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IARF Written Statement to the Senate Special Committee on Medicaid Reform

The Illinois Association of Rehabilitation Facilities (IARF) is a statewide organization of nearly 90 community-based providers of services and supports to children and adults with developmental disabilities and/or mental illness. Our members provide services in over 900 locations in Illinois in nearly all geographic regions of the state.

The Association would like to thank the Co-Chairs and members of the Committee for the opportunity to share with you the important roll Medicaid plays in the lives of individuals with disabilities and mental illness and to offer our written statement on improving the Medicaid system so that it is not only more efficient and cost-effective, but produces improved health and long-term care outcomes for individuals with disabilities and mental illness.

IARF recently provided extensive written testimony to the Governor's Healthcare Reform Implementation Council – which covers issues beyond the scope of Medicaid reform. We've provided that written testimony as an attachment to this written statement for your consideration as well.

What is your role in the Medicaid System?
Medicaid plays a significant role in the provision of community services and supports for children and adults with intellectual/developmental disabilities and mental illness, as Medicaid is the primary funder of healthcare, dental care, long term care, and community-based services and supports. Nearly 210,000 children and adults with developmental disabilities and/or mental illness are being served in community settings. Illinois administers Medicaid home and community-based waivers, including an adult waiver for individuals with developmental disabilities that provides coverage for home-based services and supports, day services as well as residential services and two children's waivers and that provide for home-based services as well as small group home services. Additionally, Illinois administers the Medicaid Rehab Option which provides reimbursement for community-based mental health services to children and adults with a diagnosis of a serious mental illness or a serious emotional disturbance.

Community-based providers are certified by the State to provide healthcare and long-term services and supports for children and adults with intellectual/developmental disabilities and/or mental illness through fee-for-service waiver programs and the Medicaid Rehab Option. Through combined efforts between the community and the state – mostly driven by the need to preserve funding for programs and maximize Medicaid claiming – nearly the entire community DD/MH system is a Medicaid system. Although community providers predominantly serve Medicaid eligible individuals, the American Recovery and Reinvestment Act of 2009 (ARRA) did not specifically designate them in the priority group of providers that states are required to reimburse on a 30 day payment cycle. This has resulted in chronic payment delays with instances in which the state was still paying community MH/DD providers in late September for vouchers processed in March – a delay of over 200 calendar days. Our research reveals that Illinois is only one of two states that don't pay <u>all</u> of its Medicaid providers on a 30 day payment cycle.

With the implementation of the *Williams* consent decree, a more robust array of community residential and specialty services (psychiatry) will be required as individuals with mental illness choose to transition from long-term care institutions and institutions for mental disease.

Community-based providers will also play an increasing role in the Medicaid system as more individuals will be Medicaid eligible after 2014 (see attached). With the change in eligibility, it is expected more individuals with mental illness not currently receiving services will be eligible for Medicaid funded services and supports.

From your viewpoint, what is the best way to reduce Medicaid costs without severely impacting services?
Probably the best way to reduce costs while improving access to Medicaid services and supports is to invest Illinois' resources more wisely. Illinois should meaningfully move forward with providing individuals with developmental disabilities and mental illness the choice and opportunity to move from state operated and private long-term care institutions into more integrated community-based services and supports. This movement will require a focus away from disproportionately investing resources into institutional settings and into maintaining and building specialized supports in the community. The Association sees value in investigating the following:

- Continue – respective of choice – transitioning individuals from state operated developmental centers and private long-term care institutions into community settings.
- Develop rate a rate methodology to provide private intermediate care facilities for the developmentally disabled (ICFDD) providers a mechanism to downsize those settings.
- Build capacity – both for residential services and specialty services (psychiatry and preventative dental services) – in areas of need in the community. This includes residential services for individuals with mental illness transitioning out of institutional long-term care settings. This focus on prevention and wellness can be accomplished through:
    - re-allocating/increasing resources in the state budget;
    - effectively utilize money follows the person programs; and
    - upward rate adjustments and policies to incentivize specialty provider participation.
- Incentivize community-based providers and community health centers to work collaboratively on preventative healthcare, treatment, and long-term services and supports
    - Develop and fund pilot programs in underserved areas of the state focused on integrating health care and long-term services and supports.

What are you doing to maximize federal funding? What else can the State do to capture these funds?
In consideration of the first question, IARF members have a well established history of working with State government to maximize federal funding. This includes collaborating on the conversion of DD grant programs to DD Waiver covered services to enhance Medicaid match for previously GRF funded services, the development of two Children's Waivers within the Division of Developmental Disabilities, and the conversion of several Medicaid mental health programs to fee-for-service. Over the past seven years, the community system has assisted the state in drawing down over $100 million in additional Medicaid claiming. Furthermore, the Association worked with the General Assembly to ensure beginning FY13 all federal match dollars generated by community services stay in designated trust fund for the provision of services and supports and are not diverted to GRF.

Regarding the second question, IARF continues to work with State government to leverage Medicaid funds. The Association has urged the Division of Mental Health and the Department of Healthcare and Family Services to develop a waiver for mental health services and supports that are not currently covered by the Medicaid Rehab Option. Therefore, the Association believes the following merit further consideration:

- Develop with stakeholder input and implement a waiver for mental health services. This will provide Illinois the opportunity to leverage additional Medicaid match dollars for community mental health services.

- Investigate the feasibility of billing all services for which there is a Medicaid match through the Department of Healthcare and Family Services. This may identify additional opportunities to draw down Medicaid and may streamline the bill processing/payment cycles. SB 3762/P.A. 96-1405 requires HFS and DMH to work collaboratively to establish this process by July 1, 2011.
- Identify staff in the Office of the Governor or HFS to be the point person(s) on investigating and identifying federal grant opportunities available to states through the Patient Protection and Affordable Care Act of 2010 (PPACA – see attachment). Illinois may not be doing enough to identify and utilize additional federal Medicaid dollars and grants.

Can you identify any inefficiencies within our State's Medicaid system? How can these inefficiencies be corrected?
Per HB 5124/P.A. 96-1141, the Association is participating on a joint state and stakeholder steering committee to prepare a final report to the Governor and the General Assembly identifying duplication and redundancies not only in the Medicaid system, but also in the contracting, auditing, and surveying processes impacting human service providers. That report will be finalized on January 1, 2011 and we anticipate it will include specific immediate and long-term recommendations. In lieu of that final report, the Association has identified the following inefficiencies and notes corrective measures that could be considered:

- Providers note there is a great deal of duplication and redundancies in the Medicaid certification, contracting, auditing, and survey processes. There seems to be a lack of coordination across state agencies and no centralized repository for contract information. IARF sees the value in the State streamlining the Medicaid provider certification, contracting, audit, and survey processes. A process worth considering is the consolidation of these processes in one state agency or through increased coordination across state agencies for providers with multiple state contracts. It should be noted the Centers for Medicare and Medicaid Services (CMS) recently issued a Proposed Rule regarding Medicaid provider and supplier enrollment processes aimed at improving integrity and reducing fraud, waste, and abuse.
- It is our understanding the State spends an estimated $150 million a year to maintain outdated databases and computer software – most of which are not integrated – even within agencies. Furthermore, community-based providers have invested resources in upgrading their own electronic records systems. Federal CMS is incentivizing states to develop integrated electronic health records and data systems in preparation for Medicaid expansion. The Association sees merit in developing a process for upgrading state systems that integrate with community provider systems – such as the *Illinois Healthcare and Human Services Framework Project.*
- The enrollment process for individuals potentially eligible for Medicaid is ripe for improvement. For example, community mental health providers must verify income for individuals with mental illness – even if they have active Medicaid cards. The State should investigate the feasibility of streamlining the enrollment process for individuals potentially eligible for Medicaid. Specifically, the Association sees the value in the Division of Mental Health and the Department of Healthcare and Family Services implementing presumptive eligibility for individuals with mental illness.

Can you identify any loopholes within state statute or administrative code that have allowed Medicaid fraud?
Unfortunately, if a Medicaid provider or vendor wishes to pursue fraudulent activity, there will always be instances where these organizations will find loopholes to commit unlawful activity. However, Illinois must be cautious not to legislate or regulate to the lowest common denominator.

IARF believes that several measures have been put into place in Illinois to try and root out cases of Medicaid fraud.

- Federal CMS has put in place several programs aimed at reducing overpayments, fraud and abuse in the Medicaid program – such as Payment Error Rate Measurement (PERM) Audits and Medicaid Integrity Program (MIP) Audits.
- The Administrative Services Organization (ASO – DMH) conducts post payment reviews to ensure the validity of submitted mental health claims.
- HB 5241/P.A. 96-0941 is aimed at increasing transparency on reimbursing medical claims under Medicaid by authorizing an internet-based transparency program.
- HB 5242/P.A. 96-0942 authorizes Illinois to contract with third party vendors to engage in 'payment recapture audits' to identify and recapture payments made in error or as a result of fraud and/or abuse.
- Federal CMS recently issued Proposed Rules for state Medicaid Recovery Audit Contractor (RAC) programs. States must submit plans by December 31, 2010 on how they plan to establish Medicaid RAC programs in their states. The State should consider investigating the implications of these Proposed Rules and consult with stakeholders on the most appropriate ways of developing these programs so they maintain the integrity of the Medicaid program without causing undue harm to Medicaid providers and vendors.