Illinois Health and Hospital Association

Statement of the
ILLINOIS HEALTH AND HOSPITAL ASSOCIATION

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Swedish Covenant Hospital and Medical Group
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Joint House Human Services Appropriations and Human Services Committees

The State of Illinois Medicaid Managed Care Organizations Request for Proposals

Room 114, Capitol Building
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Testimony before the Joint Hearing of the House Appropriations and Human Services Committee

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Chairman Harris, Chairwoman Gabel, Spokesperson Bellock and the esteemed members of the House Appropriations Human Services and Human Services Committees. It is an honor to be here today to discuss The State of Illinois Medicaid Managed Care Organization Request for Proposals, 2018-24-001 (the "RFP"). My name is Lori Guinane and I am the Associate Vice President of Managed Care for Swedish-Covenant Hospital, a safety-net hospital located on the North side of Chicago.

We commend the efforts of the Department to reduce the number of MCOs serving the Medicaid population. Swedish-Covenant has stated multiple times to legislators and the Department of Healthcare and Family Services that dealing with the large number of MCOs is very difficult. Among other things, creates staffing and logistical problems and, given the current problems with denials and collections, it is virtually impossible to track twelve MCO vendors.

We are currently forced to meet monthly with each MCO in an attempt to reconcile receivables and other concerns and you can imagine the strain it places on our staff and budget to prepare for all of these meetings, many of which end up with nothing being accomplished due to the revolving door staffing at the MCOs.

We also wish to thank the Department for the time Robert Mendonsa has devoted to being educated regarding the various issues faced by safety-net hospitals in dealing with MCOs and for his assistance attempting to resolve issues with individual MCOs.

However, while the RFP is a significant step in the right direction, it will not get us to where we need to be with respect to resolving the myriad systematic problems that hospitals face with MCOs, nor is the timing adequate to address issues in need of immediate resolution.

Our Medicaid MCO receivables at Swedish have grown by over $4 million and the aging continues to lengthen and create cash flow problems for our hospital, by way of comparison, our aging with commercial MCOs is approximately 45 days and our aging with Medicaid MCOs exceeds 110 days. Many MCO companies are selling us both services, yet the performance between commercial and Medicaid is night and day.

Unless solutions are provided on an expedited basis, our receivables will grow significantly and aging will expand between now and January, 2018 when the RFP takes effect. We are primarily concerned that MCOs currently under contract to the Department that do not compete in the RFP process and those MCOS that compete but are not awarded contracts will attempt to take even greater advantage of providers through denials and delayed payments. While they may be contractually obligated to the state to make payments, recent history suggests that collections will be extremely difficult with organizations leaving the market.

As we have advised the Department on many occasions, there is a need for standardization of MCO processing and compliance and we believe that standardization can be accomplished on an expedited basis through amendment to the existing MCO contracts The lack of standardization in the areas of payment, process and care coordination have had a significantly negative affect on safety-net hospitals, ranging from incredible amounts of claims denials to the absence of care coordination; all burdens that are absorbed by the hospital and inhibit our ability to deliver quality care to underserved communities. Even with the 5-7 MCOs projected to be awarded contracts, there is need for standardization the RFP does not address.

To that end, the following are among issues are not addressed by the RFP, yet are in need of immediate attention and standardization:

1. <u>MCOs Not Paying for Services</u> — The average claims denial rate on the commercial side at Safety-Net Hospitals is roughly 2% while the average claims denial rate for Medicaid MCOs is 15% — 20%. This is due in part to the MCO systems not being aligned with HFS billing rules to appropriately pay claims. We are asked to prepare multiple spreadsheets for claims already submitted. Even after this is completed, the system cannot be fixed to pay the claims timely and this has created a significant cash flow problem for our hospital.

2. <u>Patient Discharge</u> — Safety-Net hospitals are incurring significant costs related to caring for MCO patients who should be discharged, but instead linger in hospitals beyond medical necessity because the MCO does not transfer the patient. This issue is compounded as hospital discharge planners are not able to find providers willing to accept the patient for services when ready to be discharged. An MCO may list several in-network home health providers and we cannot find a provider willing to accept the patient forcing them to stay in the hospital.

3. <u>Admissions/Observation</u> — Possibly the most exacerbating transition to increased Medicaid enrollment with MCOs is the continuing, inappropriate imposition of an "observation" rate. Observation is not considered an admission and observation rates pay much less than rates for an admission and rarely cover the hospital's cost for services.

4. Credentialing — MCOs are not paying for services unless and until the credentialing of a provider is finalized, which can take up to a year or more under the current managed care program.

5. Care Coordination — Safety-Net Hospitals see little evidence of care coordination among the Medicaid population. The state pays monthly care coordination fees to MCOs; however, hospitals are tasked with performing this care. MCOs must bear the liability for care coordination since MCOs have been hired for this specific purpose.

I thank you for the opportunity to be here today. We remain committed to working with the Legislature and the Department to improve the system and to achieve the goals of care coordination that this needy population demands and deserves. Our leadership team at Swedish Covenant is available any time as a resource for legislators and the Department as we work to try to solve these urgent problems.