Illinois Health and Hospital Association

Statement of the
ILLINOIS HEALTH AND HOSPITAL ASSOCIATION

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**Vice President, Managed Care**
**Hospital Sisters Health Systems**

**Joint House Human Services Appropriations and Human Services Committees**

**The State of Illinois Medicaid Managed Care Organizations Request for Proposals**

**Room 114, Capitol Building**
**Springfield, IL**

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**HSHS Testimony for House Appropriations- Human Services**

*March 9, 2017*

Good morning, my name is Dan Hoodin. I serve as the Vice President for Managed Care for Hospital Sisters Health System. Thank you for the opportunity to share input on Illinois' managed care system for Medicaid clients.

HSHS has nearly 9,500 colleagues providing care at nine hospitals, three Rural Health Clinics, and scores of physician offices across central and southern Illinois. In 2016, HSHS provided services to more than 82,500 individual Medicaid Beneficiaries.

HSHS supports care coordination for all our patients. We believe the key to improving Medicaid in Illinois is better consistency and better care coordination.

HSHS also supports the Department of Healthcare and Family Services' decision to issue a request for proposals to replace the current Medicaid Managed Care program. As HFS contracts with MCOs across the state, we believe the department should use the opportunity to correct long-standing operational issues that providers have experienced with MCOs related to timely authorizations for treatment, payments and credentialing. Because HSHS operates health care facilities in both mandatory assignment areas and in areas that still operate under fee for service, we support moving toward a uniform managed care program across all 102 counties where all MCOs operate under the same standards for accountability.

By moving to a single state-wide system, the question of network adequacy can be addressed more effectively without artificial borders. Not only should distance and travel time be addressed in any network adequacy requirements, but available providers/services per 1,000 members needs to be included in any criteria, with attention to open practices and quick availability for urgent needs. Otherwise, continued inappropriate use of expensive emergency services for primary care will continue.

We believe that in order for the expansion of Medicaid Managed Care to be successful, there must be resolution of the many claims issues that exist with the current program. One way to resolve the payment issues is for each contracted MCO to be required to follow the Medical Management, claims payment policies and procedures, including appeals, of traditional Medicaid. With consistency in the reimbursement process, both the MCOs and the provider community can focus on improving the health of the Medicaid beneficiary through aligned incentives and true care coordination.

HSHS also strongly supports and applauds the current HFS efforts to standardize credentialing across all the MCOs and urges HFS to continue to work toward a single, standardized credentialing program that sets clear standards for how services provided by health care professionals who are in the credentialing process will be paid. The MCOs should also follow the HFS practice of allowing the provider to see Medicaid beneficiaries and paying for those services once the provider completes the credentialing process.

Standardizing the criteria for medical management decisions, using set criteria such as either InterQual or Milliman can reduce the variation of care, one of the biggest factors leading to increased costs. For a provider, having a clear understanding of the criteria to use is central to providing consistent care. Rapid response to requests for authorizations, measured in hours rather than days or weeks, available 24/7/365 will greatly reduce the impact of disease upon the beneficiary.

With standardized criteria, Providers can provide timely information for medical management approvals from the MCOs -such as authorization for key services. Authorizations need to be provided quickly - within 24 hours in urgent situations and within 72 hours for non-urgent requests. The current work being done by the MCOs and IHA representatives to standardize the authorization request form, which should continue, is one example of how we can improve the process through standardization. Under the current MCO contract with HFS, the MCOs have days in urgent situations and weeks in non-urgent situations to provide a response to requests for authorizations. Too often, care has already been provided and the patient discharged or moved on to the next care situation before the authorization approval or denial is received.



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With credentialing and claims payment standardized and consistent across the State, the MCOs and providers will then be free to concentrate their efforts on aligning the incentives in the contractual relationship to coordinate care and improve the health of the Medicaid beneficiary.

The focus of any contract between MCOs and providers is to align incentives rather than just fee for service, where the provider is set up for value based contracting. This means more than just fee for service with a few quality measures being reported on an annual basis or capitating the providers, neither of which aligns the incentives for how to provide care between the MCO and providers. At a minimum, quality bonuses, shared savings or shared risk contracts with quality measures, do align incentives between the MCO and the provider group.

The goal with managed care should be to have all parties working together on behalf of the patient.

As an example, MCOs, in coordination with hospitals and physicians should have processes in place where discharge planning begins upon notification by the hospital that its member has been admitted through the emergency department, or upon the granting of the authorization for an elective admission. The hospital should not be penalized financially if the MCO is unable to place the beneficiary in an appropriate post-acute care setting. There should be some level of additional payment at a reduced rate for those patients who no longer meet in-patient criteria, but the MCO is unable to place, for any reason, in a post-acute setting.

The free exchange of information between the MCO and the provider is a key component to improving the health of the beneficiary. Quality and utilization are not only the focus of the State's interest, but of the providers as well. The same information supplied by the MCOs to HFS should also be provided to the physicians and facilities providing care. Beginning with monthly reporting of assigned beneficiaries to the PCP, along with State directed minimum quality and cost reporting and other mutually agreed upon quality and cost information, should be shared with the providers responsible for the care of the beneficiary. Secure on-line computer access to real time information concerning quality and cost is pivotal to being able to deliver real health improvements to beneficiaries. Individual physicians and hospitals only see a portion of the overall care provided to a beneficiary, and can improve their operations from both a quality and cost perspective with complete information on all the care received by the Beneficiary.

Routine Joint Operating Committees (JOC) should be required by the State, to address any operational issues that arise, before they become problems. Generally, issues will arise over the application of Medical Management criteria and how to resolve any questions about the care patients should receive.

In conjunction with Joint Operating Committees is the ability to appeal a denial, whether for a request for authorization for services, incorrect payments (either paying too much or too little) in a rapid and orderly manner, with written determinations that clearly state the reason for the denial, sent to the provider. The written determination should include how to appeal to the next stage of the process for appeals of any denial.

The key to the future of Managed Medicaid is to standardize the administrative functions so the focus is on improvement of the beneficiaries' health through care coordination and the reduction of the variations in the provision of care. Working together to get the Beneficiary in to see their Primary Care Physician for an annual wellness exam is a key first step in the effort to avoid the onset of disease and closing the gaps in care when the beneficiary transitions from one care setting to another. A greater focus on preventative care and early interventions will result in not only an improvement in the health of the population, but in a reduction in the cost trend.

HSHS continues to work closely with the remaining MCOs in our service area to resolve any operational or administrative issues. We hope that HFS will continue to work with the MCOs that may not be selected under this RFP to require that they continue to comply with the prompt pay requirements and make timely final resolution of issues during the runout phase and after their contract with the state has expired.

HSHS remains committed to delivering high quality, affordable health care to all residents in the downstate communities we serve and it is our hope that new Medicaid contracts with MCOs will support those efforts.

Thank you for this opportunity to testify today.



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