or board eligibility in a primary care specialty. This omission could result in serious quality of care issues. Without this requirement, there is great potential to find participating physicians with little training in primary care, critical expertise for physicians in a gatekeeper role. This is already a problem in low-income communities and will only get worse as specialist physicians find less a demand for their services.

Co-Payments

The co-payment component is ill-conceived and counter-productive. A co-payment for pharmacy will not reduce inappropriate use of prescription drugs, as a patient can only receive prescriptions drugs when prescribed by a physician. We know from the utilization patterns of the elderly and other patients with chronic diseases that many will respond to out-of-pocket requirements by either not having their prescriptions filled or spreading out their available supply over a longer period of time than for which they were prescribed. We also know that prescription drugs are one of the more cost-effective methods of treatment, and curtailing access to them may lead to an increase of more expensive interventions, such as inpatient hospital care.

If IDPA's concern is with patients who may seek care from multiple physicians to increase their access to noxious prescription drugs, IDPA would make greater progress by investing in an information system that would allow IDPA and participating providers to identify patients with excessive use of these drugs.

Client Enrollment

The client enrollment and client assignment procedures are confusing. The waiver application refers to "random assignment" of clients not choosing a provider, and at other times explains that clients will be assigned a default provider based on "geography and client-related needs." Default assignment procedures must be clarified to understand how MediPlan Plus will work, as client choice is a critical issue for the review of any Medicaid proposal.

Impact on the Public Health System

MediPlan Plus has the potential to weaken the public health system in Illinois. The waiver asserts that state support to local health departments will be maintained. It goes on to say that "over time, however, the state will work with managed care entities to assume more responsibility for assuring preventive services and the relationships between local health departments and the managed care entities will be more clearly defined . . ." An emphasis on managed care entities providing preventive services that have been traditionally delivered by public health agencies goes well beyond what a shift toward managed care would necessarily include. Increasing the role of managed care entities in preventive care without first assessing their capabilities would fragment the efforts of local health departments in prevention and would undermine our unique role.

On a practical level, it is unrealistic to expect managed care entities to take on preventive care. Our experience to date shows that many Medicaid managed care patients come to our facilities for childhood immunizations and other routine preventive care, either because they are directly referred here by the HMO, or do not believe they will receive the appropriate care through the HMO.

Thank you for considering our comments.

Sincerely,

Sheila Lyne, RSM
Commissioner

cc: S. Richardson, HCFA
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October 11, 1994

Ms. Barbara Cooper, Acting Director
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Oak Meadows Building, Room 220
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Baltimore, MD 21207

Dear Ms. Cooper:

The Illinois Department of Public Aid recently submitted an application to your office for waivers of certain sections of Title XIX of the Social Security Act. Illinois maintains these waivers are necessary for it to initiate the Illinois MediPlan Plus program.

We are writing to you to convey the Illinois Primary Health Care Association's very serious concerns that elements of the MediPlan Plus program will jeopardize access to high quality primary care services currently provided by the state's Federally Qualified Health Centers and will diminish overall access to and quality of care available to Medicaid beneficiaries covered by the program.

There are more than 100 Federally Qualified Health Center sites located in medically underserved areas throughout Illinois. These centers serve more than 500,000 patients yearly. More than one-half of these clients are eligible for Medicaid, making Federally Qualified Health Centers the largest single model of health care delivery serving these low income communities. Many health centers are the only providers of obstetrical and primary care for infants and young children in their communities.

Our Federally Qualified Health Centers employ Board-certified physicians and other licensed medical professionals who provide high quality, comprehensive, primary care services for predominantly low-income individuals and families. Federally Qualified Health Centers routinely provide case management, health and nutrition counseling, translation and other enabling services to assure the effectiveness of medical care.

National studies demonstrate that Federally Qualified Health Centers deliver high quality care very efficiently and make significant contributions to the overall health of low-income communities. Despite the poorer overall health of their patients, recent studies in New York, California, and

Maryland demonstrate that Federally Qualified Health Centers reduce total Medicaid spending for their clients resulting in savings of 30-35 per cent.

The Illinois Primary Health Care Association has consistently supported Illinois' goals to improve access to care, shift funds towards prevention and primary care, and expand managed care options for clients. Federally Qualified Health Centers have provided comprehensive primary care in managed care arrangements for more than a decade. Indeed, many of our health centers have formed a corporate network, Community Health Care of Illinois, for the purpose of facilitating greater health center participation in managed care. We are in no way opposed to the concept of managed care.

For more than a decade we have worked with the state to address the problems of quality, fraud and uncontrollable costs Illinois cites in its waiver request. (Illinois MediPlan Plus Waiver Request, pp. 1-2). Our 34 Federally Qualified Health Centers in 75 different sites ease the state's severe shortage of primary care providers and scarcity of sources of high quality primary care. Illinois' Federally Qualified Health Centers have consistently demonstrated their strengths at recruiting primary care providers to underserved areas, providing high quality preventive and primary care, and managing subsequent diagnostic, specialty and institutional services for Medicaid beneficiaries very cost-effectively ("An Ounce of Prevention...Community Health Centers in Illinois," Coalition for Consumer Rights, October 1989).

Yet with this current waiver application Illinois is embarking on a path that relies almost exclusively on a switch to capitated provider payments to rectify the critical access and quality problems facing more than 2 million residents of Illinois medically underserved counties (*Lives in the Balance*, National Association of Community Health Centers/Lewin/VHI, March 1993, p. 22). Little more than 18 months ago Illinois eloquently articulated these problems in its request for waivers to initiate the Healthy Moms/Healthy Kids program. In that document the state described its "unacceptably high" infant mortality rate of 15.6 per thousand in Chicago, its 30 per-hundred-rate of births requiring specialized perinatal services, its 3000 Chicagoans with measles, etc. (Illinois Waiver Request, March 31, 1993, p. 2). The Illinois Primary Health Care Association supported that plan to improve access to primary care, improve quality and continuity, and reduce unnecessary Medicaid expenditures by requiring clients to enroll for six months with Federally Qualified Health Centers, or selected primary care or managed care providers. The state promised an aggressive outreach

campaign and increased fees and rates to recruit more Illinois physicians and hospital clinics to provide care to Medicaid beneficiaries.

Despite its laudable purpose, Illinois has been unable to administer the program so that its objectives could be accomplished. One-and one-half years into the program, fewer than 60,000 of the 580,000 families targeted for the program have been enrolled. And the Department of Public Aid spent substantially more serving these few families than it had budgeted to serve thousands more. On several occasions your Department has raised its own concerns about the lack of state ability to adequately administer, monitor, and evaluate the Healthy Moms/Healthy Kids program. We ask that HCFA consider this recent record in evaluating Illinois' new proposal to undertake an even more radical departure from the federal laws that govern state Medicaid programs.

But Illinois' proposal to immediately enroll more than two-thirds of its Medicaid beneficiaries in managed care must also be seen in the context of its specific experience administering managed care contracts. Since 1974, Illinois has contracted with managed care programs and encouraged clients to enroll in them. The last decade has seen a steady dwindling of managed care entities willing to continue contracting with the state. While there were more than 10 HMOs, there are now only four, with only one joining in the last decade. Chicago HMO controls more than 90 per cent of the Medicaid HMO market. The 1990 GAO study of HMOs in Chicago documents the severe quality, utilization and administrative deficiencies, most of which have never been corrected ("Medicaid: Oversight of Health Maintenance Organizations in the Chicago Area, GAO/HRD 90-81, August, 1990). The program that serves about 120,000 current AFDC clients (about 10 per cent of those eligible) continues to be plagued by high client turnover rates, unethical marketing practices, inadequate quality standards and large numbers of HMO enrollees seeking care at public clinics and Federally Qualified Health Centers that can not deny care. Despite its current zeal for managed care, Illinois has not formally solicited bids for new managed care providers since its solicitation in 1984.

With this recent experience HCFA must question Illinois' ability to implement this research and demonstration project. With no additional staff authorized by the General Assembly to plan, manage, and monitor this project, and little progress on improving the management information system necessary to assure program quality and compliance, we do not believe Illinois can meet the State's implementation ability criterion, as stated in the General Considerations section of HCFA's recent Public Notice

(59 Fed. Reg. 49249, September 27, 1994) concerning §1115 (a) research and demonstration programs.

We hope that in your review of the Illinois waiver application you will consider the general administrative environment as well as the specific ways in which MediPlan Plus severely jeopardizes Illinois Federally Qualified Health Centers.

I. CLIENTS RIGHTS TO FQHC SERVICES SURREPTITIOUSLY THREATENED DESPITE LACK OF FQHC WAIVER REQUEST

Although the state is not requesting a waiver of Title XIX sections pertaining to FQHCs, the MediPlan Plus program will jeopardize Illinois' Federally Qualified Health Center infrastructure and will deny current clients their right to FQHC services. Illinois MediPlan Plus will have devastating consequences for Federally Qualified Health Centers and their Medicaid clients for several reasons.

MediPlan Plus subtly eliminates clients' right to FQHC services.

- Illinois proposes to require clients to select a medical provider (including FQHCs) or be assigned to a managed care provider. Although the waiver application includes FQHC services as a requirement for managed care entities (Waiver Request, p. 50), the state's proposed rules and most recent RFP for managed care providers does not include FQHC services among those managed care entities must provide (Request for Proposal HMOs and Managed Care Community Networks [Working Version], October 5, 1994, pp. 7-8). This is the only mandatory service that is not requested of the managed care entities or provided outside of the MediPlan Plus program.

- If managed care entities are not required to provide FQHC services, we questioned IDPA how this mandatory service was to be provided clients. Will IDPA require contracted managed care entities to pay for the service as an "out-of-plan" service? Or will IDPA cover FQHC services as a "carved out" service?

  The Medicaid administrator has informed us that managed care entities will not be required to pay for these services as out-of-plan services, nor will the state pay for managed-care-enrolled clients who still wish to receive FQHC services. He maintains that clients have the right to FQHC services if one is available in their area and they select it on the enrollment ballot IDPA plans to distribute this December. If clients select

an HMO or managed care community network, they are waiving their right to FQHC services. (Personal communication, September 29, 1994).

- We then requested that if clients were in effect waiving their rights to a mandatory service, would the state inform them of this in advance or on the selection instrument itself? The administrator has since informed us they will not add a notice to the selection ballot alerting clients that by selecting a managed care entity they will be waiving their right to FQHC services (Personal communication, September 29, 1994).

Illinois' plan would violate the federal mandate for states to pay for FQHC services under §1905 (a)(2)(C). To comply, HCFA should require Illinois to require managed care entities to offer FQHC services, either through contracts with FQHCs or to pay for them as out-of-plan services at the same rate the state would pay. Alternatively, IDPA should consider FQHC services another "carve out," as it does all children's hospital services, and pay FQHCs directly their reasonable costs for services rendered.

FQHC's opportunities to participate as managed care subcontractors will be limited.

- Illinois claims that under the "any willing provider" clause, FQHCs are assured of participation in managed care networks (Waiver Request, p. 48).

Based on three factors, IPHCA is certain that not all managed care entities will contract with interested FQHCs. First, under state law, all staff-model managed care entities are exempted from the "any willing provider" requirement (P.A. 88-554, Sec. 5-16.3 (d) (1)(A) and (B)). There is currently one such HMO contracted to enroll Illinois Medicaid clients. Second, managed care entities will have the many loopholes in the state legislation available to avoid contracting with interested FQHCs. State law only applies the contracting requirement to FQHCs and other providers that "consistently meet the reasonable terms and conditions established by the managed health care entity, including but not limited to... financial responsibility standards, contracting process requirements, and provider network size and accessibility..." (P.A. 88-554, Sec. 5-16.3 (d) (1)). The nebulous of these criteria offer little hope that interested FQHCs could force reluctant managed care entities to contract with them. Lastly, not all health centers are prepared immediately to engage in risk contracts with managed care entities. Time is needed to overcome decades of federal policies that prevented the accumulation of capital and

other prerequisites to assume risk under managed care. With the state's implementation schedule, Federally Qualified Health Centers will not have the necessary time to prepare.

We believe HCFA should require managed care entities to contract with interested Federally Qualified Health Centers and ask Illinois to eliminate the loopholes that managed care entities may use to prevent interested FQHCs from participating in managed care networks. Stringent federal standards for FQHC designation should provide adequate protection to managed care entities.

Enrollment process denies clients their right to enroll in Medicaid at Federally Qualified Health Centers.

Illinois plans not to permit potential clients from enrolling in Medicaid at Federally Qualified Health Centers in violation of §1902 (a) (55) of the Social Security Act. The state will require clients to select a provider under MediPlan Plus at their local IDPA office. The purpose of the outstationing requirement is to enable clients to complete their application for medical assistance benefits at the site they have selected for health care service.

This restriction is particularly problematic for homeless clients of our §340 grantee, Chicago Health Outreach. This program has exerted tremendous effort to identify and outreach thousands of homeless Chicagoans who are unlikely to enroll through a mailed selection ballot. These strides will be wasted if clients are not permitted to enroll at their provider sites.

We believe HCFA should require Illinois to amend its application to assure that clients can apply for Medicaid, including the selection of a provider under MediPlan Plus, at FQHC sites, as required by federal law.

Enrollment process unfairly discriminates against selection of Federally Qualified Health Centers.

- The details of Illinois plan to enroll clients in MediPlan Plus both initially and on a continuing basis will further discourage clients from selecting Federally Qualified Health Centers.
  - ¶ Illinois will permit HMOs to station workers at IDPA offices to market their plans (Waiver Request, p. 38). This provides an unreasonable advantage to HMOs which gain the state's imprimatur by their exclusive association with the official business of the state office.

- Clients selecting managed care entities will enroll as a family or "case." Clients selecting FQHCs or other gatekeeper providers will enroll individually, with each member potentially having a different provider. This provides yet another unreasonable disincentive for clients to select FQHCs.

HCFA should require that all participating MediPlan Plus providers, including FQHCs, have the same options to inform, recruit, and enroll clients under MediPlan Plus. HCFA should prohibit the state from discriminating against the FQHC model that is supported and carefully regulated by the federal government.

II. ILLINOIS PROPOSES A DANGEROUSLY UNREALISTIC IMPLEMENTATION SCHEDULE

Illinois Primary Health Care Association is extremely concerned about the schedule for planning and initiating Illinois MediPlan Plus. Many who testified at the legislative hearings concerning this program admonished Illinois to recognize the complex and difficult administrative tasks inherent in moving providers and clients to managed care systems. Providers from states with similar § 1115 waivers acknowledged disasters associated with rapid development and potential HMOs pleaded for adequate time to assess a new market and develop strong provider networks that can provide high quality care to this difficult population.

Despite this advice Illinois proposes to plan and initiate activities with less preparation time than nearly any other state. The development of the managed care entity contract, release of the managed care entity RFP, the bidders conference, contract negotiations and awards, mass client notification and printing and distribution nearly one million client enrollment ballots are all scheduled to occur in the next 90 days, well before even the most favorable estimates of when the §1115 waiver may be granted.

Adhering to the state's proposed schedule would result in IDPA announcing to clients and providers and initiating substantial changes in the way Medicaid services are delivered prior to the approval of the federal waiver, without which MediPlan Plus can not lawfully be initiated.

We believe that careful planning for changes of this magnitude and federal scrutiny of this application are essential. Announcing to clients and providers and initiating significant program changes in advance of likely modifications is unnecessarily disruptive to clients and providers.

III. UNREASONABLE AND UNNECESSARY DEFAULT ASSIGNMENT WILL DISRUPT CARE FOR HUNDREDS OF THOUSANDS OF MEDICAID CLIENTS

We strongly object to Illinois assigning Medicaid clients who failed to select a provider exclusively to managed care entities. Although the Illinois legislation authorizes such assignment to all participating providers (P.A. 88-554, Sec. 5-16.3 (c)), the waiver application reflects Illinois' intention to assign clients only to managed care entities (Waiver Request, p. 42). This will lead to a catastrophic disruption in patient care, as tens of thousands of current Federally Qualified Health Centers clients learn that they have been assigned to another entity and must seek care from one of their available network providers.

We also find the state's plans for default assignment unclear. While we object vigorously to mandatory assignment exclusively to managed care entities, the state's wording raises several questions. First, will IDPA assign clients to a specific provider within a managed health care entity? If so, on what basis? If not, how will the managed health care entity assure that clients who have been assigned involuntarily will select a provider within their system? Or how and on what basis will the managed care entities make the selection if clients do not select a provider on their own?

The waiver application uses "random," "proportionate" to provider capacity, and "based on geography and client related needs" to describe how it will assign clients. We need clarification about how this important process will occur. The application also does not describe how clients will learn of their assignment.

HCFA should require that any default assignments should be shared among all participating MediPlan Plus providers, including FQHCs, based on capacity.

HCFA should also inquire under what circumstances the "three provider rule may be waived after consultation with area hospitals ..." (Waiver Request, p. 41) before instituting mandatory assignment for clients who fail to make a timely selection. The legislation and description in the executive summary requires the department to consult but "consultation" is not defined.

IV. GOALS FOR ENROLLMENT IN Managed Care Entities ARE UNNECESSARILY DISRUPTIVE TO PATIENT CARE

We believe the first year goal of 70 to 90 per cent enrollment in HMOs or MCCNs (Waiver Request, p. 24) is incredibly ambitious and will disrupt the

continuity of care for the tens of thousands of current Federally Qualified Health Centers patients in Chicago. Moving from enrollment in managed care entities from slightly more than 100,000 to nearly 1 million in one year (and most of these in entities whose corporate structures or provider networks don't even exist less than five months before enrollment begins) is unrealistic or if achieved, excessively and unnecessarily disruptive to clients and providers.

The state claims that "transition to MediPlan Plus will not affect continuity of care for Medicaid clients...." (Waiver Request, p. 37) With the goal of up to 90 per cent enrollment in managed care entities the first year, MediPlan Plus will necessarily disrupt the care of many of the nearly 1 million IDPA clients switched into managed care. Since many of these clients are FQHC patients, this will wreak havoc with community health centers' health care delivery and fiscal stability.

HCFA should require the state to establish managed care enrollment goals that are reasonable and attainable without relying on large numbers of clients to default and be assigned to managed care entities. Specific goals and procedures for minimizing default assignments should be also be required.

V. Co-Payments are Unreasonable and Punitive

IPHCA also objects to the imposition of co-payments on this low-income, underserved population. The stated purpose of copayments is to "reduce the serious misuse of available medical services" (Waiver Request, p. 36). But this assertion is not substantiated in the Waiver Request nor is it apparent by comparing Illinois expenditure data to those of other states. Co-payments only real impact will be to discourage clients from enrolling with FQHCs and instead to enroll with managed care entities, in which case clients will be exempt.

The co-payment provision is punitive for both clients and FQHCs. If its purpose is to discourage enrollment in FQHCs as was stated in the state's August 17 draft Waiver Request, then it is an unreasonable intrusion in client choice.

With abundant documentation about the cost-effectiveness of Federally Qualified Health Centers, Illinois has no reasonable basis to discourage clients from enrolling in this federally-regulated model of health care delivery. If its purpose is to discourage clients from using prescribed drugs and x-rays, it is an unacceptable intrusion in the

doctor patient relationship. Which prescribed drugs or X-rays would Illinois want the client to go without because of the co-payment barrier. If the amount of the co-payment is so small that it will have not deterrent effect, why spend the money to administer such a complicated function? At the least Illinois should reveal how it plans to collect the co-payments and from whom and how much it will spend to do so.

VI. CAPACITY

The state claims that, "assignment will occur only in regions with sufficient capacity to support the managed care model." (Waiver Request, p. 37) Yet nowhere does it offer any hint of what standards will be used to determine provider capacity.

HCFA should require that Public Health Service standards concerning physician to population ratios and provider productivity standards be adopted and require that they apply to Medicaid beneficiaries as well as participating providers' private paying patients.

VII. INADEQUATE IDPA CAPABILITIES

Because of serious problems with the quality, competence and conduct of the largest Illinois Medicaid HMO, Illinois' ability to oversee MediPlan Plus is a major concern to Illinois Primary Health Care Association. Even the recent experience with Healthy Moms/Healthy Kids revealed that the state establishes unrealistic deliverable deadlines, finds it difficult to properly monitor and evaluate its contractors, has limited enforcement options other than contract revocation, allocates insufficient staff to monitor and evaluate program effectiveness and contractor performance, and has inadequate data processing and management information systems to properly monitor and administer complex programs.

There is no description of any additional staff and resource allocation necessary to administer Illinois MediPlan Plus.

We believe that a program change of this magnitude warrants that HCFA require Illinois to demonstrate that it has the additional staff capacity and new systems in place to conduct the program before the waiver is approved.

VIII. FQHCs NEED AND DESERVE REASONABLE COST PAYMENTS

Lastly, Illinois Primary Health Care Association must urge HCFA to recognize the value and cost effectiveness of the Federally Qualified Health Centers model of health care delivery and require Illinois to adjust

payments to FQHCs that provide care under managed care entity contracts. This is consistent with the Public Health Service recommendations for "the State shall pay directly to the FQHCs... the difference between the capitation rate by the health plan and the FQHC's reasonable costs." ("Bureau of Primary Health Care Section 1115 Waiver Requests, Issues and Recommendations," July 1994, p. 1)

Without the assurance of continued cost-based revenue for serving Medicaid clients, this model of health care delivery is threatened and several Federally Qualified Health Centers will likely cease to exist. This will lead to diminished capacity of high quality care in the communities most in need. IPHCA has suggested several ways for the state to recognize our financial needs in the context of managed care and we would like to see these incorporated into the final waiver.

Such adjustment payments would also help satisfy the pledge of "risk adjustment" (Waiver Request, p. 57). Although it is mandated in state legislation (P.A. 88-554, Sec. 5-16.3), IDPA's proposal does not include any adjustment for the actual mix of patients enrolled with a managed care entity, other than separate rates for age groups, gender, category of assistance and geographic location.

HCFA should require Illinois to pay FQHCs directly for the added costs of caring for a population with higher morbidity compounded by multiple problems characteristic of Federally Qualified Health Centers clients. Otherwise, there will be an added disincentive for managed care entities to contract with FQHCs who serve this population subgroup.

IX. ADDITIONAL CONCERNS

- To demonstrate cost neutrality Illinois reduces its anticipated costs by 8 per cent "for managed care discounts" (Waiver Request, p. 85). This "reduction in total costs... due to the market driven changes projected to result from the implementation of MediPlan Plus" is not justified. The state only adds the assertion, "Given the relatively high utilization under the Illinois Medicaid program, the 8% was viewed as reasonable." (Waiver Request, p. 85) There is no documentation to support that this targeted population has relatively high utilization now. Indeed, 300,000 people had no utilization during the last fiscal year whatsoever (Draft Waiver Request, August 17, 1994, p. 50) And much of the expert testimony during the House hearings warned of increased costs or at least no savings, especially early in Medicaid Managed Care demonstrations.

Furthermore, Illinois does not reflect the loss of the savings of 30% to 33% accrued for care currently provided by FQHCs that will be lost to the extent current FQHC clients select managed care entities.

- One of the requirements for managed care entities is that every primary care physician and pharmacy in the network "meets the Department's standards for accessibility...and quality of care." (Waiver Request, p. 29) We want to learn what these standards are to assure potential participation of FQHCs as MCE network providers.
  HCFA should require Illinois to engage in a public process to develop these standards prior to approval of the waiver and implementation of MediPlan Plus.

- There is unfortunate inconsistency between the goals of the program and the evaluation components. The Demonstration Goals, described in the executive summary beginning on Page 4 are not consistently articulated as the program's goals throughout the document. Nor are they directly related to the Evaluation Objectives beginning on Page 72. Indeed, the Evaluation Objectives seem to ignore the Demonstration Goal "to test the efficacy of three models of 'managed health care'...." Managing the health care of their clients is central to the Federally Qualified Health Center model. Our health centers have several decades experience managing this care Medicaid and other low-income clients.
  HCFA should require the state to evaluate the FQHC model and compare it with other health care delivery models as part of this program. By not assigning clients to FQHCs and including the testing of the model as a component of the evaluation, the research potential is compromised.

- The selection criteria for Managed Health Care Entities (Page 31) includes the assurance "that the viability of essential providers is maintained."
  HCFA should require IDPA to set viability standards and explain how it will accomplish this.

- The application includes provision for "FQHCs and RHCs to earn up to 105% of their rate ... if they meet standards designed to measure effective care and reduce costs." (Waiver Request, p. 34) Utilization targets, EPSDT standards, emergency room utilization and hospital stay targets are not defined.
  HCFA should require the state to establish these standards before granting the waiver and the program is permitted to begin.

- The state will require MCE's provider networks to establish grievance committees with "at least 50% representation by network providers, at least one enrollee, ..." (Waiver Request, p. 65)
  This membership structure does not offer enrollees a reasonable likelihood of satisfaction with their concerns.

- The list of reasons to establish good cause to change providers within the 12 month lock-in is extremely limited and unless expanded will result in many clients resorting to public facilities and Federally Qualified Health Centers which can not deny care.
  We propose that Illinois also add "persons who are homeless or have become homeless" to the list of good cause reasons so they can receive services from our §340 provider.

We look forward to working together with HCFA, PHS and the state to improve access to primary care for Medicaid clients and provide clients with high quality cost-effective services. We stand ready to work with you to assure that the Illinois' goals are met without sacrificing the high quality care clients receive through the existing Federally Qualified Health Centers infrastructure.

Sincerely,

Len Sharber

Len Sharber,
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