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**Senate Special Committee on Medicaid Reform**
**Testimony – SEIU Healthcare Illinois Indiana**
**December 14th, 2010**

Dear Members of the Committee:

My name is Keith Kelleher and I am the President of SEIU Healthcare Illinois. We represent over 85,000 workers, including home care workers through the Department on Aging Community Care Program and DHS-Home Service Program, home child care providers through the DHS-Child Care Assistance Program, and thousands of nursing home and hospital workers at facilities predominantly funded through Medicaid. I am here today to discuss the Medicaid program and the reforms that are being considered by the General Assembly.

Home care workers – both home care aides and personal assistants – are an essential component of Illinois' health care system. SEIU Healthcare Illinois represents over 35,000 home care workers who work as home care aides and personal assistants through the Department on Aging's Community Care Program and Department of Human Services' Home Services Program. These workers offer some of Illinois' most vulnerable populations - older adults and people with disabilities - a safe, effective, and affordable way to stay in their homes and retain their independence while receiving the vital care they need. Home care workers protect and safeguard the health and well being of these consumers by assisting them with activities of daily life such as personal care, transportation, laundry, meal preparation, cleaning and other activities. As the need for long-term care grows, the strength and quality of our state's home care program is becoming even more important.

Nursing home and hospital workers are many of the front line caregivers in the Medicaid system, and often are the only medical care that many Medicaid recipients receive.

We appreciate the opportunity to discuss Medicaid reform. Medicaid is a huge portion of the state's budget and programming, and protecting these programs and the consumers in the program is essential to maintaining and improving the State's health care system, especially for low-income individuals. There are areas in Illinois's Medicaid system that can be improved and reformed, and we look forward to working with you to address many of these areas while preserving and improving the quality of care, consumer independence and choice, and maintaining an efficient and cost-effective program.

Below we address the specific questions that have been asked of advocates:

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**1. What is your role in the Medicaid system?**

SEIU Healthcare Illinois Indiana represent 85,000 members around the state, including 50,000 front line caregivers in the home care, nursing home, and hospital industries, primarily in or through Medicaid programs.

**2. From your viewpoint, what is the best way to reduce Medicaid costs without severely impacting services?**

The best way to reduce Medicaid costs is to focus on rebalancing the long-term care system in Illinois. This would not only avoid severely impacting services, it would also provide more quality care in home and communities where consumers want to live while saving the State millions of dollars.

Currently IL has one of the least balanced long-term care systems in the country, with significantly more dollars being spent on institutional care than on Home and Community Based Services (HCBS), at a rate of roughly $3 in institutional spending to every $1 in HCBS spending. Unsurprisingly, it is also significantly more expensive to care for individuals in institutional settings rather than in home based settings. Estimates show that just a moderate rebalancing of the system could save more than $200M per year.

The General Assembly can help push the rebalancing process by moving towards a more global budgeting. Currently long-term care budgeting is done in an isolated, or "siloed," manner, with each department and program putting together their own budgets in isolation of the other programs that are directly impacted by increases or decreases in funding. One way to move in this direction would be to implement long-term care budget hearings, forcing the various programs to discuss their budgets in the greater context of the entire long-term care budget. Home and Community Based Services funding has (rightfully) increased over the last several years, and there is strong evidence that this has led to significant savings (as seen in the recent HCBS Strategies commissioned by the Department on Aging[1] These savings need to be understood as we talk about increased funding for HCBS that will keep people out of institutions.

**3. What are you doing to maximize federal funding? What else can the State do to capture these funds?**

SEIU Healthcare Illinois Indiana has been working with the Governor's office to try and find ways to maximize federal dollars in the IDOA-Community Care Program (CCP). CCP has a low Medicaid enrollment percentage (45-50%) even though it has a much higher Medicaid eligibility percentage (roughly 65%). Simply increasing Medicaid enrollment for Medicaid-eligible consumers would bring in tens of millions of dollars to the State. SEIU HCII is also pursuing options on some form of provider

1 CCP Cost Effectiveness: Comparison of CCP growth with Nursing Facility Prevalence Reductions - HCBS Strategies – February 24th, 2010

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assessment, similar to the nursing home and hospital assessment programs, that could bring in additional tens of millions of dollars. Such an assessment is complicated due to federal rules, and we are working to determine what is possible within the frameworks of both Illinois and federal law.

**4. Can you identify any inefficiencies within our State's Medicaid system? How can these inefficiencies be corrected?**

While we believe that there are inefficiencies in the State's Medicaid system, we also believe that the State's system is actually cost-effective, and one of the cheaper Medicaid systems in the country. Among all states, Illinois ranks 42nd in per Medicaid beneficiary expenditures. The national average is $4,575 per Medicaid beneficiary, and Illinois spends $4,129 per beneficiary. Overall, Illinois effectively minimizes Medicaid cost to the taxpayers and maximizes, for the most part, the federal dollars available. [2] Illinois also has some of the lowest Medicaid rates in the country. In other words, Illinois's Medicaid system has low rates low costs per beneficiary, which makes it a cost-effective and efficient system.

As previously discussed, the greatest inefficiencies within the State's Medicaid system is the State's reliance on institutional care over home and community based care. Correcting this inefficiency will take a greater investment in Home and Community Based Services that will lead to a reduction (or, at least, minimizing the growth) of institutional spending.

There are also inefficiencies in our overall Medicaid system that doesn't adequately coordinate care in a way that incentivizes quality care and reduces unnecessary (and expensive) emergency room care and re-hospitalizations. But in order to address this, we only need to expand existing programs. Our existing model of primary care case management-disease management (PCCM-DM) for the majority of Medicaid enrollees has been showing impressive results. Illinois already links 1.7 million of the 2.4 million Medicaid recipients with primary-care doctors' offices that are paid monthly fees to manage the care for each enrollee. The program encourages outreach and preventive health-care services for patients such as screenings, tests, shots and medicines, which helps catch medical problems early and avoids costly emergency room use down the road. Efficient implementation of this care management program saved the state more than $300 million.[3] Moderate changes, such as quality add-on payments, and expansion to other populations would allow the state to maximize savings without jeopardizing consumers' choice and the quality of their care.

Moving to a capitated managed care system would have the opposite result. Capitated rates create incentives to do two things: cut rates and/or cut services. And historically, around the country, it has been shown that private HMO companies can and will do

2 "The Shriver Brief" - Sargent Shriver National Center on Poverty Law - http://www.theshriverbrief.org/2009/08/articles/health-care-reform-1/hmostyle-managed-care-is-not-the-way-to-balance-the-budget/

3 "Illinois credits program changes with $300M Medicaid savings" - Crains – April 27, 2010

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both in order to maximize their profits. This pursuit of profit has often been devastating for Medicaid consumers around the country, and private HMOs profit-driven business plan has led to direct cuts in services, refusal to fill prescriptions, refusal to provide durable medical equipment, and other various cuts in services and benefits. Many of these companies have been charged with fraud by various states as well as the federal government. Further, the state is already implementing an Integrated Care pilot program for the AABD populations, and the state should tread carefully to see how this pilot proceeds, and what outcomes it produces, before moving forward on any expansion of a capitated rate managed care program.

Most importantly, we must insist that the individuals that Medicaid serves must have a voice in decisions that will dramatically impact their lives. A Medicaid system that is efficient on paper but that ignores the needs of its constituents is more wasteful than a responsive, humane system that rejects quick-fix solutions that produce cost-savings by undermining quality and access.

**5. Can you identify any loopholes within state statute or administrative code that have allowed for Medicaid fraud?**

One of biggest areas of Medicaid fraud, both in Illinois and around the country, has resulted from the involvement of private HMOs that States have contracted with to provide various forms of managed care. This type of fraud has been present in Illinois, including Amerigroup, a managed care organization that once held a contract to provide managed care in Illinois. Amerigroup was found to have defrauded Medicaid by using discriminatory practices including avoiding pregnant women and people with disabilities.[4] We have also seen fraud issues recently with Wellcare Health, the largest Medicaid HMO in Illinois, related to fraudulent over-billing.[5] Similar cases have occurred around the country, defrauding states and the federal government hundreds of millions of dollars.

As Illinois focuses on reforming the state's Medicaid system, and in many ways focusing on fraud, it is important that the State does not open up the doors for much more for significant fraud that has been rampant in privatized managed care programs around the country and here in Illinois.

**Summary**

We also have very significant concerns about many of the other proposals that are being heard in this committee as well as the House Medicaid Reform Committee. The State's fiscal crisis cannot and will not be able to be solved on the backs of low- and moderate-income households, and these households must not be used as scapegoats for the State's fiscal problems. Many of the proposals will have little fiscal impact, but

4 Memisovski v Maram - http://www.povertylaw.org/poverty-law-library/case/53800/53827
5 Wellcare Health to repay the state $1 Million - April 28, 2010 - http://articles.chicagotribune.com/2010-04-28/business/ct-biz-0429-notebook-health--20100428_1_medicaid-recipients-illinois-medicaid-medicaid-patients

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will have significant impact on the lives of the Medicaid recipients that rely on these services.

Illinois's Medicaid system is not broken, nor is it bloated or expensive. Illinois's programs are actually cost-effective, especially in comparison to other states. But this doesn't mean that there are not ways to make the program more efficient. The State's goal should not be to eliminate people or services from the Medicaid program, but instead the goal should be to have an efficient and effective program that serves the need of low- and moderate-income households. Real efforts to rebalance the long-term care system, as well as better coordination of care, would have real and positive impacts on both the efficiency and the quality of care in the state's Medicaid programs. But these efforts need to be done in a way that includes stakeholders, including both consumers and workers, as well as provides for real protections of rates, services, and eligibility levels.