

**IN THE UNITED STATES DISTRICT COURT  
FOR THE NORTHERN DISTRICT OF ILLINOIS  
EASTERN DIVISION**

MEMISOVSKI, et al.,	)	
	)	
Plaintiffs,	)	
	)	
v.	)	Case No. 92 C 1982
	)	
BARRY S. MARAM, Director of the	)	Judge Joan Humphrey Lefkow
Illinois Department of Public	)	Magistrate Judge Martin C. Ashman
Aid and CAROL L. ADAMS,	)	
Secretary of the Illinois Department	)	
of Human Services,	)	
	)	
Defendants.	)	

**PLAINTIFFS' PROPOSED STATEMENT OF  
CONTESTED AND UNCONTESTED FACTS**

Plaintiffs, by their undersigned counsel, hereby submit their Proposed Statement of Contested and Uncontested Facts.

**PROPOSED CONTESTED ISSUES OF FACT**

1. Whether Defendants (collectively, the "State") provide appropriate early and periodic screening, diagnostic and treatment ("EPSDT") services to the Plaintiff class (the "Children").

2. Whether the State's EPSDT program, taken as a whole, has failed to deliver EPSDT services to all of the Children.

3. Whether the State has failed to effectively inform all of the Children of the EPSDT program by:

- a. Failing to use written notices and informational materials that are adequately tailored to families with low literacy or English skills and are not distributed frequently enough;

- b. Failing to use adequate oral methods to supplement the written materials;
  - c. Failing to use person-to-person outreach and case management to a sufficient extent to ensure that all Children are aware of the program and receiving services;
  - d. Failing to use Medicaid usage data to identify Children who are not using the program according to the periodicity schedule and target them for more effective informational activities, outreach and/or case management;
  - e. Failing to use adequate methods to keep track of physicians enrolled in the Medicaid program who are also currently willing to provide EPSDT services to the Children and inform the Children of the those physicians; and/or
  - f. Failing to use such methods as are sufficient to induce all of the Children to come forward for EPSDT services.
4. Whether the State has failed to deliver immunizations as required by the periodicity schedule.
5. Whether the State has failed to deliver general health, vision, hearing, dental, and blood lead screens of the type and frequency required in the periodicity schedule.
6. Whether the State has failed to deliver treatment for diagnosed medical conditions or injuries.
7. Whether the State has failed to recruit and retain in the program sufficient medical provider resources to provide EPSDT services to all Children according to the periodicity schedule and to treat diagnosed conditions or injuries.
8. Whether children in Cook County on Medicaid have access to health care equal to the access to health care enjoyed by children in Cook County insured by private or other public health insurers.

9. Whether the State's payments to medical providers are sufficient to enlist enough providers to assure that medical care and services are available to the Children at least to the extent that such care and services are available to the general population in Cook County.

10. Whether the State has set Medicaid reimbursement rates for pediatric physician services in Cook County that are significantly below the cost of providing the care.

11. Whether the State has set Medicaid reimbursement rates for pediatric physician services in Cook County that were set without any attempt to ascertain the physicians' cost of providing the services.

12. Whether the State has set Medicaid reimbursement rates for pediatric physician services in Cook County that were set without any attempt to anticipate the impact of the rates on access to health care.

### **PROPOSED UNCONTESTED FACTS**

#### **I. THE PARTIES**

1. On October 8, 1992, the Court certified the Plaintiff class of children on Medicaid residing in Cook County, Illinois (the "Children"), defined as:

All children (persons under the age of 18) in Cook County, Illinois, who, on or after July 1, 1990, have been, are or will be eligible for the Medical Assistance Program ("Medicaid") established under Title XIX of the Social Security Act.

2. There are approximately 600,000 children in Cook County within the Plaintiff Class, according to figures published by the Illinois Department of Public Aid ("IDPA") for FY 2002.

3. Defendant Barry S. Maram is the Director of IDPA, and is sued in his official capacity.

4. Defendant Maram's duties in administering the Medicaid program include adopting and implementing policies, rules, and regulations for the IDPA that conform to applicable federal laws and regulations.

5. Defendant Carol S. Adams is Secretary of the Illinois Department of Human Services ("IDHS"), and is sued in her official capacity.

6. Defendant Adams' duties include implementing policies, rules, and regulations for the IDHS in administering the Medicaid program that conform to applicable federal laws and regulations.

7. Illinois has designated IDPA as the "single state agency" responsible for administration of the Medicaid program in Illinois pursuant to 42 U.S.C. § 1396a(a)(5).

## **II. ADMINISTRATION OF THE ILLINOIS MEDICAID PROGRAM.**

### **A. Illinois' General Administrative Structure for Medicaid**

8. IDPA operates through a central office system with main offices in Chicago and Springfield.

9. IDPA does not operate a local office system in the communities it serves to provide services or direct interactions with individual Medicaid recipients

10. IDPA has delegated certain responsibilities with regard to Medicaid administration to IDHS.

11. IDHS has primary responsibility for issuing computer-generated eligibility and recipient information from its central office, such as recipient ID cards (known as "Mediplan" cards).

12. Mediplan cards are issued monthly to recipients to verify their enrollment in Medicaid.

13. IDHS has been delegated by IDPA to carry out certain personal interactions with Medicaid recipients under the Medicaid program.

14. IDHS operates local offices throughout the state where caseworkers interact directly with Medicaid applicants and recipients.

15. IDHS employees in IDHS local offices are responsible for making determinations of whether applicants are eligible for the Medicaid program.

16. Eligibility determinations constitute the primary activity of IDHS local office staff with respect to the Medicaid program.

17. Together, IDPA and IDHS are responsible for almost all functions relating to the Medicaid program in Illinois.

18. Some other state agencies and sub-agencies, such as the Department of Children and Family Services ("DCFS"), have some role in jointly administering with IDPA limited aspects of the Medicaid program to special recipient populations, such as foster children.

19. Under the Medicaid program, each state sets the reimbursement rates that it will pay to health care providers for services provided to persons on Medicaid.

20. Health care providers may decide whether or not they will accept patients who are enrolled in the Medicaid program.

21. A provider must enroll in the Medicaid program to receive any reimbursement at all from IDPA.

22. When enrolling in the Medicaid program, a provider need not make any commitment to see any certain number of Medicaid recipients.

23. IDPA contracts with five Medicaid managed care organizations ("MCOs") to provide services to Medicaid recipients in Cook County: United Healthcare of Illinois, Inc.

("United"), Amerigroup Illinois, Inc. ("Amerigroup"), Harmony Health Plan of Illinois, Inc. ("Harmony"), Humana Health Plan, Inc. ("Humana"), and Family Health Network.

24. Enrollment by Medicaid recipients in MCO programs is voluntary.

25. 20% or less of the Children currently on Medicaid in Cook County are enrolled in an MCO.

**B. The State's Provision of Services to Children**

26. IDPA's "Healthy Kids" program is intended to address the requirements of federal Medicaid law with regard to EPSDT services, as defined in 42 U.S.C. § 1396d(r).

27. IDPA's Healthy Kids program is intended to deliver scheduled preventive health care and early diagnosis and treatment for persons from birth to attainment of age twenty-one (21) who are eligible for medical assistance (Medicaid) under Title XIX of the Social Security Act.

28. States participating in Medicaid are required to provide or arrange for EPSDT services to Medicaid-eligible children, including (i) regular healthcare screening services (i.e., well-child exams and immunizations), (ii) effective diagnosis of any conditions that require treatment, and (iii) appropriate treatment for such conditions.

29. Required EPSDT health screening services include comprehensive medical and developmental histories of both physical and mental health, comprehensive unclothed examinations, immunizations, laboratory tests (including blood lead level tests), and health education.

30. Required components of an EPSDT program include age-appropriate vision, dental, and hearing screening and diagnosis.

31. States are required to provide transportation and scheduling assistance to Medicaid recipients if necessary to ensure that Medicaid recipients receive EPSDT services.

32. EPSDT services are required to be provided at periodic intervals throughout a child's development that meet reasonable standards of medical and dental practice, and more frequently as may be medically necessary for any particular child.

33. Ensuring adequate provision of EPSDT services to children was a high priority for Congress in enacting the Medicaid Act.

34. IDPA is responsible for issuing and administering policies with respect to the Healthy Kids program.

35. IDPA's policies to guide IDHS staff activity with respect to the Healthy Kids program are contained in section 20-21-00 of its Policy Manual (dated 3/1/97) and the Worker Action Guide (dated 9/22/00).

36. IDPA does not have any methods or procedures in place to monitor, supervise or enforce the activities of IDHS local office staff with regard to the Healthy Kids program.

37. Primary and preventive health care for children, including early treatment of acute illnesses and early amelioration of chronic illnesses, is an important and cost-effective method to prevent the development of more serious and costly health problems.

38. Many childhood ailments and handicaps can be prevented, cured, or corrected if detected early enough.

39. Early detection of childhood illnesses and ailments can prevent the development of more serious conditions, which may be more difficult and costly to treat if left undetected.

40. Doctors in emergency room settings routinely treat Medicaid-enrolled children who have not had timely well-child screenings or immunizations.

41. Doctors in emergency room settings routinely treat Medicaid-enrolled children who need corrective treatment, but whose need for such corrective treatment was not discovered because those children had not had timely screening examinations.

### **III. BILLING AND ENCOUNTER DATA MAINTAINED BY THE STATE.**

42. IDPA maintains records of the medical services provided to children enrolled in Medicaid in the form of individual billing and claims data submitted by medical providers.

43. IDPA's records of individual medical services billed are kept in its Medicaid Management Information System ("MMIS").

44. The data maintained in the MMIS is IDPA's only database of information concerning services received by individual Medicaid recipients.

45. The MMIS includes data on all medical services paid for by IDPA, including associated payments, and certain information pertaining to the providers and recipients of each service.

46. IDHS causes a computer system called Cornerstone to be maintained to collect information about certain tests and immunizations provided to certain Illinois children.

47. The Cornerstone system is intended to compile data from several separate systems, including IDPA's MMIS, the Cook County Department of Health, the City of Chicago Department of Health, and various not-for-profit community health agencies.

48. IDHS does not conduct quality assurance checks of the integrity of the data imported into the Cornerstone system.

49. The State has not used Cornerstone data in conjunction with MMIS data to evaluate provision of EPSDT services to Medicaid-eligible children in Cook County.

50. The State has not used Cornerstone data in conjunction with MMIS data to evaluate EPSDT rate setting.

51. IDPA does not keep data regarding rejected claims for payment by providers.

**A. The State Provides Reports to the Federal Government Based on Its Encounter Data.**

52. IDPA is required to provide reports on the level of care being provided to children on Medicaid to the federal Centers for Medicare and Medicaid Services ("CMS").

53. CMS was formerly known as the Health Care Financing Administration ("HCFA").

54. CMS is a part of the U.S. Department of Health and Human Services ("HHS").

55. IDPA is required to prepare a form known as CMS-416 to report on the level of care being provided to children on Medicaid.

56. IDPA submits a CMS-416 report annually to CMS.

57. The information on the CMS-416 serves a dual purpose: (a) to demonstrate a state's success or failure in attaining participation and screening goals; and (b) to show trend patterns and projections "from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care." See CMS State Medicaid Manual § 2700.4.A.

58. Although the information that IDPA reports to CMS on form CMS-416 is statewide data, IDPA also breaks out Cook County data (excluding children enrolled in managed care entities or who are wards of DCFS) using the same methodology that it uses in preparing the CMS-416 report.

59. IDPA also breaks out CMS-416 data for each managed care entity operating in Cook County using the same methodology that it uses in preparing the CMS-416 report.

60. IDPA reports the number of unique children who receive blood lead screenings and preventive dental care on its annual CMS-416 report.

61. Although not reported on the CMS-416 submission, IDPA compiles data on the number of children on Medicaid who receive vision and dental screenings during the year.

**B. The State's CMS-416 methodology**

62. Under the CMS-416 methodology, IDPA calculates the "participant ratio" for several different age groups: birth to attainment of age 1; ages 1-2; ages 3-5; ages 6-10; ages 11-14; ages 15-18; and ages 19-20.

63. The "participant ratio" is calculated by dividing (a) the total number of Medicaid-eligible children receiving at least one well-child screening by (b) the total Medicaid-eligible children who should receive at least one well-child screening.

64. For purposes of the "participant ratio," the numerator in the ratio is an unduplicated count of those children who received at least one well-child screening during the year covered by the 416 data.

65. For purposes of the "participant ratio," the denominator in the ratio is the product of three factors: (a) the number of total Medicaid-eligible children who should receive at least one well-child screening, multiplied by (b) the number of well-child screenings expected to be received by an individual in each age group in one year, multiplied by (c) the average period that each child in the age group was eligible for Medicaid during the year.

66. Under the CMS-416 methodology, IDPA calculates a "screening ratio" for several different age groups: birth to attainment of age 1; ages 1-2; ages 3-5; ages 6-10; ages 11-14; ages 15-18; and ages 19-20.

67. The "screening ratio" is calculated by dividing the total number of well-child screens received by children on Medicaid by the "expected" number of well-child screens.

68. The "expected" number of well-child screens, for purposes of the CMS-416 screening ratio, is the product of (a) the total number of children eligible for EPSDT services, multiplied by (b) the number of well-child screens expected to be received by a child in each age group, multiplied by (c) the average period of eligibility for those children eligible for EPSDT services.

69. In calculating the "screening ratio" for well-child screening examinations, the State counts all screening examinations received by children, even if a particular child receives more than the recommended number of screening exams.

70. The State's CMS-416 "screening ratio" does not provide an accurate measure of which children are not receiving EPSDT services, because it looks at all initial and periodic screening services received by a child, even if the total number of screens exceeds the number of screens set forth in the periodicity schedule; for example, a 1-year-old child receiving 6 screens would have all 6 screens counted for purposes of the "screening ratio" even though he should receive 3 screens (at 12 months, 15 months, and 18 months).

71. IDPA includes many types of doctor visits that do not comply with the EPSDT well-child screening criteria as "screening examinations" for purposes of CMS-416, including but not limited to prenatal visits, and brief visits with a doctor lasting 5-10 minutes.

72. For purposes of calculating the number of "screening examinations" for purposes of completing the CMS-416, IDPA includes prenatal visits by teenagers.

73. For purposes of calculating the number of "screening examinations" for purposes of completing the CMS-416, IDPA includes visits with a doctor lasting 5 to 10 minutes.

74. For purposes of calculating the number of "screening examinations" for purposes of completing the CMS-416, IDPA includes CPT Code 99212.

75. For purposes of calculating the number of "screening examinations" for purposes of completing the CMS-416, IDPA includes CPT Code 99211.

76. All Medicaid-enrolled children born in a hospital in Cook County should receive one EPSDT well-child service before leaving the hospital after birth.

**C. The State's CMS-416 Data for Cook County**

77. The State's CMS-416 data shows a "participant ratio" of less than 80% for all eligible children in Cook County in federal fiscal years 2002, 2001, 2000, and 1999.

78. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the number of Medicaid-enrolled children in Cook County, Illinois, as reported by IDPA, receiving at least one screening examination is:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Children	39,737	86,829	107,318	127,993	129,933	77,227	25,970	595,007
Children getting at least one screen	36,579	56,962	53,064	31,715	41,238	18,690	6,337	244,585
Participant Ratio	.920	.656	.562	.556	.889	.550	.677	.665

79. Data from federal fiscal years 2001, 2000, and 1999 show results similar to federal fiscal year 2002. The "participant ratios" for Medicaid-enrolled children in Cook County as reported by IDPA are as follows:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
2001	.906	.647	.533	.527	.861	.539	.648	.643
2000	.894	.628	.550	.562	.908	.566	.688	.656
1999	.871	.610	.546	.589	.912	.578	.766	.654

80. Based upon the State's own internally-prepared CMS-416 Reports for Cook County, one-third of children in Cook County enrolled in Medicaid, as calculated by IDPA, did not receive any well-child screening services.

81. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois, as calculated by IDPA, received blood lead screenings as follows:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Total Kids	39,737	86,829	107,318	127,993	129,933	77,227	25,970	595,007
Kids Receiving Screens	3,011	36,422	40,573	9,384	2,886	593	191	93,060

82. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois, as calculated by IDPA, received vision screenings as follows:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Total Kids	39,737	86,829	107,318	127,993	129,933	77,227	25,970	595,007
Kids Receiving Screens	361	1,185	5,224	15,709	21,757	9,774	2,060	56,070

83. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois, as calculated by IDPA, received hearing screenings as follows:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Total Kids	39,737	86,829	107,318	127,993	129,933	77,227	25,970	595,007
Kids Receiving Screens	254	69	11,848	68,850	28,411	12,895	609	122,936

84. Using the CMS-416 methodology, none of the MCOs that contract with IDPA to provide services to Medicaid recipients (i.e., United, Amerigroup, Harmony, Humana and Family Health Network) achieved participant ratios of 80 percent in federal fiscal years 2000, 2001, or 2002.

**D. State data regarding MCO services.**

**1. MCO performance generally**

85. Each MCO contract with the State provides that the MCO shall ensure that all Medicaid-enrolled children receive all EPSDT services.

86. Each MCO contract with the State provides that the MCO shall ensure that, at a minimum, 80% of all children enrolled receive EPSDT services.

87. IDPA requires MCOs that contract with Medicaid to monitor utilization of services, including well-child screenings.

88. All MCOs that contract with IDPA are contractually obligated to collect and report to IDPA data showing the EPSDT services provided to enrolled children on Medicaid.

89. All providers enrolled in MCOs are also enrolled to provide service to Medicaid recipients on a fee-for-service basis.

90. 100% of the physicians who participate in the IDPA managed care program are also in the IDPA fee-for-service program because the physician must be enrolled in the Medicaid program to provide services through an IDPA-contracted MCO.

91. IDPA does not collect data on how many patients a physician contracted with an MCO may or may not provide services to on a fee-for-service basis.

92. Although the State pays MCOs for medical services based on "capitated" rates (i.e., a certain amount per member, per month), MCOs can pay enrolled providers on a fee-for-service basis.

93. None of the five MCOs providing services to Medicaid-enrolled children in Cook County have achieved the contractually required level of performance in providing well-child exams to MCO-enrolled Medicaid-eligible children in Cook County.

94. None of the five MCOs providing services to Medicaid-enrolled children in Cook County have achieved the contractually required level of performance in providing immunizations to MCO-enrolled Medicaid-eligible children in Cook County.

95. No MCO has ever met the 80% EPSDT participation minimum set forth in the MCO contract with the State.

96. Using the CMS-416 data, Amerigroup did not meet the contracted 80% EPSDT participation minimum in 2000, 2001, or 2002.

97. Using the CMS-416 data, Harmony did not meet the contracted 80% EPSDT participation minimum in 2000, 2001, or 2002.

98. Using the CMS-416 data, Family Health Network did not meet the contracted 80% EPSDT participation minimum in 2000, 2001, or 2002.

99. The State is entitled to sanction MCOs for contractual noncompliance.

100. On October 2, 2002, Nelly Ryan, IDPA Division of Medical Programs, notified each of the MCOs contracting to provide care to Medicaid recipients in Cook County (United, Amerigroup, Harmony, Humana, and Family Health Network) that each was failing to achieve the participation goals set forth in their respective contracts with IDPA.

101. IDPA has not taken any action to enforce the MCO contractual performance requirements concerning provision of well-child examinations and immunizations to MCO-enrolled Medicaid-eligible children in Cook County.

102. The State has chosen not to enforce the performance requirements of the MCO contracts with regard to well-child examinations and immunizations to Medicaid-eligible children through available sanctions.

103. No MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has met the EPSDT performance requirements in the MCO's contract with IDPA.

104. No MCO that has ever contracted with IDPA to provide services to the Medicaid population in Cook County has ever been sanctioned for failure to provide EPSDT services as required in the MCO's contract with IDPA.

## **2. Immunization data**

105. Cornerstone immunization data from August 12, 2003 for children in Cook County enrolled in Medicaid shows that more than 60% of these children have not completed either the 4-3-1-3 (4 DtaP, 3 IPV, 1 MMR, and 3 HIB) or 4-3-1 (4 DtaP, 3 IPV, 1 MMR) shot groups by 36 months of age.

106. Approximately half of the children enrolled in Medicaid statewide have completed the 4-3-1-3 and 4-3-1 shot groups by 36 months of age.

107. The U.S. National Immunization Survey of the U.S. Centers for Disease Control for the third quarter of 2001 through the second quarter of 2002 showed that children in the City of Chicago from 19 to 35 months of age had an overall immunization rate of 72.9% for the 4-3-1 shot group and 71.2% for the 4-3-1-3 shot group.

108. Based on data from the National Immunization Program of the United States Centers for Disease Control, children in Illinois and children in Chicago between 19 and 35 months of age have a higher immunization rate for the 4-3-1-3 and 4-3-1 shot groups than do children enrolled in Medicaid in Cook County.

109. Cornerstone immunization data from August 12, 2003 for each MCO covering children on Medicaid in Cook County shows that from 60-70% of these children receiving care from managed care organizations have not completed either the 4-3-1-3 and 4-3-1 shot groups by the age of 36 months.

**(a) 4-3-1-3 shot group**

110. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with United Healthcare, 21.95% (236 of 1,075 clients) had received the 4-3-1-3 shot group by age 24 months, and 27.08% (315 of 1,163 clients) had received the 4-3-1-3 shot group by age 36 months.

111. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Harmony, 28.94% (840 of 2,902 clients) had received the 4-3-1-3 shot group by age 24 months, and 33.32% (968 of 2,905 clients) had received the 4-3-1-3 shot group by age 36 months.

112. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Family Health Network, 34.36% (758 of 2,206 clients) had received the 4-3-1-3 shot group by age 24 months, and 37.08% (609 of 1,642 clients) had received the 4-3-1-3 shot group by age 36 months.

113. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Americaid, 24.76% (571 of 2,306 clients) had received the 4-3-1-3 shot group by age 24 months, and 29.05% (676 of 2,327 clients) had received the 4-3-1-3 shot group by age 36 months.

114. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Humana, 22.94% (251 of 1,094 clients) had

received the 4-3-1-3 shot group by age 24 months, and 29.32% (317 of 1,081 clients) had received the 4-3-1-3 shot group by age 36 months.

**(b) 4-3-1 shot group**

115. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with United Healthcare, 22.60% (243 of 1,075 clients) had received the 4-3-1 shot group by age 24 months, and 28.28% (329 of 1,163 clients) had received the 4-3-1 shot group by age 36 months.

116. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Harmony, 29.63% (860 of 2,902 clients) had received the 4-3-1 shot group by age 24 months, and 34.28% (996 of 2,905 clients) had received the 4-3-1 shot group by age 36 months.

117. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Family Health Network, 35.31% (779 of 2,206 clients) had received the 4-3-1 shot group by age 24 months, and 38.36% (630 of 1,642 clients) had received the 4-3-1 shot group by age 36 months.

118. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Americaid, 25.32% (584 of 2,306 clients) had received the 4-3-1 shot group by age 24 months, and 30.59% (712 of 2,327 clients) had received the 4-3-1 shot group by age 36 months.

119. Cornerstone immunization data from August 12, 2003 showed that, for Medicaid recipients in Cook County enrolled with Humana, 23.67% (259 of 1,094 clients) had received the 4-3-1 shot group by age 24 months, and 30.52% (330 of 1,081 clients) had received the 4-3-1 shot group by age 36 months.

**3. Other measures: United Healthcare**

120. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in United Health Care of Illinois, Inc., as calculated by IDPA, received a screening examination:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	567	1,880	3,323	5,745	7,029	3,657	215	22,448
Screens	357	703	683	392	572	190	31	2,928

121. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in United Health Care of Illinois, Inc., as calculated by IDPA, received preventive dental services:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	567	1,880	3,323	5,745	7,029	3,657	215	22,448
Services	0	146	1,205	1,711	1,710	656	40	5,468

122. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in United Health Care of Illinois, Inc., as calculated by IDPA, received a blood lead screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	567	1,880	3,323	5,745	7,029	3,657	215	22,448
Screens	24	455	687	260	72	10	1	1,509

123. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in United Health Care of Illinois, Inc., as calculated by IDPA, received a hearing screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	567	1,880	3,323	5,745	7,029	3,657	215	22,448
Screens	2	1	379	3,730	1,974	663	0	6,749

124. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in United Health Care of Illinois, Inc., as calculated by IDPA, received a vision screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	567	1,880	3,323	5,745	7,029	3,657	215	22,448
Screens	0	0	367	3,140	3,761	802	0	8,070

125. Data for federal fiscal years 2001 and 2000 show similar results as to each of the measures in the five preceding paragraphs.

**4. Other measures: Amerigroup**

126. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Amerigroup Illinois, Inc., as calculated by IDPA, received a screening examination:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,502	4,712	6,080	6,771	5,759	2,506	834	28,112
Screens	1,301	2,217	2,058	1,045	1,035	346	167	8,169

127. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Amerigroup Illinois, Inc., as calculated by IDPA, received preventive dental services:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,502	4,712	6,080	6,771	5,759	2,506	834	28,112
Services	5	338	2,269	2,126	1,463	482	187	6,870

128. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Amerigroup Illinois, Inc., as calculated by IDPA, received a blood lead screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,502	4,712	6,080	6,771	5,759	2,506	834	28,112
Screens	68	1,242	1,433	335	60	8	8	3,154

129. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in Amerigroup Illinois, Inc., as calculated by IDPA, received a hearing screening:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,502	4,712	6,080	6,771	5,759	2,506	834	28,112
Screens	4	4	624	4,436	1,527	493	3	7,091

130. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Amerigroup Illinois, Inc., as calculated by IDPA, received a vision screening:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,502	4,712	6,080	6,771	5,759	2,506	834	28,112
Screens	1	3	586	3,667	3,069	597	4	7,927

131. Data for federal fiscal years 2000 and 2001 show similar results as to each of the measures in the five preceding paragraphs.

## 5. Other measures: Family Health Network

132. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Family Health Network, as calculated by IDPA, received a screening examination:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,336	3,509	2,878	2,704	2,067	1,023	364	13,881
Screens	1,246	2,081	1,197	504	462	202	87	5,779

133. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Family Health Network, as calculated by IDPA, received preventive dental services:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,336	3,509	2,878	2,704	2,067	1,023	364	13,881
Services	1	262	1,160	927	530	179	73	3,132

134. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Family Health Network, as calculated by IDPA, received a blood lead screening:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,336	3,509	2,878	2,704	2,067	1,023	364	13,881
Screens	111	1,368	1,087	262	48	3	3	2,882

135. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in Family Health Network, as calculated by IDPA, received a hearing screening:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,336	3,509	2,878	2,704	2,067	1,023	364	13,881
Screens	4	1	368	1,981	569	187	2	3,112

136. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Family Health Network, as calculated by IDPA, received a vision screening:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	1,336	3,509	2,878	2,704	2,067	1,023	364	13,881
Screens	0	2	338	1,634	1,165	240	2	3,381

137. Data for federal fiscal years 2000 and 2001 show similar results as to each of the measures in the five preceding paragraphs.

**6. Other measures: Humana**

138. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Humana Health Plan, Inc., as calculated by IDPA, received a screening examination:

Age	0-1	1-2	3-5	6-9	10-14	15-18	19-20	All
Kids	770	1,819	2,628	3,291	2,894	1,321	289	13,012
Screens	531	514	376	193	223	84	58	1,979

139. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Humana, as calculated by IDPA, received preventive dental services:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	770	1,819	2,628	3,291	2,894	1,321	289	13,012
Services	1	91	901	1,041	714	242	43	3,033

140. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Humana, as calculated by IDPA, received a blood lead screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	770	1,819	2,628	3,291	2,894	1,321	289	13,012
Screens	14	217	251	71	10	3	2	568

141. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in Humana, as calculated by IDPA, received a hearing screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	770	1,819	2,628	3,291	2,894	1,321	289	13,012
Screens	0	1	276	2,068	675	222	2	3,244

142. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Humana, as calculated by IDPA, received a vision screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	770	1,819	2,628	3,291	2,894	1,321	289	13,012
Screens	0	1	271	1,744	1,363	269	2	3,650

143. Data for federal fiscal years 2000 and 2001 show similar results as to each of the measures in the five preceding paragraphs.

**7. Other measures: Harmony**

144. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Harmony Health Plan of Illinois, Inc., as calculated by IDPA, received a screening examination:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,346	4,226	6,640	8,716	8,490	3,940	640	33,998
Screens	1,006	1,965	2,047	1,171	1,706	558	139	8,592

145. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Harmony, as calculated by IDPA, received preventive dental services:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,346	4,226	6,640	8,716	8,490	3,940	640	33,998
Services	0	276	2,742	3,121	2,630	753	133	9,655

146. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Harmony, as calculated by IDPA, received a blood lead screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,346	4,226	6,640	8,716	8,490	3,940	640	33,998
Screens	38	849	1,336	333	81	6	0	2,643

147. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, Medicaid-enrolled children in Cook County, Illinois enrolled in Harmony, as calculated by IDPA, received a hearing screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,346	4,226	6,640	8,716	8,490	3,940	640	33,998
Screens	1	22	628	4,615	1,809	567	2	7,644

148. Pursuant to data generated in completing CMS-416 Reports for federal fiscal year 2002, the following Medicaid-enrolled children in Cook County, Illinois enrolled in Harmony, as calculated by IDPA, received a vision screening:

Age	<b>0-1</b>	<b>1-2</b>	<b>3-5</b>	<b>6-9</b>	<b>10-14</b>	<b>15-18</b>	<b>19-20</b>	<b>All</b>
Kids	1,346	4,226	6,640	8,716	8,490	3,940	640	33,998
Screens	0	20	717	3,888	3,449	716	2	8,792

149. Data for federal fiscal years 2000 and 2001 show similar results as to each of the measures in the five preceding paragraphs.

### **8. Other MCO data: HEDIS reports**

150. Many MCOs prepare annual reports under the aegis of the National Committee on Quality Assurance, the MCO credentialing organization, which are commonly known as HEDIS reports.

151. The National Medicaid HEDIS Database Project of NCQA collects standardized data from Medicaid MCOs on health care performance measures.

152. United Healthcare's 2002 HEDIS reports show that the majority of Medicaid-enrolled children enrolled with United Healthcare never saw a doctor in 2002.

153. In United Healthcare's 2002 HEDIS report, United Healthcare reported that 50.99% of its enrolled MCO child members between the ages of 12 and 24 months did not have a visit to a primary care practitioner in 2002.

154. In United Healthcare's 2002 HEDIS report, United Healthcare reported that 65.09% of its enrolled MCO child members between the ages of 25 months and 6 years did not have a visit to a primary care practitioner in 2002.

155. In United Healthcare's 2002 HEDIS report, United Healthcare reported that 70.84% of its enrolled MCO child members between the ages of 7 and 11 years did not have a visit to a primary care practitioner in 2002.

#### **IV. DR. DARLING'S ANALYSIS OF STATE ENCOUNTER DATA.**

156. The Children retained Dr. Thomas Darling to analyze the State's encounter data from the MMIS and Cornerstone systems to determine the level of medical services that have been provided to the Children for the period of July 1, 1998 through December 31, 2001 (the "Data Period").

157. Dr. Darling received his Ph.D. in Public Administration and Policy, with concentrations in policy analysis and administrative behavior, from the Rockefeller College of Public Affairs and Policy, State University of New York at Albany, in 1994.

158. Dr. Darling is on the faculty of The School of Public Affairs at the University of Baltimore in Baltimore, Maryland, where he is the Director of Government and Technology at the Schaefer Center for Public Policy.

159. Dr. Darling has extensive professional and academic experience in conducting sophisticated analyses of large amounts of data, including working with a variety of state agencies on developing outcome-based performance measures regarding the provision of social services to children.

160. Dr. Darling analyzed the encounter data from the MMIS and Cornerstone systems to determine the level of services provided to the Children during the Data Period, including the number of services that each child received and the number of children who received, e.g., no services, one service, two services, etc. in a given time period.

161. Dr. Darling's analysis showed that over one-third of Medicaid-enrolled children in Cook County did not receive any preventive health care during the Data Period.

162. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received well-child exams.

163. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received a blood lead screening.

164. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received a vision screening.

165. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received a hearing screening.

166. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received Haemophilus B (HIB) immunizations.

167. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received Polio (IPV) immunizations.

168. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received Diphtheria and Tetanus (DtaP) immunizations.

169. IDPA has never performed an analysis of its MMIS data to identify all of the children on Medicaid that have not received Measles, Mumps and Rubella (MMR) immunizations.

170. Neither IDPA nor IDHS has ever performed an analysis of Cornerstone data to identify all of the children on Medicaid that have not received Haemophilus B (HIB) immunizations.

171. Neither IDPA nor IDHS has ever performed an analysis of Cornerstone data to identify all of the children on Medicaid that have not received Polio (IPV) immunizations.

172. Neither IDPA nor IDHS has ever performed an analysis of Cornerstone data to identify all of the children on Medicaid that have not received Diphtheria and Tetanus (DtaP) immunizations.

173. Neither IDPA nor IDHS has ever performed an analysis of Cornerstone data to identify all of the children on Medicaid that have not received Measles, Mumps and Rubella (MMR) immunizations.

**A. Data Analyzed by Dr. Darling**

**1. MMIS data**

174. Dr. Darling analyzed data produced by IDPA on August 15, 2002 on two CD-ROM disks containing three files of ASCII text data, entitled "Eligibility.txt," "Encounters.txt," and "Diagnosis.txt."

175. The Eligibility.txt file contains "an individual eligibility segment for each distinct Medicaid eligibility period for each child identified in the class," and "consists of all eligibility data for the children involved in this action."

176. The data contained in the Eligibility.txt file consists of 3,415,448 records representing 957,710 unique Medicaid recipients.

177. Recipient identifiers included in the IDPA data files are unique, but encoded by IDPA to avoid disclosure of individual patient identities.

178. The Encounters.txt file contains "a record for each encounter during which a child identified in the class received a potentially countable EPSDT service," and "consists of all encounter data for the children involved in this action."

179. The data contained in the Encounters.txt file consists of 8,376,145 records of services provided to 695,165 Medicaid recipients in the course of 6,391,072 distinct provider visits.

180. All service records in the Encounters.txt file had a matching recipient number in the Eligibility.txt file.

181. The records in the Encounters.txt file identify, by procedure code, which specific services were received by the Medicaid recipient.

182. The Diagnosis.txt file contains "the Diagnosis Codes" used for encounters in the Encounters.txt file, and "consists of Diagnosis codes that correspond to encounters used in the Encounter table."

183. Dr. Darling reviewed a number of specific procedures identified by their unique 5-digit "CPT codes."

184. An examination coded as 99201 connotes a "new patient" visit where the patient presents only limited or minor problems, and where a physician will typically spend only 10 minutes face-to-face with the patient and/or his or her family.

185. An examination coded as 99202 connotes a "new patient" visit where the patient presents problems of low to moderate severity, and where a physician will typically spend roughly 20 minutes face-to-face with the patient and/or his or her family.

186. An examination coded as 99203 connotes a "new patient" visit where the patient presents problems of moderate severity, and where a physician will typically spend 30 minutes face-to-face with the patient and/or his or her family.

187. An examination coded as 99211 connotes an "established patient" visit where the patient may not require even the presence of a physician. Typically, such patients present minimal problems, and a physician will typically spend, at most, only 5 minutes performing or conducting services.

188. An examination coded as 99212 connotes an "established patient" visit where the patient presents only limited or minor problems, and where a physician will typically spend only 10 minutes face-to-face with the patient and/or his or her family.

189. An examination coded as 99213 connotes an "established patient" visit where the patient presents problems of low to moderate severity, and where a physician will typically spend 15 minutes face-to-face with the patient and/or his or her family.

190. In light of the lag between the date services are provided and the date payment information is entered into IDPA's billing system, Dr. Darling reasonably limited his analyses to services provided between July 1, 1998 and December 31, 2001.

191. Dr. Darling's analyses, limited to the date range of July 1, 1998 to December 31, 2001, included records for 910,451 unique Medicaid recipients.

192. The data analyzed by Dr. Darling reflected 7,363,206 services provided to 654,946 unique Medicaid recipients between July 1, 1998 and December 31, 2001.

## **2. Cornerstone data**

193. Dr. Darling also analyzed additional data produced by IDPA on June 12, 2003 on a CD-ROM entitled "Cornerstone Data," which included a data file entitled "Cornerstone.txt" containing 2,865,073 records of immunization services.

194. Dr. Darling reasonably limited his analyses of Cornerstone data records to services occurring within the July 1, 1998 to December 31, 2001 time period.

195. Dr. Darling reasonably excluded from his analysis records of services containing no Medicaid recipient identifier.

196. Dr. Darling reasonably excluded from his analysis records of services associated with recipient identifiers that did not exist among the 910,451 unique Medicaid recipients identified in the IDPA's MMIS data.

197. The date of birth associated with 2,527 recipient identifiers contained in the Cornerstone data failed to match the date of birth associated with those recipient identifiers in the MMIS data, and that the gender code associated with 4,653 recipient identifiers contained in

the Cornerstone data failed to match the gender code associated with those recipient identifiers in the MMIS data.

### **3. Data sources**

198. Emergency rooms do not regularly provide well-child services or immunizations.

199. Federally Qualified Health Centers ("FQHCs") bill for all well-child, immunization, and sick-child encounters.

200. IDPA's Provider Manual for Healthy Kids Providers requires that physicians bill IDPA for well-child visits under well-child codes only.

### **B. Analysis Of Well-Child Services**

201. Dr. Darling analyzed the number of well-child examinations that were received by Children during the Data Period in a variety of age groupings, including: ten (10) days to eleven (11) months; eleven (11) months to twenty-three (23) months; twenty-three (23) months to thirty-five (35) months; thirty-five (35) months to forty-seven (47) months; forty-seven (47) months to fifty-nine (59) months; and fifty-nine (59) months to seventy-one (71) months.

202. Dr. Darling's analysis does not include services received prior to 10 days of age in order to factor out any services received in the hospital as part of birth and postpartum services.

203. In analyzing the number of children that received appropriate well-child examinations, Dr. Darling looked at two categories of examinations: first, those examinations in which doctors are required to provide all components of an EPSDT screening (Dr. Darling described these services as "Healthy Moms Healthy Kids examinations" or "HMHK examinations" because these services satisfy the requirements for payment of the Healthy Moms

Healthy Kids EPSDT program); and second, all services that IDPA counts as "well-child" examinations for federal reporting purposes (Dr. Darling referred to these as "IDPA well-child examinations").

204. The category of IDPA well-child examinations includes all "HMHK examinations" and also other services that do not satisfy the requirements of an EPSDT screen, such as prenatal examinations for pregnant teenagers and exams of five minutes length.

205. Dr. Darling also analyzed a set of examinations that was broader than IDPA well-child examinations, which includes "sick kid" visits. Dr. Darling referred to this category of visits as "any child" exams.

206. Dr. Darling defined "HMHK well-child examinations" to include all services identified by procedure code W7018, procedure codes 99381 to 99385, and procedure codes 99391 to 99395.

207. Dr. Darling defined "IDPA well-child examinations" to include: (i) all HMHK well-child examinations; plus (ii) services identified by procedure codes 99204, 99205, 99215, 99201 through 99203; plus (iii) services identified by procedure codes 99211 through 99214 where the service also carries a related diagnosis code between "V20" and "V202," or has a related diagnosis code of V70, V703, V705, or V709; plus (iv) services identified by procedure codes 99431 and 99432 for children 11 months of age or less.

208. Dr. Darling defined "any child examinations" to include (i) all IDPA well-child examinations, plus (ii) services identified by procedure codes 99204, 99205, 99215, 99201 through 99203, plus (iii) services identified by procedure codes 99211 through 99214 where the service does not carry a related diagnosis code between "V20" and "V202" or have a related diagnosis code of V70, V703, V705, or V709.

209. According to the MMIS data, 60.6% of all eligible Children between the age of 10 days and 11 months during the Data Period received 2 two IDPA well-child examinations or less paid for by IDPA, with 43% not receiving a single IDPA well-child examination paid for by IDPA.

210. According to the MMIS data, only 8.2% of Children between the age of 10 days and 11 months received at least six IDPA well-child examinations paid for by IDPA.

211. According to the MMIS data, 65.3% of Children between the age of 11 months and 23 months received one (1) IDPA well-child examination or less paid for by IDPA, with 49.7% not receiving a single IDPA well-child examination paid for by IDPA.

212. There would be no significant difference in the results of Dr. Darling's findings if he limited his analyses to those Children who were "continuously eligible" for Medicaid throughout the period, or included Children who had periods where he/she was not covered by Medicaid.

### **C. Analyses Of Specific Screens And Immunizations**

#### **1. Immunizations**

213. According to the State's MMIS and Cornerstone data, 48.0% of all Medicaid-eligible children in Cook County that were between the age of 10 days and 11 months did not receive any HIB immunizations paid for by IDPA; 9.6% received one HIB immunization paid for by IDPA; 15.2% received two HIB immunizations paid for by IDPA; and 27.2% received three HIB immunizations or more paid for by IDPA.

214. According to the State's MMIS and Cornerstone data, 52.3% of all Medicaid-eligible children in Cook County between the age of 10 days and 5.5 months did not receive any polio (IPV) immunizations paid for by IDPA; 15.5% received one IPV immunization

paid for by IDPA; 28.7% received two IPV immunizations paid for by IDPA; and 3.5% received three or more IPV immunizations paid for by IDPA.

215. According to the State's MMIS and Cornerstone data, 46.6% of all Medicaid-eligible children in Cook County between the age of 10 days and 11 months did not receive any Diphtheria and Tetanus (DtaP) immunizations paid for by IDPA; 8.8% received one DtaP immunization paid for by IDPA; 11.3% received two DtaP immunizations paid for by IDPA; and 33.2% received three DtaP immunizations or more paid for by IDPA.

216. With respect to Measles, Mumps and Rubella (MMR) immunizations, 56.6% of all Medicaid-eligible children in Cook County between the age of 11 and 25 months did not receive any MMR immunization paid for by IDPA.

## **2. Blood lead screens**

217. All children on Medicaid should receive a screening blood lead test between 12 and 24 months, and children over the age of 24 months, up to 72 months of age, for whom no record of a previous screening blood lead test exists, should also receive a screening blood lead test.

218. According to the State's MMIS data, 77.9% of all Medicaid-eligible children in Cook County between the ages of 11 months and 23 months did not receive a blood lead screening test paid for by IDPA during the Data Period.

219. Medicaid-enrolled children in Cook County are more likely to have elevated blood lead levels than children in Cook County not on Medicaid.

## **3. Vision screens**

220. All children should receive annual vision screenings from ages 3 through 6, and further vision screenings at ages 8, 10, 12, 15 and 18.

221. According to the State's MMIS data, 97.3% of Medicaid-eligible children between the age of 35 months and 47 months did not receive a vision examination paid for by IDPA during the Data Period.

#### **4. Hearing screens**

222. All children should receive a subjective hearing screening as part of each well-child visit.

223. All children should receive an objective audiological screening to begin at age four, annually for children between the ages of 4 through 6, and at 8, 10, 12, 15, and 18 years of age.

224. According to the State's data, 93.6% of Medicaid-eligible children between the age of 47 months and 59 months did not receive a hearing examination paid for by IDPA during the Data Period.

### **V. STATE EFFORTS TO INFORM RECIPIENTS OF EPSDT SERVICES**

225. The "Healthy Kids" program is IDPA's name for its EPSDT program.

226. The "KidCare" program is an umbrella term for all medical programs operated by the State of Illinois relating to children.

227. The KidCare program includes not only those children who are Medicaid-eligible, but also other children who are not eligible for Medicaid but who receive medical coverage through the State Children's Health Insurance Program ("SCHIP").

228. Eligibility for medical benefits under KidCare is broader than eligibility for medical benefits under Medicaid.

229. All children who receive KidCare are entitled to all of the covered services available under the Illinois Medicaid program.

230. The State has recently made efforts to increase enrollment in the KidCare program by actively marketing the eligibility standards of the KidCare program.

231. IDPA has effectively publicized and marketed the KidCare program to increase enrollment through a variety of means, including: (i) public service announcements on television and radio; (ii) public presentations at fairs and festivals; (iii) public presentations at community meetings; (iv) grants to community groups to assist in promoting KidCare to hard-to-reach groups or targeted groups such as families in certain ethnic groups, families in rural areas, and families who do not speak English; (v) radio, television, newspaper, and community advocacy directed to African-American families; (vi) radio, television, newspaper, and community advocacy directed to Hispanic and Spanish-speaking families; (vii) sponsoring events such as the Ringling Brothers Barnum and Bailey Circus; (viii) general advertising through radio, newspaper, and bus billboards in the Chicago area; (ix) mass transit advertising; and (x) distribution of KidCare-branded objects such as bookmarks, tattoos, stickers, coloring books, crayons, balloons, pins, and hand fans at fairs (including the Illinois State Fair).

232. KidCare marketing materials were developed by outside marketing and advertising consultants hired by the State.

233. Marketing materials for the KidCare program do not specifically include any information regarding the Healthy Kids/EPSTDT program.

**A. Information Provided to Medicaid Applicants**

234. Children and their families may apply for Medicaid coverage in one of three ways: (1) applying for Medicaid through a local IDHS office either in person or by mail; (2) mailing a KidCare application to the IDPA KidCare central processing unit; or (3) completing a KidCare application with a KidCare application agent (KCAA), who then sends the application to the IDPA's KidCare central processing unit.

235. The documents relating to EPSDT that a child receives depends on which enrollment method (s)he used in applying to the Medicaid program.

236. Most children in the Medicaid program in Cook County enrolled through IDHS local offices as opposed to through the central KidCare unit.

237. IDPA uses two documents to describe its Healthy Kids/EPSDT program to recipients: an 89-page KidCare Member Handbook, and a four-page pamphlet entitled "Healthy Kids: Good Health for Children and Teens" (also known as IDPA Form 1123).

238. The State has no documents except the KidCare Member Handbook and Form 1123 intended to provide general information about EPSDT services available to new Medicaid recipients.

239. The KidCare Member Handbook is an 89-page document which explains benefits and coverage under the KidCare program, recipient responsibilities such as co-pays and premiums, the periodicity schedule for child exams and immunizations, and grievance and appeal procedures.

240. Children who apply for the Medicaid program through local IDHS offices are given only the four-page Form 1123.

241. The KidCare Member Handbook is not provided to Medicaid recipients who apply for the Medicaid program through IDHS local offices.

242. Neither IDHS nor IDPA has any policy or procedure to govern the content and manner of how IDHS local office staff are to orally inform applicants of the Healthy Kids program.

243. Neither IDHS nor IDPA has any written training manuals relating to advising Medicaid applicants or recipients of the Healthy Kids program.

244. Neither IDHS nor IDPA has any procedure in place to track or monitor whether Medicaid applicants are actually told about the Healthy Kids program or given the Form 1123 document by IDHS local office staff.

245. The KidCare Member Handbook is distributed to persons who apply for the Medicaid program through the IDPA's KidCare central processing unit.

246. Staff of the IDPA's KidCare central processing unit are not required to orally explain the Healthy Kids program or EPSDT services generally to persons who enroll in the Medicaid program through that unit.

247. IDPA has no procedures or policies in place regarding orally informing Medicaid applicants and recipients of the Healthy Kids program for those persons who apply for Medicaid through the KidCare central processing unit.

248. Children who apply for KidCare through the IDPA's KidCare central processing unit are not provided with a copy of the Form 1123 document.

249. KidCare application agents are not required to orally inform Medicaid applicants about the Healthy Kids/EPSDT program.

250. KidCare application agents are not instructed in writing to inform Medicaid applicants about the Healthy Kids/EPSDT program.

251. The State does not provide to Medicaid recipients either in writing or orally any explanation of the reason for well-child medical care.

252. IDHS local office staff are not required to provide to Medicaid recipients at intake any oral explanation of EPSDT.

253. IDHS local office staff are not required to provide to Medicaid recipients at intake any oral explanation of the underlying medical reasons why well-child medical care is important.

254. IDHS local office staff are not required to work with families applying for Medicaid at intake to identify doctors who will provide EPSDT services to the Children.

255. IDHS local office staff are not required to work with families receiving Medicaid after intake to identify doctors who will provide EPSDT services to the Children.

256. IDHS local office staff are not provided with any instructions or guidance for informing Medicaid recipients about EPSDT services after the intake stage.

**B. Other EPSDT Notices Provided to Medicaid Recipients**

257. IDPA Form 1802 is a document sent by the IDHS central office annually to all children enrolled in Medicaid to provide information about the availability of EPSDT services.

258. IDPA Form 1802 is a document included once a year in mailings of Mediplan cards to Medicaid recipients.

259. IDPA Form 2286 is mailed to individual children on Medicaid periodically based on the individual child's date of birth.

260. IDPA Form 2286 informs children that they "may" be due for a well-child examination based on IDPA's periodicity schedule.

261. IDPA does not track how many Form 2286 notices are returned as undeliverable or follow up with families to whom notices are not delivered.

262. Other than as set forth above, there are no other methods employed by IDPA or IDHS to systematically disseminate information to children enrolled in Medicaid, or their families, about the Healthy Kids/EPSDT program.

263. IDPA does not send any EPSDT notices to children who receive Medicaid as part of a subsidized adoption agreement with the Illinois Department of Children and Family Services (DCFS).

264. IDPA does not survey whether Medicaid recipients receive automated periodicity notices or whether these notices are an effective way of notifying parents to take their children to medical providers.

265. IDPA does not study whether Medicaid recipients receive automated periodicity notices or whether these notices are an effective way of notifying parents to take their children to medical providers.

**C. Development of EPSDT Informational Materials**

266. All of IDPA's written informational materials regarding the Healthy Kids/EPSDT program, including Forms 1123, 1802, and 2286, are developed in-house by IDPA or IDHS.

267. IDPA does not field test its written informational materials regarding the Healthy Kids/EPSDT program with focus groups of actual recipients.

268. IDPA does not use outside linguists to develop or evaluate its written informational materials regarding the Healthy Kids/EPSDT program.

269. IDPA does not have any expert evaluate its written informational materials regarding the Healthy Kids/EPSDT program to ensure that they are readable by persons with limited education, literacy, or English proficiency.

270. IDPA does not evaluate its written informational materials regarding the Healthy Kids/EPSDT program with regard to persons with limited American cultural literacy.

271. IDPA's written informational materials regarding the Healthy Kids/EPSDT program are not tailored in any way to account for different recipient circumstances other than birthdate and gender.

272. IDPA's written informational materials regarding the Healthy Kids/EPSDT program are not tailored in any way to account for "at risk" populations, e.g., new moms, new recipients, recipients for less than 2 years, victims of sexual abuse, foster children.

273. IDPA does not evaluate the effectiveness of its written informational materials regarding the Healthy Kids/EPSDT program based on general Medicaid usage experience or history.

274. IDPA does not evaluate the effectiveness of its written informational materials regarding the Healthy Kids/EPSDT program as to particular recipients based on those recipients' individual Medicaid usage and history.

275. IDPA has not done any geographic studies as to Medicaid recipients who do or do not participate in or receive EPSDT services.

276. IDPA has not done any cultural studies as to Medicaid recipients who do or do not participate in or receive EPSDT services.

277. IDPA has not done any demographic studies as to Medicaid recipients who do or do not participate in or receive EPSDT services.

278. IDPA and IDHS do not have EPSDT notices in any languages other than English or Spanish.

279. IDPA and IDHS do not have any written policies regarding how to inform applicants who do not speak English or Spanish about EPSDT.

280. IDPA has not studied the most effective mix of oral and written material for informing recipients about EPSDT.

**D. Dr. Shanahan Analysis of Written EPSDT Materials**

281. Timothy Shanahan, Ph.D., is Professor of Reading Education at the University of Illinois at Chicago and the Director of the UIC Center for Literacy.

282. Professor Shanahan has received the Milton D. Jacobson Readability Research Award for his work on text difficulty analysis.

283. Professor Shanahan has worked on text difficulty and revision projects for a variety of organizations, including the Illinois Cancer Center and the Chicago Bar Association.

284. The Children retained Professor Shanahan to analyze the readability of the primary documents used by the State to inform Medicaid recipients about the Healthy Kids/EPSTD program.

285. Professor Shanahan evaluated each of the State's EPSTD informational documents with respect to the average reading grade level required to comprehend those documents.

286. Public health documents should have a difficulty level of approximately 4th to 6th grade to assure that a large proportion of adults understand the material.

287. Various pages of IDPA Form 1123 have average difficulties ranging from grade 3.7 to grade 7.9.

288. The child screening examination and immunization forms included in the Form 1123 are difficult to read.

289. IDPA Form 2286 has an average difficulty rating of grade 8.1.

**E. Other Informational Efforts Regarding EPSTD**

290. The State does not have written policies regarding how to inform applicants or recipients who are blind or deaf about EPSTD.

291. The State has no materials to effectively provide necessary EPSTD information to Medicaid applicants or recipients who are blind or deaf.

292. The State has not employed any methods for publicizing the EPSTD program to non-English or non-Spanish speaking populations such as public service

announcements or advertisements in other language media such as radio, television, and newspapers.

293. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using public service announcements on television or radio.

294. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using public presentations at fairs and festivals.

295. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using public presentations at community meetings.

296. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using grants to community groups to assist in promoting Healthy Kids to hard-to-reach groups or targeted groups such as families in certain ethnic groups, families in rural areas, and families who do not speak English.

297. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using radio, television, newspaper, and community advocacy directed to African-American families.

298. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using radio, television, newspaper, and community advocacy directed to Hispanic and Spanish-speaking families.

299. The State has not chosen to publicize and market the Healthy Kids/EPSDT program by sponsoring events such as the Ringling Brothers Barnum and Bailey Circus.

300. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using general advertising radio, newspaper, and bus billboards in the Chicago area.

301. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using mass transit advertising.

302. The State has not chosen to publicize and market the Healthy Kids/EPSDT program using distribution of Healthy Kids-branded objects.

303. IDPA has not issued instructions to non-primary care medical providers (such as emergency room doctors, hospitals, and specialists) about informing acute care or specialty patients about EPSDT services.

304. IDPA does not provide financial incentives for successful referrals of children receiving Medicaid to EPSDT providers.

305. The State has not chosen to disseminate information regarding the availability of the Healthy Kids/EPSDT program by outreach activities such as the development of cooperation agreements with local school districts, public health agencies, charities, clinics, hospitals and other health care providers, including developmental disability and mental health providers.

306. The State has not chosen to disseminate information regarding the availability of the Healthy Kids/EPSDT program by using the media for public service announcements and advertisements of the Healthy Kids/EPSDT program.

307. The State has not chosen to disseminate information regarding the availability of the Healthy Kids/EPSDT program by developing posters advertising EPSDT for display in hospital and clinic waiting rooms.

308. The State has not chosen to disseminate information regarding the benefits of preventive health care by outreach activities such as the development of cooperation agreements with local school districts, public health agencies, charities, clinics, hospitals and other health care providers, including developmental disability and mental health providers

309. The State has not chosen to disseminate information regarding the benefits of preventive health care by using the media for public service announcements and advertisements of the Healthy Kids/EPSDT program.

310. The State has not chosen to disseminate information regarding the benefits of preventive health care by developing posters advertising EPSDT for display in hospital and clinic waiting rooms.

**F. Other IDPA Information Sources: IDPA Hotline**

311. IDPA maintains a toll-free "hotline" to field all calls from recipients or applicants who may have questions of any kind regarding the Medicaid program or KidCare.

312. The IDPA hotline is staffed by a combination of permanent and temporary personnel.

**1. EPSDT information given through hotline**

313. IDPA does not provide any specific training to hotline staff regarding the Healthy Kids/EPSDT program.

314. The manual used to guide the hotline staff who answer calls is over 1,000 pages and contains information on various aspects of the Medicaid program for adults as well as children.

315. Only one (1) page in the IDPA hotline manual gives any guidance to hotline staff regarding the Healthy Kids/EPSDT program.

**2. Physician referrals through hotline**

316. IDPA's general hotline can provide, on request, information about doctors who might be willing to provide EPSDT services from a referral database.

317. It is difficult for parents of children on Medicaid to locate pediatricians and pediatric specialists to treat their children.

318. Parents of children on Medicaid call many doctors and are rejected for treatment because the doctor does not accept Medicaid reimbursement.

319. From March through August 2002, requests for assistance in finding a provider constituted the third highest category of calls to the IDPA hotline.

320. The hotline is often understaffed.

321. The hotline had a call abandonment rate of 25% in July 2003.

322. IDPA includes in its doctor referral database every doctor who has billed Medicaid for a service even once within the prior 18 months.

323. Annually, approximately 2,000 providers are determined to be non-participating, which means that that provider has not billed for a single service in the past 18 months.

324. IDPA does not maintain information regarding the willingness or availability of doctors listed in the IDPA hotline database to accept Medicaid patients, other than the fact that the doctor billed IDPA for at least one Medicaid service in the prior 18 months.

325. IDPA does not maintain information regarding the number of Medicaid patients a given provider in the IDPA hotline database will accept.

326. IDPA does not request information from enrolled providers on their availability to accept additional Medicaid patients.

327. IDPA does not request information from enrolled providers on their willingness to accept Medicaid patients.

328. Some providers on the IDPA hotline referral list who are listed as active providers have closed their practice to new Medicaid patients.

329. A Medicaid-enrolled provider need not guarantee that he or she will accept any Medicaid patients.

330. IDPA does not analyze the number of Medicaid patients providers who are enrolled in the Medicaid program will accept for treatment.

331. The IDPA hotline does not make appointments for Medicaid recipients, but instead leaves it to the recipient to call individual physicians from the referral list and ask if that physician is accepting Medicaid patients.

332. IDPA does no follow-up to determine whether a recipient who has been given a physician referral through the hotline was able to get an appointment with that physician.

333. In providing referrals, the hotline staff does not have information about, issues such as waiting times for appointments, board certification of physicians, or office hours of physicians.

**G. Information and Assistance Provided by IDHS Local Office Staff.**

334. The Healthy Kids Section of the IDHS Policy Manual is the sole written policy given to IDHS local offices regarding EPSDT duties.

335. IDPA does not train the IDHS local office staff in practices or procedures for referring or assisting Medicaid recipients in locating physicians.

336. IDPA does not train the IDHS local office staff in practices or procedures for scheduling appointments with physicians.

337. IDPA does not train the IDHS local office staff in practices or procedures for providing transportation to Medicaid recipients.

338. IDPA does not monitor the IDHS local offices' practices or procedures for referring or assisting Medicaid recipients in locating physicians

339. IDPA does not monitor the IDHS local offices' practices or procedures for scheduling appointments with physicians.

340. IDPA does not monitor the IDHS local offices' practices or procedures for providing transportation to Medicaid recipients.

341. IDHS caseworkers do not know that they should volunteer information on EPSDT to recipients at intake.

**1. Physician referrals and scheduling**

342. Neither IDHA nor IDPA check to ensure that IDHS local office caseworkers offer Medicaid recipients assistance in locating medical providers.

343. IDHS local offices do not have access to a computer database containing names of Medicaid-enrolled physicians to make referrals to children on Medicaid.

344. On a quarterly basis, IDPA sends a paper list of the physicians who have billed Medicaid within the prior 18 months to IDHS local offices.

345. IDHS local office staff maintain a paper physician list in binders located within each local IDHS office.

346. IDHS local office staff do not have a procedure in place for checking the accuracy of or updating the physician referral information provided by IDPA.

347. Many IDHS caseworkers are unaware that local offices have referral books with doctor lists.

348. IDHS local office staff do not receive training on how to make referrals for children on Medicaid to available physicians.

349. IDHS local offices do not have written procedures or guidelines in place to guide caseworkers in making referrals to physicians, such as how many or what types of physicians a Medicaid recipient should be referred to.

350. If asked by a Medicaid recipient for assistance in locating a doctor, IDHS local offices generally refer clients to the local clinics, and then refer to the IDPA's paper physician lists only if the person cannot be seen at the clinic.

351. IDHS local offices do not provide the IDPA hotline number to clients seeking information about physicians.

352. IDHS local office staff do not keep records of any referrals to physicians that they have made for children on Medicaid.

353. IDHS local office staff do not have information regarding the actual availability of doctors enrolled in the Medicaid program to accept a new Medicaid patient.

354. IDHS local office staff do not have information on the actual capacity of doctors enrolled in the Medicaid program to accept Medicaid patients.

355. IDHS local office staff do not have information on the specialties nor the board certification status of doctors enrolled in the Medicaid program.

356. IDHS local office staff generally do not call or otherwise communicate with physicians prior to making a referral to a recipient.

357. IDHS local office staff generally do not check with a Medicaid recipient after making a referral to a physician to ensure that the client was able to see that doctor.

358. IDHS local office staff do not keep records on how many or which clients call back after being referred to a physician for another referral.

359. Many IDHS caseworkers do not know what to do when asked by recipients for help finding a doctor.

360. Neither IDPA nor IDHA provide the children on Medicaid with scheduling assistance to ensure that appropriate and timely appointments for EPSDT services are made.

## **2. Transportation**

361. IDHS caseworkers do not know that the State will pay for transportation to care as part of EPSDT.

362. IDHS caseworkers generally do not know how to provide transportation assistance to ensure that children on Medicaid receive EPSDT services.

363. IDHS caseworkers generally do not know how to authorize transportation assistance to ensure that children on Medicaid receive EPSDT services.

364. Children in Cook County must generally receive prior approval from Dyntek, an IDPA transportation subcontractor, before they can receive any medical transportation assistance.

365. Dyntek staff make all decisions as to what type of transportation assistance will be provided, such as whether a child's medical condition precludes medical transportation by bus.

366. Dyntek makes improper assessments for transportation assistance by erroneously denying taxi assistance for children with asthma or physical disabilities who cannot take public transportation.

367. Dyntek does not provide sufficient subcontracting medicar providers to serve children on Medicaid.

368. Requests for transportation from hospitals are routinely denied by Dyntek.

369. Requests for transportation from hospitals often cannot be arranged for by Dyntek due to an overloaded hotline system.

370. Requests for transportation from hospitals to Dyntek are often not feasible due to tardy or absent medicar providers.

371. Hospitals such as University of Chicago Hospitals often have to arrange for their own transportation for children who must come to appointments after the children have tried unsuccessfully to arrange transportation through Dyntek.

372. Dyntek has sent transportation providers to hospitals who have cars without seatbelts.

373. Dyntek has denied transportation to siblings of children coming in for appointments.

#### **H. Follow-up Efforts For Enrollees Who Do Not Receive Care**

374. Based on the data collected by the State, IDPA could identify all of those Medicaid-enrolled children who have not seen a doctor who has billed IDPA for EPSDT services within a given timeframe.

375. The State does not attempt to identify all of the individual Medicaid recipients who have not received scheduled EPSDT services within a given timeframe.

376. The State does not provide IDHS local office staff or caseworkers with information concerning which individual children on Medicaid are not receiving EPSDT services paid for by IDPA.

377. The State does not determine if children on Medicaid need case management services to gain access to services required to diagnose and/or treat a condition found during a screening service.

378. IDPA provides no case management services to children.

379. IDHS provides case management services to children enrolled in Medicaid through its Family Case Management program.

380. The IDHS Family Case Management program has limited eligibility and enrollment.

381. The IDHS Family Case Management program is only available to children under age one.

382. Under 30,000 children were enrolled in the IDHS Family Case Management program as of May 2003.

383. The IDHS Family Case Management program does not have sufficient capacity to provide services to all of the children enrolled in Medicaid.

384. The IDHS Family Case Management program does not have sufficient capacity to provide services to all children under age one enrolled in Medicaid.

385. Most children on Medicaid under age one do not receive case management services.

386. IDHS operates a program known as the Women, Infants and Children (WIC) Program.

387. WIC is a nutrition program federally funded by the U.S. Department of Agriculture.

388. The WIC Program provides nutrition education, certain limited food items, and referral for services to pregnant women and infants.

389. The WIC Program may include children up to five (5) years of age who have a medical or nutritional risk.

390. The WIC Program has limited eligibility and enrollment.

391. The WIC Program does not have sufficient capacity to provide services to all of the children enrolled in Medicaid.

392. There is a significant overlap in the enrollees of the Family Case Management and WIC programs.

393. Approximately 87 to 88 percent of enrollees in the Family Case Management program are also in WIC.

394. Approximately 75 to 78 percent of WIC enrollees are also in Family Case Management.

395. The State does not operate any programs other than Family Case Management and WIC to ensure that individual children receive appropriate medical services.

396. The great majority of children on Medicaid in Cook County receive no case management services.

## **VI. THE STATE'S EFFORTS TO EVALUATE PROVISION OF EPSDT SERVICES TO THE CHILDREN.**

397. IDPA has not evaluated the level of health education being provided by EPSDT providers, including the need for making EPSDT visits.

398. IDPA has not evaluated the quality of health education being provided by EPSDT providers, including their education of recipients on the need for making EPSDT visits.

399. IDPA has not evaluated whether EPSDT providers appropriately schedule return EPSDT visits for recipients.

400. IDPA has not evaluated whether geographical factors amongst Medicaid recipients impact EPSDT usage.

401. IDPA has not evaluated whether demographic factors amongst Medicaid recipients impact EPSDT usage.

402. IDPA has not evaluated whether ethnographic factors amongst Medicaid recipients impact EPSDT usage.

403. IDPA has not used data from the Cornerstone system in conjunction with Medicaid billing/usage data to determine EPSDT programming.

404. IDPA has not used data from the Cornerstone system in conjunction with Medicaid billing/usage data to determine EPSDT rate setting, other than calculating the liability associated with rate changes.

405. IDPA does not assure that individual recipients receive EPSDT services.

406. IDPA does not monitor individual receipt of EPSDT services.

407. IDPA does not follow up to determine why no EPSDT services have been billed as to certain recipients.

408. Other than Family Case Management and WIC, the State does not engage in outreach efforts to increase the level of EPSDT services received by Medicaid recipients.

409. The State does not conduct "chart reviews" to assure that all EPSDT services are being provided to all Medicaid recipients.

410. If an invoice from a provider shows that the child did not receive a full EPSDT screen, the State takes no follow-up action to determine whether the child is receiving appropriate EPSDT services.

411. The State does not require that providers submit any EPSDT reports or other information on the care provided to children; instead, the State relies solely on the invoices for services.

412. The State does not conduct in-person checks of providers to determine whether they are providing the full complement of EPSDT services.

413. The State does not determine whether a Medicaid-enrolled provider has received appropriate training in providing the full complement of EPSDT services.

414. Neither IDPA nor IDHS require caseworkers at intake to inquire whether families and children have regular doctors.

415. Neither IDPA nor IDHS require caseworkers at intake to identify possible doctors for families and children who do not have a doctor.

416. Neither IDPA nor IDHS require caseworkers after intake to inquire whether families and children have regular doctors.

417. Neither IDPA nor IDHS require caseworkers after intake to identify possible doctors for families and children who do not have a doctor.

418. The State does not collect data by survey or otherwise as to why Medicaid recipients do or do not receive EPSDT services.

419. The State does not evaluate the quality of EPSDT services provided to Medicaid recipients.

420. The State does not evaluate whether providers carry out all EPSDT components with respect to Medicaid recipients.

421. The State does not collect survey or other data that would allow the quality of EPSDT services provided to Medicaid recipients to be evaluated.

422. IDPA has not studied average waiting times in provider practices on the ability of Medicaid recipients to secure EPSDT services.

423. IDPA does not pay incentives for providers whose Medicaid patients receive the full schedule of EPSDT services.

424. IDPA does not evaluate the distribution of information regarding transportation assistance for EPSDT.

425. IDPA does not evaluate its provision of transportation assistance to Medicaid recipients.

426. IDPA has not evaluated transportation as a factor in whether Medicaid recipients will or will not receive EPSDT services.

427. IDPA does not evaluate whether acute care services received by children receiving Medicaid are related to inadequate receipt of preventive and EPSDT services

428. IDPA does not employ a process to ensure timely initiation of treatment following diagnosis because primary care doctors cannot find specialists who accept Medicaid and can provide specialty treatment in a timely manner.

429. IDPA has never evaluated whether there is sufficient medical capacity in Cook County to provide all required EPSDT services to all eligible recipients.

430. The number of doctors participating in the Medicaid program is not sufficient to provide all of the required EPSDT services to Medicaid-enrolled children in Cook County.

431. IDPA has not performed any analysis or study to determine whether doctors who have provided one or more services to the Children in the past are willing to provide additional services and, if not, why not.

432. The State has not studied the impact of average waiting times in clinics and physician practices on the ability of children enrolled in Medicaid to receive EPSDT services.

## **VII. MEDICAID REIMBURSEMENT RATE LEVELS FOR MEDICAL SERVICES**

### **A. How Reimbursement Rates are Set**

433. IDPA sets a schedule of reimbursement rates for each medical service that is provided to children on Medicaid.

434. Reimbursement rates are a factor that influences physicians' decision whether to accept patients.

435. IDPA reimbursement rates for Medicaid are chiefly determined by the amount of funds allocated to IDPA by the Bureau of the Budget.

436. IDPA fee-for-service physician reimbursement rates for Medicaid are set with little or no consideration of the affect of rate increases or decreases on provider participation.

437. Medicaid fee-for-service physician reimbursement rates are set by IDPA with little or no consideration of the comparison of Medicaid rates to Medicare rates.

438. Medicaid fee-for-service physician reimbursement rates are set by IDPA with little or no consideration of the comparison of Medicaid rates to private insurance rates.

439. Medicaid fee-for-service physician reimbursement rates are set by IDPA based primarily on the legislative budget/appropriation; in other words, on the total number of dollars available in the state budget for the given year.

440. Yearly budget-making for Medicaid services is not based on any long-range plan.

441. Yearly budget-making for Medicaid services is not targeted to any optimal level of funding.

442. IDPA has not conducted any analysis to determine "ideal" Medicaid fee-for-service physician reimbursement rates for pediatric well-child services which would maximize access to care.

443. Medicaid fee-for-service physician reimbursement rates for pediatric well-child services are not designed to maximize access to care.

444. Medicaid fee-for-service physician reimbursement rates for pediatric well-child services are not targeted to maximize access to care.

445. IDPA decreased Medicaid fee-for-service physician reimbursement rates by 3% in 2002 solely because of a budget downturn.

446. When IDPA has increased Medicaid fee-for-service physician reimbursement rates for office-based medical services, there has been a corresponding increase in the number of office-based services billed by providers.

447. In the last five years IDPA has not evaluated Medicaid fee-for-service physician reimbursement rates based on inflation.

448. In the last five years IDPA has not adjusted Medicaid fee-for-service physician reimbursement rates based on inflation.

449. In the last five years IDPA has not increased Medicaid fee-for-service physician reimbursement rates based on inflation.

450. In setting Medicaid fee-for-service physician reimbursement rates, IDPA does not consider the costs incurred by fee-for-service physicians in providing care.

451. In setting Medicaid fee-for-service physician reimbursement rates, IDPA does not consider the market value of physician services.

452. In setting Medicaid fee-for-service physician reimbursement rates, IDPA does not consider the costs of operations and material incurred by fee-for-service physicians in providing care.

453. IDPA has considered marketplace rates in efforts to attract more nurses into the Medicaid program.

454. The costs of medical practice are generally higher in Cook County than in downstate Illinois.

455. The Medicaid fee-for-service physician reimbursement rates in Cook County are the same as the rates elsewhere in the State.

456. IDPA does not monitor whether pediatric providers receiving so-called "enhanced" rates will or will not refuse to see current Medicaid patients.

457. IDPA has never conducted a study to measure access to care by children in Cook County served by private or non-Medicaid public insurance to determine a target or benchmark for access to care by Medicaid-enrolled children in Cook County.

458. IDPA has never conducted a study to measure the impact of Medicaid reimbursement rates on access to care.

459. IDPA has never analyzed whether the reimbursement rates paid by IDPA cover the overhead costs of doctors.

460. IDPA does not analyze Medicaid usage data from previous years when determining reimbursement rates.

461. IDPA does analyze Medicaid usage data from previous years when calculating anticipated Medicaid liability.

462. Past usage data is not considered by IDPA as a relevant factor for setting reimbursement rates.

463. Access to care fostered by past reimbursement rate levels is not considered by IDPA as a relevant factor for setting reimbursement rates.

464. The prevailing Medicare rates vary in each state and region.

465. The prevailing private insurance market rates vary in each state and region.

466. The costs to doctors in Cook County to treat a child with a certain condition does not vary based on whether that patient is covered by Medicaid, Medicare or private insurance.

467. The costs to doctors in Cook County to provide a certain screening exam or immunization does not vary based on whether that patient is covered by Medicaid, Medicare or private insurance.

**1. IDPA views on reimbursement rates**

468. The Medicaid fee-for-service physician reimbursement rates paid for doctors' service impact the availability of those services.

469. If reimbursement rates were increased, more providers would participate in the Medicaid program.

470. IDPA reimbursement rates are lower than the usual and customary charges of physicians.

471. Medicaid reimbursement rates are relatively low compared with Medicare rates.

472. If IDPA were to be allocated more funds by the Bureau of the Budget, IDPA would increase provider reimbursement rates.

**2. IDPA's study of rates in Springfield, Illinois**

473. IDPA completed a study comparing Illinois Medicaid reimbursement rates for physician services (i) to Medicare rates applicable to Springfield, Illinois and (ii) to the prevailing private market reimbursement rate in Springfield, Illinois.

474. In its comparison of Medicaid reimbursement rates to the Medicare reimbursement rates applicable to Springfield, Illinois, IDPA found that the Medicaid reimbursement rates were lower than the Medicare reimbursement rates by more than 30%.

475. The Medicare reimbursement rates applicable to Cook County, Illinois are higher than the Medicare reimbursement rates applicable to Springfield, Illinois.

476. The private market insurance rates in Cook County, Illinois are generally higher than the private market insurance rates in Springfield, Illinois.

477. Private insurance rates change based on geographical practice cost variations.

478. The private market insurance reimbursement rates in Cook County, Illinois are generally higher than the private market reimbursement rates in Springfield, Illinois.

479. It is more costly to maintain a medical practice in Cook County, Illinois and in Springfield, Illinois.

480. In its comparison of Medicaid reimbursement rates to the private market insurance reimbursement rates in Springfield, Illinois, IDPA found that Medicaid reimbursement rates were lower than private market insurance rates reimbursement rates by more than 50%.

### **3. Payment Cycle Issues**

481. The length of the IDPA payment cycle affects physicians' willingness to participate in the Medicaid program.

482. The IDPA's payment cycle is generally longer than other payers' payment cycles.

483. IDPA has not studied the impact of payment cycle delays on access to pediatric well-child services.

### **B. Dr. Samuel Flint's Analysis of Physician Reimbursement Rates**

484. The Children retained Dr. Samuel Flint to analyze the effect that reimbursement rates have on physicians' willingness to provide care to the Children, including a comparison of their willingness to provide care to privately insured children.

485. Dr. Flint is a consultant in the fields of health policy, health economics, and child health care, and received his Ph.D. from the University of Chicago.

486. Dr. Flint is qualified to opine on the effect that reimbursement rates have on physicians' willingness to provide care to the Children.

487. Dr. Flint is qualified to opine on a comparison of physicians' willingness to provide care to the Children with their willingness to provide care to privately insured children.

488. Dr. Flint compared Illinois' Medicaid physician reimbursement rates for Cook County (i) to Medicare rates for the same region; and (ii) to private insurance reimbursement rates for the same region.

**1. Comparison of Medicaid physician rates to Medicare physician rates**

489. Medicaid fee-for-service physician reimbursement rates are, on average, approximately half of the Medicare reimbursement rates for the same physician services provided in Cook County, Illinois.

490. Medicare rates are a proper benchmark for a comparison of Medicaid rates as a matter of health policy because Medicare rates are a readily available, well-established standard based on current and accurate geographical practice cost variations.

491. Medicare rates are compiled by the CMS, in collaboration with the American Medical Association, based on the cost of providing the service modified to take into account differences in regional costs.

492. Medicare rates account for geographic differences in practice costs using a methodology known as the resource base relative value scale (RBRVS), which includes a factor that addresses the cost of delivering care in different locations, known as geographic practice cost indices (GPCIs).

493. Medicare rates are set to allow a physician to recover his overhead costs and a modest profit.

494. Medicare rates are derived by a production cost theory and analyzed with actual provider fee and charge data and clinician review.

495. Health care economic analyses generally use Medicare reimbursement rates as an appropriate comparison to Medicaid reimbursement rates.

496. Dr. Flint compared the respective rates under Medicaid and Medicare for the most commonly billed physician service in the Illinois Medicaid program, designated "Established Patient Office Visit; Moderate Complexity."

497. The maximum Medicaid reimbursement rates paid for an "Established Patient Office Visit; Moderate Complexity" service in 2002 was \$29.85 (which includes an "Add-On" rate).

498. "Add-Ons" to Medicaid rates were paid only to 37% of the providers who billed IDPA for an "Established Patient Office Visit; Moderate Complexity" service in 2002.

499. The Medicare reimbursement rate in 2002 for an "Established Patient Office Visit; Moderate Complexity" service in Cook County was \$54.16.

500. In 2002, Medicaid paid, at most, 55% of the rate that Medicare paid in Cook County for "Established Patient Office Visit; Moderate Complexity".

501. As the "Add-On" for "Established Patient Office Visit; Moderate Complexity" was paid to only 37% of providers who sought reimbursement from IDPA for this service, the rate Illinois paid 63% of the time was even lower.

502. Illinois has the lowest Medicaid to Medicare ratio of all but 8 states.

503. Illinois is in the lowest third of all states in their Medicaid to Medicare ratio.

504. Illinois pays roughly half of what Medicare pays for the same service, delivered in Cook County, by the same physician.

505. Medicare rates for children's physician services are an appropriate comparison to Medicaid rates for the same service.

506. Historically, Medicare reimbursement rates are generally below private market reimbursement rates.

507. Dr. Flint is qualified to compare Medicaid rates to Medicare rates.

508. Dr. Flint's comparison of Illinois' Medicaid rates to Medicare's Cook County rates is accurate.

## **2. Comparison of Medicaid rates to private insurance rates**

509. Medicaid physician reimbursement rates are, on average, significantly lower than private insurance reimbursement rates for the same pediatric service.

510. Precise commercial insurance payment rate information is not generally available.

511. Many health insurers treat their reimbursement rates as trade secrets and require contracting physicians to agree not to disclose payment rates.

512. To provide a proxy for purposes of his analysis, Dr. Flint collected data on median fees received from private insurance for two Cook County pediatric practices that serve approximately 14,500 children with 7.5 full time equivalent (FTE) pediatricians.

513. Illinois Medicaid reimburses, on average, less than 50% of the amount paid by private health insurance for the same service in Cook County.

514. Illinois does not pay Medicaid physician reimbursement rates that are competitive with Medicare rates in Cook County.

515. Illinois does not pay Medicaid physician reimbursement rates that are competitive with private insurance rates in Cook County.

## **3. Comparison of Medicaid rates to costs of maintaining practice**

516. Medicaid fee-for-service physician reimbursement rates generally do not cover the physician's cost of overhead.

517. A pediatric fee-for-service practice in Cook County relying solely on Medicaid beneficiaries' maximum reimbursements could not survive.

518. Medicaid pays nearly 10% less than the median practice costs in Cook County.

519. Given current Medicaid reimbursement rates in Illinois it would not be economically feasible to run a fee-for-service Medicaid practice in Cook County with a 100% Medicaid patient population.

520. The Illinois Medicaid program reimburses less than the median practice overhead costs in Cook County.

#### **4. Impact of rates on physician willingness to serve the Children**

521. Studies have shown that pediatricians limit the availability of their practices to Medicaid patients because of low Medicaid reimbursement.

522. Studies have shown that pediatricians limit the availability of their practices to Medicaid patients because of an unpredictable Medicaid payment system.

523. Studies have shown that pediatricians limit the availability of their practices to Medicaid patients because of Medicaid payment delays.

524. Low Medicaid reimbursement rates are the primary factor that a private physician uses in determining whether to accept Medicaid patients.

525. Physicians' opinions on whether to accept Medicaid will be influenced by whether the reimbursement rates cover their overhead costs and whether the reimbursement rates provide a profit.

526. In communities in which there is not a competitive Medicaid reimbursement rate, access to physicians for Medicaid recipients will be limited, as physicians will opt to treat non-Medicaid children first or exclusively.

527. All of the major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in a private physician's decision regarding whether to participate in the Medicaid program.

528. All of the major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in a private physician's decision regarding whether to participate in the Medicaid program in a limited fashion.

529. All of the major studies on physician reimbursement rates have concluded that physician reimbursements are the predominant factor in a private physician's decision regarding whether to decline to participate in the Medicaid program.

530. Low reimbursement rates are a disincentive for physicians to participate in the Medicaid program.

531. Factors such as slow payment, paperwork excesses and low capitation rates are disincentives for physicians to participate in the Medicaid program.

532. When physicians can treat children covered by insurance plans that pay higher than Medicaid, they generally will do so rather than treat Medicaid patients.

### **C. Other Evidence of the Impact of Medicaid Reimbursement Rates**

#### **1. Impact on practices**

533. Pediatric departments at major hospitals in Cook County that have large Medicaid patient populations are sustaining significant losses each year due to low Medicaid physician reimbursement rates.

534. There are pediatric practices in Cook County that have closed to new Medicaid patients due to economic problems caused by low Medicaid reimbursement rates and slow Medicaid payment systems.

535. There are pediatric practices in Cook County that have closed entirely to Medicaid patients due to economic problems caused by low Medicaid reimbursement rates and slow Medicaid payment systems.

536. Some pediatric providers in Cook County choose not to see patients on Medicaid due to the low reimbursement rates.

537. Some pediatric providers in Cook County choose not to see Medicaid patients because reimbursement is not paid in a timely manner.

538. Although IDPA has sought assistance from the Illinois Chapter of the American Academy of Pediatrics to enlist additional providers to provide care to children on Medicaid in Cook County, such efforts has been largely unsuccessful because of the widespread dissatisfaction with IDPA's reimbursement rates.

539. The number of children on Medicaid in Cook County has risen significantly since 1992.

540. The number of physicians in Cook County who are enrolled in the Medicaid program has not increased at the same percentage or rate as the number of children on Medicaid in Cook County has risen.

541. In 2002, the University of Chicago Hospitals Department of Pediatrics 47th Street Clinic closed its practice to Medicaid patients because Medicaid reimbursement rates were too low to sustain the economic viability of the practice.

542. The University of Chicago Hospitals loses money on virtually every outpatient service provided to a child on Medicaid because reimbursement rates for Medicaid are less than that cost to provide the service.

543. The 47th Street Clinic is one of the largest primary care providers in the University of Chicago Hospitals network.

544. In evaluating locations to open and operate pediatric clinics, the University of Chicago Hospitals has concentrated on areas that do not have large Medicaid patient populations.

545. In evaluating locations to open and operate pediatric clinics, the University of Chicago Hospitals has concentrated on areas that do not have large Medicaid patient populations due to the low reimbursement rates for Medicaid.

546. Medical staff at the University of Chicago Hospitals are frequently unable to locate private pediatric providers on the south side of Chicago willing to accept referrals of Medicaid-enrolled children.

547. Medical staff at the University of Chicago Hospitals are able to locate private pediatric providers on the south side of Chicago willing to accept referrals of privately-insured children.

548. Children's Memorial Hospital has an average caseload of about 45% Medicaid patients.

549. Medicaid reimbursement represents only about 12% to 15% of Children's Memorial Hospital's average receipts.

550. Children's Memorial Hospital has determined that Medicaid reimbursements cover approximately 45% of the true cost of services provided, including overhead, professional fees, and equipment.

551. Children's Memorial Hospital outpatient services sustained a net loss due to Medicaid reimbursement of \$5,014,199 in FY 2002.

552. Medicaid reimbursement in FY 2002 only paid an average of 36.4% of the cost to the Children's Memorial Hospital outpatient department of providing services to Medicaid patients.

553. Children's Memorial Hospital outpatient services sustained a net loss due to Medicaid reimbursement of \$5,014,199 in FY 2002 because Medicaid reimbursement only paid an average of 36.4% of the cost to the hospital outpatient department of providing services to Medicaid patients.

554. The Department of Pediatrics at Children's Memorial Hospital operates a clinic in the Uptown area of Chicago with a high Medicaid patient population, and experiences significant economic losses in operating that clinic because of low Medicaid reimbursement rates.

555. The Pediatric Faculty Foundation at Children's Memorial Hospital has estimated that it will go bankrupt within two years at the current rate of losses experienced by the pediatric practice as a result of low Medicaid reimbursements and high Medicaid patient load.

556. The patient mix of the Department of Pediatric Dentistry at Children's Memorial Hospital is approximately 50% Medicaid.

557. The Department of Pediatric Dentistry at Children's Memorial Hospital has concluded that private insurers typically pay approximately 80% to 90% of usual and customary pediatric dentistry charges.

558. The Department of Pediatric Dentistry at Children's Memorial Hospital has concluded that Medicaid pays about 20% of usual and customary pediatric dentistry charges.

559. The Chair of the Department of Pediatric Dentistry at Children's Memorial Hospital knows of no pediatric dentist in private practice in the entire Chicago area who accepts Medicaid.

560. The Department of Pediatric Dentistry at Children's Memorial Hospital limits its Medicaid patients to those who have been hospitalized or are patients at the Hospital, because the Department is financially unable to accept more Medicaid patients.

561. At Loyola University Hospital, a majority of the pediatric physicians are restricting access for pediatric patients on Medicaid due to the low Medicaid reimbursement rates.

562. At Loyola University Hospital, the percentage of physicians limiting their practice for pediatric patients on Medicaid is increasing.

563. It is increasingly difficult for physicians at Loyola University Hospital to refer patients on Medicaid to pediatricians or specialists within and outside of the Loyola University system due to the increasing number of physicians who limit the number of Medicaid patients that they will see.

564. An increasing number of Medicaid patients are referred to the surgery and specialty clinics at Loyola University Hospitals because the local surgeons will not accept Medicaid patients.

565. Very few privately insured patients are referred to Loyola because other physicians readily accept privately insured patients for treatment.

## **2. Impact on quality of care to the Children**

566. Pediatric patients throughout Cook County who are on Medicaid are more likely to be seen by a federally qualified health clinic (FQHC) or a resident clinic rather than by a private pediatrician.

567. Pediatric patients throughout Cook County who are on Medicaid are more likely to be seen by a federally qualified health clinic (FQHC) or a resident clinic rather than by a private pediatrician because a limited number of private physicians accept Medicaid.

568. Most clinics, including resident and federally qualified health clinics, do not provide night and weekend hours.

569. Most clinics, including resident and federally qualified health clinics, do not provide emergency capabilities.

570. Most clinics, including resident and federally qualified health clinics, do not provide continuity of care.

571. Pediatric patients on Medicaid are more likely to be treated by a doctor who is not a board-certified pediatrician than patients with private insurance.

572. Pediatric patients on Medicaid are more likely to be treated by a doctor who is not a board-certified pediatrician than patients with private insurance due to the limited number of private board-certified pediatricians who accept Medicaid.

573. Pediatric patients on Medicaid are more likely to be treated by a doctor who is not a board-certified family practitioner than patients with private insurance.

574. Pediatric patients on Medicaid are more likely to be treated by a doctor who is not a board-certified family practitioner than patients with private insurance due to the limited number of private board-certified family practitioners who accept Medicaid.

575. Physicians who are not board-certified in family practice or pediatrics are generally less qualified to provide medical services to children than physicians who are board-certified in family practice or pediatrics.

576. Children who have private insurance of any type generally receive well-child care and medical treatment from physicians who are either board-certified pediatricians or board-certified family practitioners.

577. Board certification of a physician is considered a marker of quality and training and level of competence.

578. In 1991, IDPA studied number of physicians potentially available for providing medical care to children and only considered physicians who were board-certified pediatricians, family practitioners, or internists as appropriate physician providers.

579. IDPA does not require that participating physicians be board-certified in family practice or pediatrics to provide medical services to children.

580. IDPA requires only that a physician be licensed in Illinois to provide medical services to children.

581. IDPA has never studied the individual capacity of board-certified pediatricians or family practitioners in Cook County.

582. IDPA has never compared the capacity of board-certified pediatricians or family practitioners in Cook County to the number of children on Medicaid in Cook County who require health care services.

583. In areas such as the south side of Chicago, with high concentrations of Medicaid patients, the availability of medical services to children on Medicaid is lower than in areas with a low number of Medicaid patients.

584. In areas such as the south side of Chicago, with high concentrations of Medicaid patients, the quality of well-child medical services available to children on Medicaid is lower than in areas with a low number of Medicaid patients.

585. Children on Medicaid in Cook County are often unable to find any medical provider specifically trained to treat children, such as pediatricians and family practitioners.

586. Children on Medicaid in Cook County have much greater difficulty in getting appointments with specialists than children with private health insurance in Cook County.

587. Emergency room physicians in Cook County are seeing an increasing number of children on Medicaid who lack primary care providers.

588. Emergency room physicians in Cook County have difficulty in referring Medicaid patients to private primary care or specialty providers after discharge from the emergency room because of the number of private providers who have limited or closed their practices to Medicaid patients.

589. Emergency room physicians in Cook County are seeing an increasing number of children on Medicaid who present health problems that could have been prevented by routine primary care.

### **3. Impact on availability of hearing, vision and dental services**

590. Dentists in Cook County limit the availability of their practice to Medicaid patients.

591. Dental practices in Cook County would fail financially if they accepted all Medicaid patients who presented themselves for treatment due to the low Medicaid reimbursement rates.

592. Pediatric dentists are more qualified than adult dentists to handle children's dental care because of specialized training and certification requirements.

593. There are very few pediatric dentists in Cook County who accept Medicaid reimbursement.

594. Dentists have difficulty referring children with Medicaid to a pediatric dentist in Cook County.

595. Dentists have difficulty referring children with Medicaid to a pediatric dentist in Cook County because most or all of the pediatric dentists in Cook County do not accept Medicaid patients.

596. Children on Medicaid in Cook County are less likely to see a pediatric dentist than children with private insurance due to the limited number of pediatric dentists who accept Medicaid reimbursement.

597. Children on Medicaid in Cook County frequently do not get vision and hearing screens from the physicians who provide well-child services.

### **VIII. LEVELS OF PROVIDER PARTICIPATION IN MEDICAID**

598. IDPA measures the extent of physician participation in Medicaid by analyzing only the total number of providers enrolled in the Medicaid program, the total number of providers billing more than 100 services per year, and the total number of office visits billed to IDPA.

599. IDPA has never measured the percentage of physicians participating in the Medicaid program nor the number of services provided per patient.

#### **A. Dr. Darling's Analysis of Providers**

600. Although many doctors have "enrolled" in the Medicaid program, the majority enroll in order to seek reimbursement for providing care to an occasional child.

601. 63% of enrolled medical providers in Cook County did not provide a single well-child examination to any recipient between July 1, 1998 and December 31, 2001.

602. Approximately 6% of enrolled medical providers in Cook County provided only one well-child exam between July 1, 1998 and December 31, 2001.

603. Between July 1, 1998 and December 31, 2001, approximately 10,494 medical providers billed IDPA for at least one "any child examination" provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 216 months (18 years).

604. Between July 1, 1998 and December 31, 2001, 6,667 of the 10,494 medical providers who had billed IDPA for at least one "any child examination" provided to a

Medicaid-enrolled child in Cook County between the ages of 10 days and 216 months (18 years), or 63.5%, had not provided any recipient with an "HMHK well-child examination."

605. Between July 1, 1998 and December 31, 2001, 6,026 of the 10,494 medical providers who had billed IDPA for at least one "any child examination" provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 216 months (18 years), or 57.4%, had not provided any recipient with an "IDPA well-child examination."

606. Between July 1, 1998 and December 31, 2001, 7,131 medical providers billed IDPA for at least one "any child examination" provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 84 months (7 years).

607. Between July 1, 1998 and December 31, 2001, 3,851 of the 7,131 medical providers who had billed IDPA for at least one "any child examination" provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 84 months (7 years), or 54.0%, had not provided any recipient with an "HMHK well-child examination."

608. Between July 1, 1998 and December 31, 2001, 3,404 of the 7,131 medical providers who had billed IDPA for at least one "any child examination" provided to a Medicaid-enrolled child in Cook County between the ages of 10 days and 84 months (7 years), or 47.7%, had not provided any recipient with an "IDPA well-child examination."

609. Most of the doctors who provide sick child services to children on Medicaid in Cook County do not also provide well-child exams.

## **B. Provider Views on Medicaid**

610. Many doctors in Cook County either will not see children on Medicaid or they significantly limit the number of children on Medicaid that they will accept as patients.

611. Doctors who practice in hospitals in Cook County see a high percentage of patients who are on Medicaid and who do not have a regular pediatrician.

612. Doctors who practice in hospitals in Cook County see a much lower percentage of patients with forms of insurance other than Medicaid who do not have a regular pediatrician.

613. Doctors who practice in Cook County have difficulty finding a pediatrician or specialists who will accept referrals of children on Medicaid.

614. Many pediatricians limit their practice by not accepting Medicaid patients or accepting only a limited number of Medicaid patients.

615. It is much easier to refer patients in Cook County with forms of health insurance other than Medicaid.

616. A substantial number of children on Medicaid in Cook County have had adverse health outcomes because they have not been able to see a pediatrician regularly due to their difficulty in finding a pediatrician.

617. There are few doctors in Cook County willing to provide well-child services in those areas that are low income and have high percentages of children on Medicaid.

618. The numbers of pediatric patients on Medicaid in Cook County coming to emergency rooms to receive treatment for primary care medical issues because they cannot find a primary care physician to treat them has been increasing significantly due to a lack of pediatricians who accept Medicaid.

619. Emergency rooms are not generally equipped to provide well-child care, immunizations, hearing, vision, and lead screens to children.

620. IDPA has never completed surveys of the fee-for-service Medicaid recipient population to measure access to care in Cook County.

621. IDPA does not know how many of the providers who bill Medicaid more than 100 times per year care for children.

622. IDPA does not know how many of the providers who bill Medicaid more than 100 times per year are located in Cook County.

623. IDPA does not know how many of the providers who bill Medicaid more than 100 times per year are board-certified in either pediatrics or family practice.

624. IDPA does not know how many of the providers who bill Medicaid more than 100 times per year are specialists.

625. IDPA does not know, with regard to those providers who bill Medicaid more than 100 times per year, how many Medicaid patients each physician sees or is willing to see.

626. The rate of screenings and immunizations for patients on Medicaid is lower than rates for the generally insured patient population.

627. Physician professional societies regularly complain to the IDPA regarding the low Medicaid reimbursement rates.

628. The primary issue for the provider constituency of the Illinois Academy of Pediatrics is increasing provider participation in the Medicaid program through increases in pediatric reimbursement rates.

629. A coalition of pediatricians through the Illinois Chapter of the American Academy of Pediatrics is advocating that the state increase reimbursement rates to pediatricians in order to increase the numbers of physicians participating in the Medicaid program.

630. Many members of the Illinois Chapter of the American Academy of Pediatrics have limited or closed their practices to Medicaid patients because Medicaid reimbursement rates are insufficient to cover practice overhead costs.

**C. IDPA Efforts to Assure the Children's Access to Care**

631. IDPA has not studied or collected data on whether or how physicians limit their practice to Medicaid patients.

632. IDPA has not compared the number of doctors willing to provide services to children on Medicaid in Cook County to the number of services that this population needs.

633. IDPA staff does not know how many providers in Cook County are accepting new Medicaid patients.

634. IDPA staff does not know how many providers in Cook County have limited the number of Medicaid patients that they will accept.

635. IDPA staff does not know how many providers in Cook County are not accepting any Medicaid patients.

636. IDPA has not analyzed how many active providers in Cook County treat children on Medicaid.

637. IDPA does not collect data on how many pediatricians in Cook County are enrolled in Medicaid.

638. IDPA does not collect data on how many family practitioners in Cook County are enrolled in Medicaid.

639. IDPA does not collect data on how many physicians in Cook County provide services to children on Medicaid in Cook County.

640. IDPA does not collect data on how many physicians in Cook County provide EPSDT services, including well-child exams, lead blood tests, immunizations, vision or hearing screenings, to children on Medicaid in Cook County.

641. IDPA sets a target number of dentists and doctors that should be enrolled in Medicaid, but in setting that target IDPA does not consider how many dentists or doctors would be necessary to provide a certain level of services to Medicaid recipients.

642. IDPA has not analyzed the number of providers necessary to provide the full schedule of recommended pediatric services to all eligible children ("optimal system capacity").

643. IDPA has not conducted comparison studies between children served by Medicaid and children served by private insurance to assess whether children served by Medicaid have equal access to well-child services.

644. IDPA has not conducted comparison studies between children served by Medicaid and children served by private insurance to assess whether children served by Medicaid have access to a choice among providers of well-care services.

645. IDPA has not conducted comparison studies to assess whether there are differentials as between children served by Medicaid and children served by other forms of insurance in waiting times for appointments.

646. IDPA has not conducted comparison studies to assess whether there are differentials as between children served by Medicaid and children served by other forms of insurance in quality of care.

647. IDPA has not conducted comparison studies to assess whether there are differentials as between children served by Medicaid and children served by other forms of insurance in provider patient loads.

648. IDPA has not conducted comparison studies to assess whether there are differentials as between children served by Medicaid and children served by other forms of insurance in access to specialists.

649. IDPA has not conducted comparison studies to assess whether there are differentials as between children served by Medicaid and children served by other forms of insurance in well-child providers' relationships with hospitals.

650. IDPA has not conducted geographic studies of provider availability to identify underserved geographic areas.

651. IDPA does not plan on a geographic basis to improve access through opening of clinics or providing incentives to pediatricians.

652. Past Medicaid usage data is not analyzed by IDPA to evaluate the Medicaid delivery system, such as referrals or provider recruitment.

653. IDPA does not use Medicaid usage data as to individual recipients to improve access or target information, outreach or care for those individuals.

654. IDPA has not studied the relative impact of various factors on access to care for children receiving Medicaid, such as (i) reimbursement rates; (ii) outreach efforts; (iii) geographical location of clinic/practice; (iv) case management; (v) parent behavior; and (vi) managed care.

655. IDPA does not know the relative impact of various factors on access to care for children receiving Medicaid, such as (i) reimbursement rates; (ii) outreach efforts; (iii) geographical location of clinic/practice; (iv) case management; (v) parent behavior; and (vi) managed care.

656. IDPA's efforts to recruit providers to enroll in Medicaid are not based on targeted access to care or geographical considerations within Cook County.

## **IX. EXPERIENCES OF MEDICAID RECIPIENTS IN COOK COUNTY**

657. Medicaid recipients in Cook County have difficulty in locating quality pediatric primary and specialty care providers for children on Medicaid.

658. Medicaid recipients in Cook County have difficulty in locating pediatric dentists.

659. Many pediatric primary and specialty care providers in Cook County refuse to treat children because they are on Medicaid.

660. Many dentists in Cook County refuse to treat children because they are on Medicaid.

661. IDPA and IDHS do not provide assistance to children on Medicaid in locating quality pediatric primary and specialty care providers in Cook County who accept Medicaid.

662. IDPA and IDHS do not provide assistance to children on Medicaid in Cook County in locating quality dentists who accept Medicaid.

663. Medicaid recipients in Cook County must engage in extensive efforts to locate dentists and pediatric primary and specialty care providers willing to accept Medicaid, including seeking referrals from state agencies, local charities, and calling physicians listed in the phone book.

664. Children on Medicaid in Cook County frequently seek care at emergency rooms because they cannot find a pediatrician willing to accept Medicaid.

665. IDHS caseworkers have told Medicaid recipients in Cook County that they could not help find a provider for the Children.

666. Medicaid recipients in Cook County may have to travel great distances to find a dentist or pediatric provider willing to accept Medicaid.

667. Medicaid recipients in Cook County often must wait several hours to see a provider at a clinic willing to accept Medicaid.

668. Medicaid recipients are often referred by the IDPA's hotline to doctors who are unwilling to accept new Medicaid patients.

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Respectfully submitted,

MEMISOVSKI, et al.

By: \_\_\_\_\_  
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