Community for All Coalition • Medicaid Managed Care • Fact Sheet

The State of Illinois is proposing a Medicaid Managed Care pilot program for DuPage, Kane, Kankakee, Lake, Will, and suburban Cook Counties. The Department of Health Care and Family Services (HFS) hopes to save the state $200 million over the life of this five-year program. It would impact nearly 40,000 people with disabilities and seniors in the areas covered, and we believe it is a bad idea for these reasons:

Health Maintenance Organizations (HMOs) are driven by profit and not always the well-being of persons with disabilities and seniors

- As the national health care debate recently showed, many view an individual's choice of doctor, treatment, preventive care etc. as a fundamental right and not a privilege or commodity. HMOs view individuals' health care, especially those on Medicaid, who do not necessarily seem worth the risk and added expense, as a means to bolster their shareholders' bottom lines. In this pilot program, 12% of monies granted by the state to the two participating HMOs in the pilot project will cover everything from case management, administrative costs, and pure profit. Since HMOs think in terms of profit and loss, those people with disabilities, particular persons with extremely high health care costs, are not cost effective for the companies involved. At that point, the State of Illinois becomes the safety net for the individual that the HMOs choose not to cover, providing the State with no monetary savings whatsoever.

Other states have tried Medicaid Managed Care without success

- A 2005 study in California showed the state's Medicaid program working more efficiently before the switch to Medicaid Managed Care, and according to the study, the changing programs showed no improvement in health outcomes. A similar study examining 15 states exposed down sides to managed care, including limited primary care physician choice, shorter visits with physicians, inability to see highly specific specialists not in the managed care plan, and limits on treatments, such as physical therapy and counseling.

The fear of loss of access and choice is very real for persons with disabilities

- In the program, people with disabilities and seniors would only have the choice of the two HMOs that won the contract with the state; and if they chose neither, they would be assigned to an HMO. Studies show HMOs severely limit access to long-term care services, highly trained specialists, durable medical equipment, and other aspects of health care considered very important to people with disabilities and seniors. This is not an example of true choice in health care delivery systems. This is an example of the state pushing its responsibilities to private, for-profit businesses, thereby displacing blame for bad decisions from policy makers and others involved in state government.

The disability community has not had a REAL voice in the process

- The disability community in the pilot area is represented by six Centers for Independent Living (CILs) which serve approximately 1,600 people with physical disabilities. Of those, 70-80% (or 1,120-1,280) will be required to enroll in the managed care pilot program. An additional 3,000-4,000 people with developmental disabilities, including 1,140 people living in three State Operated Developmental Centers in the pilot area, will be forced into this program. Yet, only one of the 7 HMOs submitting bids has contacted any the CILs in the pilot area. HFS did not include any advocates or consumers from the disability community during the development of the pilot or even communicate with providers and consumers in the pilot area their intent to implement this program until after it was developed.

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