



July 1, 2011

Submitted via email: hfs.webmaster@illinois.gov

Julie Hamos, Director
Illinois Department of Healthcare and Family Services
201 South Grand Avenue East
Springfield, IL 62763-0002

Dear Director Hamos:

Molina Healthcare, Inc. (“Molina Healthcare”) is pleased to offer the following comments as requested by the Illinois Department of Healthcare and Family Services (“HFS”) for the Coordinated Care Program.

Molina Healthcare has over 30 years of experience serving patients who have traditionally faced barriers to obtaining quality healthcare, primarily individuals covered by Medicaid, the Children’s Health Insurance Program (“CHIP”) and other government-sponsored health insurance programs. Molina Healthcare’s operations in ten states currently serve over 1.6 million low-income, vulnerable individuals. Molina Healthcare also serves as the fiscal intermediary in five states covering another 2.8 million beneficiaries.

Molina Healthcare recently received licensure as a Health Maintenance Organization (“HMO”) in the State of Illinois and anticipates participating in future Medicaid managed care opportunities.

Molina Healthcare appreciates the efforts made by the HFS to ensure that the healthcare system is accessible and affordable to millions of Illinoisans. The following information reflects Molina Healthcare’s decades of experience related to care management and how that experience should inform strategies for implementing the Illinois Coordinated Care Program.

1. How comprehensive must coordinated care be?

The Coordinated Care Model

As detailed below, in order to meet the health care needs of low-income families and individuals in the most effective and cost efficient manner while also optimizing access to appropriate care for the beneficiary, coordinated care contracts should require entities to arrange for the full spectrum of health care benefits, including physical and behavioral health services, pharmacy and related ancillary benefits.

In states where full-risk managed care models for Medicaid beneficiaries have been adopted, managed care organizations have consistently demonstrated the ability to generate savings while enhancing quality and access to care. Coordinated care models utilize accessible and diversified provider networks, robust information systems, quality improvement programs and risk management strategies to deliver the appropriate care in the appropriate setting. In fact, an analysis by The Lewin Group suggests that the Medicaid managed care model typically yields cost savings even among high-cost populations.¹

Evidence demonstrates that Medicaid members have unique social and health care needs that are best met through Medicaid-focused managed care health plans. Specifically, Medicaid members face transportation, language and other socio-economic barriers that can impede access to necessary care. Managed care health plans that are focused on the Medicaid member are equipped to meet these needs in ways that other providers are not. For example, Medicaid managed care plans have broad access to information related to services received by their members enabling coordination of comprehensive health care services that take into consideration multiple aspects of the member's health. Therefore, Molina Healthcare encourages the State to allow managed care entities to be responsible for the full continuum of coordinated care, including mental health and chemical dependency.

Pharmaceutical Benefit Coordination

Molina Healthcare supports including pharmacy benefits in the coordinated care contracts and believes that the inclusion of all services provides for a better program by allowing a single entity to fully manage and coordinate care for the beneficiary. By including pharmacy benefits, the incentives of prescribers are better aligned with the cost containment goals of the State and managed care entities are able to coordinate care with complete knowledge of the patients' history of care and prescription drug usage. Studies have shown that managed care provides drug coverage in a more cost-effective manner than fee-for-service programs, via formulary management, high generic fill rates, comprehensive drug utilization reviews, and integrated coordination of care. Managed Care Organization ("MCO") formularies are created specifically to ensure that the list of drugs is administered as intended and utilizes reports that are routinely reviewed to make sure all coding is consistent with formulary requirements.

HFS should provide managed care organizations with the flexibility to manage their own formularies and utilization review programs and should refrain from implementing a single, statewide formulary. Also, HFS should not mandate particular drugs from which

¹ The Lewin Group, *Medicaid Capitation Expansion's Potential Cost Savings*. April 2006.

providers must prescribe. MCOs should be given the flexibility to customize pharmacy utilization management programs to ensure the cost-effective and safe use of drugs. Formulary management is one of the key tools that managed care organizations successfully use to control pharmacy costs and ensure appropriate utilization of pharmaceuticals, thereby helping to serve the state's best long-term pharmacy cost management interests.

Provider Incentives

As of a condition of participation, coordinated care entities should be required to establish relationships with a broad, diverse network of healthcare providers so that enrollees will have access to all Medicaid covered services. However, as history shows, even with an extensive network of providers, some out-of-network services will occur for a variety of reasons. In the absence of a contract or state regulatory guidelines, charges to coordinated care entities, and ultimately the state's Medicaid program, for these out-of-network services are often significantly higher than the fee-for-service rate schedule, which can ultimately increase overall Medicaid costs.

Molina Healthcare has long advocated that out-of-network payments should be tied to the Medicaid fee schedule. Further, Molina Healthcare suggests that the limit for out-of-network services should be no more than 95% of the Medicaid fee schedule so that there is an incentive for providers to contract with Medicaid organizations and the state's contracted coordinated care entities. Allowing out-of-network payments to be based on alternative arrangements impedes the goal of cost containment and discourages providers from participating in Medicaid MCO networks, thereby adversely impacting access and quality of care.

2. What should be appropriate measures for health care outcomes and evidence-based practices?

In order to maintain quality of services delivered to Illinois Medicaid beneficiaries by managed care organizations, Molina Healthcare recommends that HFS require that all managed care organizations maintain National Committee for Quality Assurance (NCQA) accreditation and that Healthcare Effectiveness Data and Information Set (HEDIS) quality metrics measurements be adopted.

Molina Healthcare recognizes the importance of utilizing uniform standards of care and measurements as an important policy mechanism to eliminate inconsistencies that make it difficult to compare outcomes and success rates of various care models. Molina Healthcare recommends that the HFS require a similar commitment from its contracted

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coordinated care organizations to ensure consistent demonstration of a commitment to improve quality through measurement and reporting.

According to the Agency for Healthcare Research and Quality (AHRQ), HEDIS measures are widely used by state Medicaid agencies to assess their contracted Medicaid managed care plans. Molina Healthcare recommends that the HFS adopt specific, standardized existing measures that have been developed by specialists and experts in the field and are already widely utilized.

The HFS should further ensure that quality of care is measured along the care continuum with focus on patient outcomes. Measures selected for the program should address each component of the triple aim – cost, quality, and patient care. With time, quality measures may come to include efficiency factors as well such as risk adjusted medical utilization and cost.

As policymakers work to address quality of care in the Medicaid program, it is essential that new requirements are streamlined with existing standards to limit the burden on providers and health plans. Finally, Molina Healthcare recommends that similar data reporting standards and methodology is used for both Medicaid managed care and Medicaid fee-for-service to allow the state to conduct valid comparisons.

3. To what extent should electronic information capabilities be required?

A critical building block for enabling electronic information sharing rests with the health care providers' ability to develop and maintain the electronic health information concerning their patients.

Currently, the healthcare industry is migrating providers from paper-based health records to a system that stores health information electronically and employs computer-aided decision support systems. In part, this is due to a growing recognition that a robust information technology (IT) infrastructure is integral to addressing concerns related to improving the safety and quality of health care and rising health care costs. The efforts of all parties to advance the deployment of Electronic Health Records (EHR) systems, would benefit from a common set of expectations about electronic information capabilities and the functional requirements that would need to be met over a specific period to enable collective information sharing.

Initially, the HFS should provide an EHR backbone for taking paper records and turning them into EHR immediately. This would (1) improve patient care, (2) make electronic records available to compliant providers instantly, (3) better-highlight the practice

benefits of EHR to slower adopters, and (4) more rapidly move providers to the new technology. This could be funded by a per-record fee charged to non-compliant users that would be eliminated should such users become compliant. Alternatively, the Department could bid this infrastructure out to a private contractor who would provide the services on a fee-for-service basis.

As all providers have operational variances, the state must also recognize that each provider will have access to and utilize different resources to demonstrate meaningful use of the utilization of electronic information capabilities. This is especially true for provider networks that primarily focus on financially vulnerable populations. For example, at Molina Healthcare, we provide services to patients who have traditionally faced barriers to obtaining quality healthcare and who are under-insured or uninsured. In general, physician providers in networks dealing with underserved populations may be less technically advanced than others due to reimbursements being typically less than the commercial population.

4. What are the risk-based payment arrangements that should be included in care coordination?

Risk-Based Arrangements

Molina Healthcare supports a risk-adjusted, capitated payment care coordination model which has proven to be successful in saving Medicaid program funds and that could significantly reduce the rate at which Medicaid expenditures are increasing. Previous experience has also demonstrated that some providers are not equipped to handle financial risk and allocation or full capitation arrangements. While shifting risk is an effective way to manage costs, it works only when the entities taking on risk have a secure financial position and are able to accept capitated risk. Unlike MCOs, very few provider organizations are large enough or have the infrastructure to manage global capitation.

In the 1990s, the state of California experienced an unprecedented number of providers take on risk for delivering care, which in turn led to the rapid expansion and ultimately the failure of many under-capitated risk-bearing organizations. Provider insolvency became such a large problem that the California Legislature enacted laws that require providers who accept financial risk to obtain a license similar to that of an HMO. Risk-bearing arrangements have broad implications for the stability of the healthcare market and for beneficiary access. For these reasons, reasonable barriers to entry, vigorous regulations and strict solvency requirements must govern risk-taking for coordinated care models.

Medical Cost Ratios

Although Molina Healthcare supports the principle that an appropriate amount of the health care dollar should be spent on medical costs, we oppose setting a mandatory minimum Medical Cost Ratio (“MCR”) on health plans. Little information is typically provided about how an appropriate minimum MCR is determined and there is no evidence that any numerical MCR correlates to better or higher quality care. Mandating an MCR will also not lower the cost of health care and in fact will discourage efficiency in the short- and long-term. It may be possible to mitigate some of the efficiency issues by allowing health plans with appropriate quality measures and low medical cost ratio to reinvest the “savings” into health care improvement efforts or health-related community programs.

Medical Cost Ratio requirements may also penalize health plans that provide effective quality health care for patients and better manage utilization of services. Medicaid health plans have been working to implement case management strategies such as disease management, care coordination, prevention and wellness programs, and other service programs that improve care and health outcomes. However, these additional services often increase administrative costs which may lead carriers to eliminate or reduce these important services. Therefore, establishing a mandatory minimum MCR impedes the use of such important services as disease management, utilization management, quality assurance and improvement initiatives, or improved health information technology.

5. What structural characteristics should be required for new models of coordinated care?

Participating coordinated care providers should be required to hold Department of Insurance certification thereby demonstrating that they are bound by a legal structure that ensures their ability to take financial risk and contract with providers and suppliers that meet program requirements. Certification ensures health plans are in compliance with operational requirements that are subject to monitoring by state regulators and makes health plans subject to periodic comprehensive quality assurance evaluation by a third-party reviewing organization and generally by the insurance department. Most health plans must also submit quarterly and annual statutory financial statements and utilization reports, as well as other required reports. For these reasons, health plans are stable, operationally proven models to participate in the coordinate care program.

Medicaid MCOs also provide for greater continuity of care and coordination at the point of service than traditional fee-for-service Medicaid. Managed care organizations give

beneficiaries the benefits of a medical home with access to programs such as case management, disease management, wellness and health education, and transportation services. Considering the characteristics of the Illinois population and of both current and projected economic and budgetary factors, federal and state agencies must consider innovative coordinated care solutions that achieve the simultaneous objectives of maintaining high-quality care for Medicaid eligibles while stabilizing expenditures. Molina Healthcare's fully-integrated, full-risk capitated managed care model provides the following coordinated care benefits:

- Allows for the creation of a team-oriented, multidisciplinary comprehensive care coordination model for the member, which has been demonstrated to produce better outcomes when compared to the fragmented care coordination services delivered under fee-for-service or less comprehensive models;
- Promotes the development, implementation, and maintenance of individualized care plans and the establishment of a point-of-contact that facilitates the coordination of care between providers and other stakeholders, resulting in prioritized delivery of necessary services and therefore improved member satisfaction;
- Improves programmatic evaluation capabilities from all stakeholders' perspectives, minimizing the number of participants and/or programs to be reviewed;
- Improves access to care by leveraging the contracted network of providers that can be made readily available to the member;
- Results in improved outreach programs that support substantial education efforts, which promotes successful program implementation; and
- Aligns managed care organization and regulatory incentives by preventing unnecessary and/or long-term admissions to nursing facilities and promoting increased utilization of Home and Community-Based Services (HCBS), thus accomplishing the objectives of reducing costs and slowing cost-shifting between Medicaid and Medicare while providing care in the least restrictive setting.

6. What should be the requirements for client assignment?

Auto-Enrollment

In an effort to provide coordinated quality care at a lower cost to states, Molina Healthcare supports mandating the use of managed care for Medicaid beneficiaries. With auto enrollment, managed care organizations are in a position to identify the health care needs of individuals as early as possible, thus helping to avert costly treatments and the poor outcomes that often accompany untreated or poorly-managed medical conditions, including high-risk pregnancies. Molina Healthcare recommends that the HFS require its contracted health plans to auto-assign members to primary care physicians (or specialists assuming the primary care physician (PCP) role) when they do not make an active PCP choice to ensure each member is assigned to an appropriate medical home. This process should assign PCPs to members in accordance with programmed auto-assignment criteria, such as provider specialty, members' age/sex, provider distance from members' residence, members' PCP history, and members' primary language. The health plan should be responsible for clearly communicating to the member the PCP assignment and for addressing any issues and questions.

A phased-in auto-enrollment approach based on volume and geographic region may be necessary to enable contracted MCOs to collaborate with HFS and other state agencies, make initial contact with dual eligible members to determine transition of care needs, arrange for continuation of services, and communicate with providers and community-based groups to develop a solid collaborative foundation to ensure successful transition into the coordinated care program.

Aged, Blind and Disabled Enrollment

While the Aged, Blind, and Disabled (ABD) population typically makes up a small percentage of Medicaid beneficiaries, they represent one of the highest-cost categories within the Medicaid program. In an effort to improve care coordination for this special needs population, Molina Healthcare recommends that the ABD population also be auto-enrolled in a Medicaid managed care program. These individuals typically require extensive services, care management and coordination. Managed care plans, such as Molina Healthcare, provide better access to care and will provide the necessary services and benefits to meet the unique needs of this and other high-cost populations. Requiring that the ABD population is enrolled in managed care will enhance the healthcare services coordination for beneficiaries while reducing costs.

7. How should consumer rights and continuity of care be protected?

Molina Healthcare believes that substantial weight should be given to the special circumstances of low-income populations as the HFS designs and implements the coordinated care program to ensure continuity of care. Health plans and providers that have traditionally served Medicaid beneficiaries have vast experience in delivering effective health programs and benefit packages for low-income populations that make them uniquely qualified to serve these individuals.

Health Insurance Exchanges

Medicaid health plans should be given the option to participate in state Exchanges without negatively impacting their ability to contract with a state to provide Medicaid benefits for eligible beneficiaries. Experts anticipate a large number of participants will move between the Exchange and the Medicaid and CHIP programs, and some suggest this movement may be more seamless if Medicaid health plans are participants in the Exchange.

Molina Healthcare focuses exclusively on serving a vulnerable population that relies on government-funded health programs. As such, it is better equipped to provide the specialized care and services the Medicaid and CHIP populations require. Should health plans with Medicaid contracts in Illinois be required to participate in the Exchange, many not-for-profit and Medicaid-specialized health plans like Molina Healthcare (that do not offer commercial products) may be pushed from the marketplace as they may not be able to compete against larger, multi-line plans with significantly more experience and back-office capacity in the commercial market. As a result, the quality and continuity of care, and access provided to the Medicaid population may be jeopardized.

Basic Health Plan

The Affordable Care Act (ACA) provides states with an option to create a “Basic Health Program” for low-income individuals, in lieu of receiving coverage through the health insurance exchange. Molina Healthcare believes that the State of Illinois should give immediate and serious consideration to the adoption of a Basic Health Program as the ideal alternative to the health insurance exchange to cover the lower-income segments of the exchange-eligible population.

The State of Illinois and low-income individuals could benefit from the Basic Health Program in a number of very significant ways:

- Individuals with incomes less than 200% of FPL will be the vast majority of consumers eligible for exchange-based subsidies (per the American Academy of

Actuaries, November 2009). They share significant characteristics with the Medicaid/CHIP population; e.g., they have kids in Medicaid/CHIP, family members on other government programs, greater healthcare needs, require enhanced services (case/care management, language services), used to getting care from community health centers, safety net providers, etc.

- The state could provide Medicaid, CHIP, and Basic Health coverage through the same community and other managed care plans and keep families together, resulting in greater enrollment, more stable coverage, and fewer coverage gaps.
- The Basic Health Program could smooth out the differences between Medicaid benefits, which generally have very limited cost sharing and no monthly premiums, and the benefits and cost sharing under the health insurance exchange.
- The state could design the benefits to reduce the cost to the state and to adjust the benefits to the income and the unique needs of the population.
- Health plans that traditionally serve Medicaid and CHIP are well-qualified to serve Basic Health Program members based on experience, cost, readiness, and knowledge of the population.
- The Basic Health Program can provide a state more leverage in its direct purchase of health coverage because it is buying on behalf of additional covered lives, for example, through its Medicaid program.
- The Basic Health Program would also provide needed support to safety net providers remaining viable by retaining their current low-income patients who may otherwise be forced into commercial plans and networks in the health insurance exchange.
- If CHIP funding is not extended after 2015, the Basic Health Program is a natural fit to absorb a share of these children with minimum service and care disruption.
- States could invest unused Basic Health Program funds into additional services, including ones that are traditionally funded with state dollars. Under the exchange, by comparison, a State would be required to pay for any additional services not defined under the essential health benefits.

The Basic Health Program provides a model opportunity for Illinois to cover low-income populations in a cost effective and culturally sensitive manner and will reduce the churn of low income individuals in the health insurance exchanges, leading to controlled medical and administrative costs. The funding and cost reduction potential of the Basic

Health Program makes it a viable alternative that the State of Illinois could adopt to cover their low-income population below 200% of the FPL.

8. What is your organization's preliminary anticipation of how it might participate in coordinated care?

Molina Healthcare welcomes the opportunity to provide the State of Illinois with its full-risk managed care plan services. Using a member-centered, cost-effective model of managed healthcare services, Molina Healthcare would arrange for a broad spectrum of care for Illinoisans that often requires the integration of overlapping services, including coordinating acute, behavioral health, substance abuse and long-term care services. Molina Healthcare has extensive experience in managing and providing for quality healthcare services to vulnerable populations, including an established track record of effectively providing integrated care coordination for members who have multiple or complex conditions.

The key strengths of Molina Healthcare's model of healthcare services include the following:

- Administering an efficient managed care model that provides quality services in a cost efficient and sustainable manner while meeting all state, regulatory and other requirements;
- Maintaining a robust service delivery network focused on contracting with primary care physicians, many of whom are contracted to support a medical home environment, as well as specialists, hospitals and ancillary providers to ensure access to experienced community and safety net practitioners;
- Providing flexible and innovative care management delivery approaches to integrate service coordination for persons with disabilities, chronic medical conditions, and behavioral health and substance abuse issues to ensure delivery of the right care, at the right time, in the right setting;
- Ensuring plan members receive comprehensive, integrated care management through programs and services that include:
 - Care Coordination that is member-centric and integrates an array of health care services designed to improve health outcomes for chronically ill, disabled and aged populations, including individuals with acute, behavioral health and/or substance abuse issues, and persons with long-

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term care needs;

- Care Transition services that ensure members are educated prior to hospital admission (or any change in level of care). Members also receive post-discharge support services to prevent readmission and ensure members adhere to discharge instructions.
 - Disease Management designed to educate and actively engage members in addressing their own health care needs, and which have been proven effective in reducing inpatient admissions, readmissions and emergency room services;
 - Case Management based on risk-stratification of members with complex medical conditions for assessment of needs, interventions and evaluation of outcomes;
 - Utilization Management designed to ensure quality, cost-effective and medically necessary services are delivered across the continuum of care;
 - A dedicated multi-lingual Nurse Advice Line available 24 hours per day, seven days per week that is staffed by registered nurses who provide comprehensive and personalized telephone services with a goal of decreasing inappropriate use of emergency room services; and
- Utilizing a scalable information technology system capable of handling and processing complex data requirements.

Molina Healthcare is committed to supporting the State of Illinois in its effort to provide coordinated care to Medicaid members. We appreciate your commitment and leadership in ensuring the healthcare system is accessible and affordable to millions of low-income Illinoisans.

Thank you for your consideration of our comments. Please feel free to contact me should you need additional information at (888) 562-5442 (ext. 114667) or John.Puente@MolinaHealthCare.Com

Sincerely,



John M. Puente
VP Deputy General Counsel