1. What is your role in the Medicaid system?

Harmony Health Plan is Illinois' largest Medicaid managed care organization (MCO). Since 1996, Harmony has had licensure to provide services as a health maintenance organization to those Illinoisans who qualify for Medicaid and reside in our geographic areas. Currently, Harmony has over 140,000 members in Cook, Kane, Jackson, Madison, Perry, Randolph, St. Clair, Washington and Williamson counties.

Illinois' managed care program is voluntary and our members have selected Harmony as their health plan after being educated about their delivery system options and the benefits an HMO offers. Harmony provides comprehensive healthcare services to its members, including several enhanced benefits not offered in the traditional Medicaid program. For example, we offer care and case management programs to help manage various disease states and improve the overall health of our members. We have an intensive care management program focused on healthy birth outcomes called Harmony HUGS focused on providing prenatal and postpartum care to expectant mothers. Through this program we provide our pregnant mothers with nurses and social workers to educate them about a healthy pregnancy, timely prenatal visits, breastfeeding and parenting. Through care / case management programs such as HUGS, we are able to provide targeted access to appropriate healthcare services, thus improving the quality of care delivered to our members.

Harmony maintains a comprehensive network of providers who delivery timely services to our members. Our current network includes over 900 primary care providers, 3,500 specialists and more than 60 hospitals. We require our providers to maintain 24/7 access for our members and strict standards for appointment times. We are uniquely positioned to improve access to care to specialists and hospitals, often paying premiums to providers to include them in our network. Providers are inclined to partner with our health plan because we offer prompt payment (99% of claims paid within 30 days) and incentive programs such as our pay-for-quality program. Through our pay-for-quality program, providers receive enhanced payments for delivering the "right" care at the "right" time, based on national quality standards. In addition to our pay-for-quality program, Harmony has developed pay-for-performance contracting mechanisms that together yield relationships with providers that form accountable care structures. By developing these relationships, we have not only increased quality, but also managed costs by aligning incentives with our providers. Harmony is unique in its ability to deliver these accountable care structures in Illinois and we have been doing so for over 13 years.

Our contract with the Illinois Department of Healthcare & Family Services (HFS) includes a quality withhold. A portion of our premium is withheld by the State and if we deliver quality services to our members we earn back the premium. If we don't deliver services that meet or exceed national benchmarks, the State retains those dollars. Through this penalty provision in our contract, HFS is able to hold Harmony and other MCOs accountable for the delivery of quality services to its members. Through our pay-for-quality program we offer our providers a financial incentive to be accountable and deliver quality healthcare to our members. Our continued focus on care / case management and quality improvement has resulted in Harmony making statistically significant improvements in the majority of HEDIS measures during the most recent measurement period.

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

By design, capitated managed care allows states to contain costs in its Medicaid program while maintaining high levels of care. Managed care's actuarially sound capitation rates are 4 – 5 percent less than the State's actual cost to provide services themselves in an unmanaged fee-for-service environment. Over the past five years, the overall cost to provide medical services in Illinois has risen 5 – 7 percent, but capitated managed care rates have remain steady and flat during this same time period. A September 2010 report by the Kaiser Family Foundation indicates total Medicaid spending growth averaged 8.8 percent across all states in FY 2010, the highest rate of growth in eight years[1].

It is our belief that expanding the use of capitated managed care in Illinois' Medicaid program with licensed managed care plans that have extensive knowledge and experience delivering care to the Medicaid beneficiaries in Illinois, will contain costs, offer the state cost predictability, and improve administrative efficiency. In addition, we believe that the expanded use of capitated managed care can enhance and improve access to quality healthcare, through timely payments to providers, enhanced payments to specialists and hospitals and financial incentive programs.

Further, we suggest moving Illinois' integrated care pilot for the aged, blind or disabled population into statewide managed care. Through the expansion of proven strategies that contain and reduce Medicaid costs, Illinois can reduce its Medicaid costs and expand access to appropriate care to this high cost population.

In response to the Senate's Special Committee on Medicaid Reform's request for information on the State of Ohio's managed care expansion, please reference

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[1] Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010 and 2011, September 2010, http://www.kff.org/medicaid/upload/8105.pdf

the chart included in Appendix I, including a detailed timeline of Ohio's phased-in approach of statewide mandatory managed care.

Harmony also believes there are some short term opportunities for cost savings within the Illinois' current Primary Care Case Management (PCCM)/ Disease Management (DM) programs. Please see our response to Question #4 for more details.

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

In our role as a contractor with HFS, Harmony has not been involved in federal funding maximization discussions with the State of Illinois. However, as an organization that provides coordinated care benefits in eight other states we have seen a variety of maximization strategies in use, including: provider / MCO rate increases to draw down additional matching funds under enhanced matching period and early implementation of ACA (demonstration / pilots) to qualify for grants and capture enhanced matching dollars. Illinois agency leadership and the Healthcare Reform Implementation Council should continue working to take advantage of early and enhanced Federal matching funds available to states for Health Information Technology/Health Information Exchange program development, eligibility / enrollment improvements and innovative care management program development and implementation.

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

Illinois recent focus on "medical home" is a positive first step in improving access to primary care providers. The statewide implementation of PCCM / DM program and the upcoming implementation of the Integrated Care pilot are appropriate next steps in improving the efficiency of the Medicaid program and the use of more traditional managed care approaches. Though these are steps in the right direction, we do believe there are opportunities for increased efficiency through appropriate controls and alignment of incentives with the Illinois Health Connect Program.

Today, primary care physicians/medical homes are paid a $2 or $3 per member per month (annualized ~$25M/year for the state) management fee for all Medicaid beneficiaries assigned to their practice. Providers are being paid these fees without any specific performance requirements and with no audits or proof that providers qualify as a "medical home". The management fees may not always be reinvested in adding coordination services to member. We recommend that the state consider more explicit requirements to qualify as a medical home and periodic audits to ensure continued eligibility.

Under the current Illinois Health Connect structure, there are no explicit referral and authorization requirements. From our experience, a defined authorization process, built around the use of industry standard criteria (e.g. Interqual), allows us to better managed the use of high cost services. We have found by building more explicit provider accountability (e.g. timely access to appointments and decreased ER utilization), we have been able to decrease unnecessary utilization of high cost services.

We applaud the recent moves to a more managed environment. We believe Illinois should continue evaluating and implementing more effective and cost efficient managed care programs. These programs guarantee access to primary care providers and specialists to better addresses the healthcare needs of our elderly, disabled and institutionalized populations.

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

The fee-for-service system has numerous examples of fraud and is resource constrained to prosecute offenders. Managed care however, is perfectly positioned to better detect and eliminate fraudulent activity. Moving more to a managed care environment is the most cost effective way to reduce fraud and abuse.

Harmony Health Plan's current contract includes numerous provisions related to fraud and abuse. Specifically, managed care organizations are required to proactively evaluate and investigate provider and member fraud, abuse and criminal activity. When fraud or abuse is suspected we must immediately notify HFS and its Office of Inspector General. Additionally, our contract requires the health plan to submit quarterly reports detailing any suspected fraud or abuse, certification that no fraud or abuse occurred, and/or the status of any fraud or abuse reported in the previous quarter.

Harmony Health Plan and its parent company maintain an internal Special Investigations Unit (SIU) that is solely charged with the responsibility of detecting, investigating and reporting suspected fraud, waste and abuse among our providers, members and associates. In addition, all of our associates are required to complete annual education and training on fraud, waste and abuse, including their fiduciary responsibility to report any suspected fraud or abuse to our SIU and/or Compliance Department. Over the past few years we have enhanced our efforts to improve and expand our monitoring and evaluation of provider, member and associates fraud, waste or abuse.

APPENDIX I

Ohio's Medicaid Managed Care Program				
Year	**Description of Managed Care Program**	**Populations Eligible for participation**	**Other Delivery System**	**Notes**
1978	Voluntary managed care on limited basis in Cuyahoga County (Cleveland Area)	Pregnant Women	FFS	State agency filed waiver to implement managed care on county-by county basis
1989	Mandatory enrollment begins in Montgomery County (Dayton Area)	Pregnant Women	FFS	
1990 - 1995	State continues use of managed care on limited basis	Pregnant Women	FFS	State agency and county departments of health continued encouraging enrollment in managed care plans in managed care plans where health plans operated (urban / populous areas)
1995 - 1997	Expansion of mandatory enrollment in urban counties	TANF / Mom's & Babies; SCHIP	Non-mandatory counties - FFS; Mandatory counties - non-choosers auto-assigned to MCO	Ohio Care waiver program, added six mandatory counties; rest of State remained in FFS
1997 - 2000	Commercial plans exit program - Under-capitalized health plans go out of business; Enrollment in managed care becomes voluntary in counties that had managed care, including mandatory counties	TANF / Mom's & Babies; SCHIP	FFS	Mandatory program; state agency accepted any willing plan to participate in MCO program, resulted in turnover and financial failures; insufficient market opportunities and financial insolvency contributed to plans terminating / rescinding their contracts
2001 - 2003	Preferred option added to existing voluntary and mandatory options - Enrollment grows statewide	TANF / Mom's & Babies; SCHIP	FFS; affirmative choice; non-choosers auto assigned to MCO	Enrollment broker / choice counselor added to program
2003 - 2005	Mandatory enrollment reinstated in nine counties - Hospital based plans exit; New plans enter Ohio	TANF / Mom's & Babies; SCHIP	Non-mandatory counties - FFS; Mandatory counties - non-choosers auto-assigned to MCO	
2006	Statewide mandatory managed care implementation begins	TANF / Mom's & Babies; SCHIP; Aged, Blind & Disabled (ABD)	Non-choosers auto assigned to MCO	Regional based implementation; competitive procurement of three plans per region; regional enrollment took place over four months (TANF); procurement for ABD

Source: Ohio Medicaid Performance Audit 2006, http://www.auditor.state.oh.us/auditsearch/Reports/2006/Ohio_MedicaidProgram_12_19.pdf