Illinois Health and Hospital Association

Statement of the
ILLINOIS HEALTH AND HOSPITAL ASSOCIATION

Thursday, March 9, 2017

Patrick Gallagher
Senior Vice President
Health Policy and Finance
Illinois Health and Hospital Association

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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Good afternoon Chairman Harris, Chairwoman Gable and Minority Spokeswoman Bellock and members of the House Human Services Appropriations and Human Services Committees. I am Patrick Gallagher, Senior Vice President, Health Policy and Finance at the Illinois Health and Hospital Association (IHA). On behalf of the over 200 hospitals and 50 health systems that are members of IHA, I would like to thank you for holding a hearing addressing the recent release of a Medicaid Managed Care Organization Request for Proposals (RFP).

IHA appreciates the ongoing efforts by the Department of Healthcare and Family Services (HFS) to address a wide range of clinical and operational issues. In particular, we commend HFS for its recent efforts to:

- Report on Medicaid MCO performance, both from a quality standpoint and an operational perspective.
- Implement HFS' MCO Performance Benchmarks as a step in the right direction of increased HFS oversight of the MCOs.
- Document provider complaints of MCO performance through an HFS provider portal.
- Implement a single credentialing vendor to process provider applications for much needed standardization.

The RFP will provide a consistent format by which MCOs interested in bidding for additional Medicaid business will be able to clearly articulate their unique capabilities. In particular, the RFP includes the following beneficial components:

- A scoring approach that requires bidders to demonstrate documented expertise in areas including overall approach to healthcare quality, access and cost; information technology; innovation in payment models; operations and care coordination philosophies;

- Emphasis on increased standardization in processes to streamline and reduce complexity for members and providers;
- Requiring managed care organizations to share specific examples of operating innovative, value-based models with network providers;
- Awarding overall RFP points for technical and clinical capabilities that are significantly larger than the financial component, which emphasizes the need to have a robust and comprehensive managed care platform in order to implement a high-performing managed care program.

IHA recognizes the state's desire to expand the mandatory managed care program, but before managed care is expanded into new populations and geographic regions, existing problems need to be fully resolved. We therefore recommend that systemic and chronic issues be addressed and resolved prior to expansion of managed care statewide:

- First, providers are still experiencing a wide range of issues including lack of timely payment, inappropriate claim rejections, lack of timely provider credentialing, cumbersome prior authorization requirements, lack of timely communication from MCOs regarding care coordination needs, and network adequacy issues that have impacted access for beneficiaries. While progress has been made to resolve outstanding issues, the pace at which resolution is being achieved is still slow. Further expansion of managed care without fundamental system and operational fixes could further exacerbate issues.
- Second, expansion of the populations included under the new program, specifically special needs children who are eligible for Medicaid through Supplemental Security Income (SSI), Divisions of Specialized Care for Children (DSCC), or children in the care of the Department of Children and Family Services (DCFS). The existing care coordination structures designed to serve the Affordable Care Act (ACA), Family Health Plan (FHP), and Integrated Care Program (ICP) populations have proven to be difficult with a lack of effective communication between MCOs and providers. We have a concern about the MCOs readiness to serve additional, high-need populations, when the initial populations are still not being adequately served. At a minimum, we believe the RFP should further delineate how MCOs are prepared to serve these additional populations.
- Third, from a timing perspective, based upon the RFP timetable, selected bidders would have approximately six months to fully implement a statewide model. Such development is challenging under any circumstances; however six months may not be sufficient time to adequately rollout a statewide network. MCO efforts will be increasingly focused on new network development rather than resolving long-standing provider issues. We request that HFS reconsider the RFP timeframe to allow for adequate resolution of issues that have been presented to the MCOs.

- Additionally, IHA would ask that HFS provide additional guarantees as to the ability and willingness of those MCOs that may not be selected under this RFP to ensure final resolution of issues after their contract with the state has expired. Providers are still trying to resolve issues from 2014, and there is a fear that MCOs that are unsuccessful bidders will have little incentive to resolve these outstanding issues.

While HFS intends to reduce the number of MCOs, the real key to a successful program is creating the proper incentives for the MCOs to perform and be held accountable. We encourage HFS to explore additional options for monitoring and oversight, particularly in the way of performance incentives and requiring corrective action plans when specific quality or operational targets are not met. Corrective action plans should incorporate financial or administrative penalties such as financial withholds. The model contract should incorporate provisions covering operational areas such as the following:

- Credentialing and re-credentialing of providers. The model MCO contract for selected contractors should have specified timeframes that MCOs must meet. Untimely credentialing delays the ability of beneficiaries to receive prompt medical care and creates a network adequacy issue. MCOs that fail to meet specific performance metrics, such as credentialing completed within a 30-day timeframe, should be subject to financial sanctions.
- Claims payment time frames. The contract should ensure that MCOs meet specific standards for the payment of clean claims within specific time frames. Best practices in other states with Medicaid managed care use ranges from 90% of clean claims to be paid within 30 days to 99% of clean claims to be paid within 90 days. This would provide some predictability in knowing what standards the MCOs are required to meet.
- Prior authorization timeframes. The contract should require timely processing of requests to approve medical services, in which standard, urgent, and expedited requests from providers are periodically reviewed and appropriate actions are taken when MCOs do not follow specific requirements.
- Provider Grievance and Appeals. The model contract should have an established policy and procedure for provider appeals and grievances including provider obligations and expected timeframes.
- MCO infrastructure. The contract should specify the requirements necessary to support day-to-day operations. This should include everything from eligibility verification to claims processing to prior authorization and case management. MCOs should be required to have claims portals that provide the ability to check claims status on an open-ended number of claims. Also, HFS must move as expeditiously as possible to a new Medicaid Management Information System that will reduce administrative costs to providers and the MCOs.

Finally, while an improved contract with greater MCO accountability will help lessen the administrative burden that has been imposed on providers, greater auditing of MCO performance is still needed. It will be critical to periodically audit MCO performance in the areas of claims rejections, denials, provider credentialing and timeliness of prior authorization.

IHA believes that a managed care model ultimately can work in the State of Illinois and deliver improved clinical results and outcomes as well as reduce overall costs in the system. However, we firmly believe that further accountability of MCO performance is needed - either through penalties or other incentives that are aligned with specific expectations of MCO performance.