

**MEDICAID AND CARE COORDINATION**  
***HEALTHY HOSPITALS = HEALTHY COMMUNITIES***

**Hospitals support the State moving forward with provider-based models to improve the coordination of care for Medicaid enrollees.** Enhancing the current successful Primary Care Case Management (PCCM) program holds the greatest promise to improve quality and access for patients while controlling costs for the state. The State should continue and improve a proven model instead of starting over and incurring the startup costs associated with a new model.

Medicaid Reform Goal: Under the State's Medicaid Reform legislation, 50% of Medicaid beneficiaries are to be enrolled in a care coordination program by January 1, 2015. Such care coordination programs can and should include provider-based programs where hospitals, physicians and other collaborating providers have some financial risk based on the quality and efficiency of the care they provide to their patients.

**Build on the current Primary Care Case Management (PCCM)** program to satisfy the 50% care coordination requirement. Incentivize providers to coordinate patient care and thereby reduce unnecessary utilization (ER visits, duplicate testing, hospitalizations, etc.).

- The current PCCM program has 1.8 million Medicaid beneficiaries enrolled with a primary care provider. This program is estimated to have saved Illinois over \$400 million from 2007 to 2010. Let's build on this success.
- With the PCCM program, the savings benefit the State, not an HMO.
- North Carolina has had a PCCM program for many years that has been very effective in improving quality and containing costs.
- Connecticut recently announced that it was abandoning its heavy reliance on Medicaid HMOs finding that they had not delivered on their quality or cost savings promises.
- This approach is consistent with federal health reform and Medicare which is encouraging providers to share risk for providing high quality cost-effective care.

**HMOs are not a Silver Bullet solution.** Simply mandating all Medicaid beneficiaries into an HMO will not solve the State's budget challenges.

- Many states with higher Medicaid HMO enrollment are spending more per enrollee than Illinois. With Illinois' low reimbursement rates, how will HMOs achieve savings? How will access to care be affected?
- Illinois tax dollars should be used to fund care, not HMO overhead and profits (typically about 15%) especially for firms located outside of Illinois.
- Patient and provider protections will be needed to assure access and protect against past problems with Medicaid HMOs, such as going insolvent or improperly denying services to beneficiaries.

**The Hospital Assessment should not be used to finance HMO payments.** Hospitals are opposed to paying an Assessment that is used to finance payments to HMOs and then negotiating with HMOs over rates. Hospitals would have no assurance that their community will benefit from paying the Assessment. **Such a system could result in substantial redistribution of dollars from one community to another.** How will the State replace the \$900 million annual Hospital Assessment?

Hospitals have a bricks and mortar commitment to their communities – they are there in good times and in bad.

**Expand Care Coordination through Provider-Based Programs and the PCCM Program.**