ILLINOIS DEPARTMENT OF Healthcare and Family Services

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April 16, 2012

To the members of the General Assembly:

We are pleased to present you with the final report from the Cross-Agency Medicaid Commission, as required by Public Act 96-0878.

This report reflects the recommendations of the Commission to identify ways in which claiming processes may be streamlined, identify expenditures that may be eligible for federal reimbursement, and recommend changes to implement such claiming based on input from member agencies, including the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), the Department of Children and Family Services (DCFS), and the Illinois State Board of Education (ISBE); as well as representatives from four vendors of services that are eligible for federal Medicaid matching funds, funded through each of the four respective member agencies.

This report includes background on current claiming amounts for services as well as the Commission's recommendations.

We are honored to be a part of providing healthcare benefits to Illinois residents.

Sincerely,

Julie Hamos
Director

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Cross-Agency Medicaid Commission

FINAL REPORT TO THE GENERAL ASSEMBLY OF RECOMMENDATIONS TO MAXIMIZE THE AMOUNT OF FEDERAL MEDICAID MATCHING FUNDS RECEIVED BY ILLINOIS

April 2012

Cross-Agency Medicaid Commission
Final Report

Public Act 96-0878 amended the Illinois Public Aid Code by creating the Cross-Agency Medicaid Commission. The Commission includes the Director of Healthcare and Family Services, the Secretary of Human Services, the Director of Children and Family Services, and the State Superintendent of Education, or their respective designees, as well as four vendors of services that are eligible for federal Medicaid matching funds, funded through each of the four respective agencies.

The Commission is to study ways for the State agencies to coordinate activities and programs to maximize the amount of federal Medicaid matching funds received by the State and report its findings to the General Assembly. This report represents the Commission's final findings and recommendations.

BACKGROUND

As the designated Medicaid single State agency, the Department of Healthcare and Family Services (HFS) is charged with administering the Illinois Medicaid program under Title XIX of the Social Security Act. While federal law and regulations allow HFS to delegate some of these administrative responsibilities to other governmental entities, the department is solely responsible for assuring compliance with federal law. All claims for federal reimbursement, including costs incurred by other government agencies, must be submitted by HFS. In addition to Medicaid funding, HFS administers a largely parallel program under the State Children's Health Insurance Program (Title XXI of the Social Security Act) for children and pregnant women with higher incomes. Like the Medicaid program, claims for federal funds under Title XXI must be submitted by HFS. Throughout this report, descriptions of claiming processes for Title XIX are also representative of those for Title XXI, unless otherwise noted.

The Medicaid program is a cost-based federal program, where expenditures must be incurred in support of the program prior to receiving a partial reimbursement through the federal Centers for Medicare and Medicaid Services. Medicaid claiming falls into two broad expenditure categories—medical services and administrative costs necessary to manage the program. The *Social Security Act* defines various matching rates for these services and administrative costs.

CURRENT CLAIMING

State Medicaid programs receive a federal match rate (Federal Medical Assistance Percentage or FMAP) for Medicaid services based on the per capita income of the state relative to national per capita income. FMAP rates range from 50% to 83% for most services provided under Title XIX and a limited number of services are reimbursed at higher rates. All services provided under Title XXI are reimbursed at an enhanced FMAP rate.

Illinois has generally received the minimum 50% rate since the inception of the Medicaid program and a 65% enhanced FMAP under Title XXI as a result of the American Recovery and Reinvestment Act of 2009 (ARRA). For payments made between October 1, 2008, and December 31, 2010, the Medicaid reimbursement rate was increased for most services. The ARRA enhanced federal reimbursement rate for Illinois was about 62% but varied slightly based on the Illinois unemployment rate. The ARRA did not affect the reimbursement rate under Title XXI. However, Illinois' current FMAP rate for services has reverted back to 50% with the expiration of ARRA funding.

To be eligible for federal matching funds, services must be defined through a federally approved State Plan for Title XIX, and a separately approved plan for Title XXI, or through individually approved waivers (Sections 1915(b) [freedom of choice], 1915(c) [home- and community-based services] or 1115 [demonstration projects] of the Social Security Act, respectively).

Most costs necessary for the administration of the Medicaid program are claimable at a 50% match rate. These include salaries and benefits, indirect and overhead costs, and applicable contractual expenditures. However, certain functions are claimable at higher rates. These include certain activities of skilled professional medical personnel (75% rate), costs associated with quality improvement organizations (75%), costs of a federally approved claims processing system (75%), cost associated with assuring that those entering or residing in a long term care facility have been identified and are appropriately receiving necessary mental health services (pre-admission screening and resident reviews, 75%), and certain pre-approved modifications of a federally approved claims processing system (Medicaid Management Information System, 90%). All administrative costs must be described in federally approved cost allocation plans. Administrative costs claimed under Title XXI receive a 65% match rate.
The following table lists HFS services that are currently receiving FFP and the amount of match.

Service (Classification)	Current Match Rate
Medicaid medical services	**50.00%**
Disproportionate share hospital adjustment payments	**50.00%**
SCHIP medical services	**65.00%**
Family planning services	**90.00%**
Nurse's aide training	**50.00%**
Money Follows the Person demonstration project	**75.00%**
Medicaid administration	**50.00%**
Skilled professional medical personnel	**75.00%**
Pre-admission screening	**75.00%**
Survey and certification	**75.00%**
Medical and utilization review	**75.00%**
Independent review of MCO's	**75.00%**
Immigration status verification	**100.00%**
Fraud detection and control	**75.00%**
Approved development of MMIS	**90.00%**
Operations of MMIS	**75.00%**

HFS currently administers a comprehensive process of claiming Medicaid funds incurred by multiple state agencies, state universities and local governments. This claiming includes both medical services funded through agencies and local governments, as well as administrative costs incurred in support of Medicaid. HFS has developed a comprehensive approach to identify existing state and local expenditures that can be claimed for federal matching dollars without increasing state expenditures. Such efforts have resulted in increasing the receipt of federal funds that are in turn deposited into either the General Revenue Fund, specific funds administered by agencies or state universities, or local governments. The following table presents the amount of federal funds earned under Title XIX and XXI for administration and medical services:

FY 2011 Receipt Federal Funds under
Titles XIX and XXI by Location of Expenditure (in millions)

	Medical Services	Administration	Total
HFS	$7,426.4	$135.9	$7,562.2
Other State Agencies	$1,535.8	$155.7	$1,691.6
SIU / U of I	$84.2	$5.4	$89.6
Local Governments	$107.8	$73.1	$180.9
Total	$9,154.3	$370.1	$9,524.4

Federal Claiming Limitations

In order to receive federal Medicaid funding for a medical service, the following conditions must be met:

1) The service must be defined in the Medicaid State Plan or an approved waiver.
2) The payment for the service must be consistent with payment methodology defined in the State Plan. The total payment may not be above or below the established rate methodology.
3) The provider of the medical service must meet the provider qualifications defined in the State Plan and be an enrolled provider.
4) The expenditure for the medical service must be an expenditure of tax supported funds, either at the state or local government level and may not include federal funds.
5) The expenditure may not also be used as part of meeting a federal Maintenance of Effort (MOE) required to secure a non-Medicaid funding source.
6) Except for capitation or case management payments, the payment must occur after the service is provided.
7) Generally, the medical service may not be provided as part of a non-Medicaid program (state or federal).

Along with these limitations of medical service claiming, administrative claims are limited to the public expenditures (at either the state or local government level), for the efficient administration of the Medicaid program. The Secretary of Health and Human Services has broad discretion to determine what administrative costs meet the "efficient administration" standard. Generally, administrative costs must be allocated to all benefiting programs where time and effort must be objectively documented to be in support of the Medicaid program. As an example, certain local school employees may, through time study reports, document time spent on approved Medicaid activities as a way to document local school district expenditures in support of the administration of the Medicaid program.

Given these limitations, the Cross-Agency Medicaid Commission reviewed various existing public expenditures occurring at multiple agencies and local governments to determine the extent to which additional federal Medicaid funds could be claimed.

LOCAL EDUCATION AGENCIES

Federal Medicaid funding is generally not available when a medical service is provided to meet the requirements of another state or federal program. Two exceptions to this

rule are certain services provided by a Local Education Agency (LEA) or local health departments. In Illinois, LEAs consist of nearly 1,000 local school districts and special education cooperatives. Medical services that are required under the federal Individuals with Disabilities Education Act (IDEA) may be claimed against Medicaid if the services are also available under the state's Medicaid program. In addition, certain administrative costs surrounding the delivery of these services may also be claimed. Illinois was the first state in the nation to receive Medicaid administrative reimbursement for local school districts. As a result, over the last 14 years, more than $2 billion in FFP has been earned and returned back to local school districts.

While claiming in conjunction with the IDEA accounts for the vast majority of Medicaid reimbursement to schools, several districts have also established school based clinics that operate in coordination with the district's local health department.

Illinois continues to utilize one of the nation's most effective methodologies for returning Medicaid funds to local school districts. However, no claiming has been established for funding costs incurred by the Illinois State Board of Education, which funds the placement of children in residential facilities. To the extent that such placements can be coordinated with the Department of Human Services' waiver for children with disabilities, there may be additional claiming opportunities.

RECOMMENDATION:

The Commission recommends that the Department of Healthcare and Family Services, Department of Human Services, and the Illinois State Board of Education review current residential placement for children with developmental disabilities and continue to explore the feasibility of including such placements as part of a home and community based waiver for developmentally disabled children and thereby receive FFP for such placements.

LOCAL HEALTH DEPARTMENTS

Currently, 86 local health departments receive grants from the Department of Human Services to provide case management services to pregnant women and children as part of its maternal and child health program. The DHS grant payments to the local health departments are included in the agency's administrative claim. To the extent that these grants do not cover the full cost of case management for Medicaid clients, the Department of Healthcare and Family Services identifies the additional costs to earn additional FFP and returns these funds to the local health department.

In addition to this administrative claiming process, the current state plan allows for a similar wrap around claiming process for Medicaid services when the reimbursement

rate does not cover the full costs incurred by a governmental entity. This has allowed additional claiming for dental clinics as well as other medical services provided by the health departments.

There are currently 22 local health departments that operate dental clinics. Of those clinics, 17 have reported costs and are in the process of having past claims adjusted to represent the full cost of providing dental services. The Department of Healthcare and Family Services and the Department of Human Services have also recently added new time study and cost reporting categories so that local health departments can determine the full cost of providing other medical services. To date, 7 local health departments have reported such costs.

RECOMMENDATION:

The Commission recommends that the Department of Healthcare and Family Services continue to provide support to local health departments in order to increase the amount of federal dollars being returned to these local governments.

MEDICAID SERVICES FUNDED THROUGH STATE AGENCIES

The majority of state expenditures for Medicaid services are paid through appropriations to the Department of Healthcare and Family Services. However, certain medical services and populations of Medicaid eligible individuals also receive significant services through other state agencies as required by state statutory provisions and the accompanying appropriations to those various agencies. In the last few years, all agencies have worked closely to maximize the amount of federal Medicaid funds received due to their respective expenditures. While the remaining unclaimed payments have been minimized, there continues to be challenges that should be addressed. These include the need to design medical service payments in ways that meet Medicaid claiming requirements, reduce the amount of unnecessary agency specific requirements, adopt a single billing process consistent with all Medicaid requirements, and revising fund appropriation language so that earned FFP will be returned to the agency, thus maintaining an on-going incentive to assure effective federal claiming.

Payment Methodologies

DCFS, DHS, and DJJ all have significant agency expenditures on behalf of Medicaid recipients. These agencies also have other non-Medicaid programs that fund health services which may be funded through federal financing programs or state dollars.

Historically, many of these services have been provided through up-front grants to medical providers. While the current state budget crisis has eliminated many of these non-Medicaid expenditures, agencies should continue to evaluate the extent to which services may be redefined in a way that meets federal Medicaid claiming requirements without jeopardizing other federal funding sources.

RECOMMENDATION:

The Commission recommends that HFS, DHS, DCFS and DJJ consider wrap around services for children receiving specialized foster care and after school programs that address the mental health and other medical needs of these children. Specific consideration should be given to unbundling current clinical services from boarding and housing costs to better maximize costs attributable to federal foster care funding (Title IV-E) and Medicaid funding. These agencies should also continue to develop ways to isolate Medicaid claimable services provided in after-care situations for juvenile offenders and assure that such juveniles are enrolled with Medicaid immediately upon their return to the community.

The Commission also recommends the elimination of any grant payments for Medical services. Federal Medicaid funds may not be received for grants. Any remaining grants should be used to fund fee-for-service or other Medicaid claiming expenditures. Similarly, contracts should be reviewed to identify if Medicaid services are included in broadly defined payments. Such contract components should be isolated and paid by agencies separately following Medicaid requirements.

Consistent Requirements

Illinois currently maintains multiple billing systems by which medical providers are reimbursed. These include the DASA Automated Reporting and Tracking System (DARTS) for DASA providers and the DHS Community Reporting System (also known as ROCS) for other DHS providers as well as the HFS' Medicaid Management Information System (MMIS). While providers may be paid through these various data systems, all claims must ultimately be processed through MMIS in order to receive FFP for such payments.

While some costs of these payment systems are allocated to the overall Medicaid administrative claim, the federal match rate for such expenditures may not exceed 50%. At the same time costs associated with processing claims through the MMIS receive a 75% match rate. Certain program developments of MMIS receive a 90% match rate.

Apart from the specific billing requirements of the various databases, each agency, and each program within these agencies, has developed specific requirements for becoming certified providers. Separate, independent requirements also exist for auditing, compliance and reporting standards. These program specific requirements require providers to learn multiple billing and compliance standards.

These inconsistencies have created a cumbersome, inefficient patchwork of requirements for medical providers. As a result, P.A. 96-1141 (HB5124) was passed to address these inefficiencies. As a result, a separate steering committee pursuant to HB5124 is recommending that agencies; 1) consolidate billing and compliance requirements, 2) develop a single billing platform, and 3) develop a single point of reference by which all providers receive consistent instructions.

RECOMMENDATION

The Commission concurs with the preliminary findings of the Management Improvement Initiatives Commission Steering Committee and urges their adoption. The Commission also recommends that the agencies continue working collaboratively to create a single MMIS system that addresses the specific needs to the individual programs and thereby establish a more efficient data system that is eligible for enhanced federal match rates.

CLAIM REJECTIONS

Most Medicaid claims must be processed through the MMIS prior to issuance of a payment to a provider. However, several of the non-MMIS data systems result in payments being issued to enrolled Medicaid providers without regard to such claims passing MMIS edits. As a result, such claims will often reject from MMIS, which disqualifies the payments for FFP until it is successfully resubmitted. As best, this sequence creates a serious cash flow of federal funds. Depending on the reason for the rejection, there may be little incentive for the provider to bill correctly, thus resulting in a loss of federal funds.

Such claims may reject for many reasons, including the provider being enrolled with the funding agency but not Medicaid. The clients must also be eligible on the day service is provided. Also, certain services may not overlap on the same day. While this potentially conflicting information is identified and known as claims are processed through MMIS, it may not be known with payments initiated through a stand-alone payment system.

The most significant point of claim rejects occurs within the various home and community based waiver programs. Along with rejections due to provider or client

enrollment, claimable waiver services are limited to one waiver at a time. As a result of waiver service limitations or clients moving from one waiver to another, the correct waiver enrollment information is often not passed on to MMIS prior to a claims submission, resulting in the claim rejecting.

The State Finance Act requires that FFP earned from a public expenditure be deposited into the General Revenue Fund unless the fund language from which the expenditure occurred directs the FFP to be deposited differently. In most cases, FFP is deposited into the General Revenue Fund. Over time, this often created little incentive for agencies to make sure procedures are in place to assure Medicaid claiming compliance.

RECOMMENDATION

The Commission recommends that when Medicaid payments are made independent of the MMIS, the appropriation language from which the expenditure is made should be amended to have a least a portion of the federal funds returned to the operating agencies. In doing so, operating agencies will have an on-going incentive to establish payment policies that assure claiming compliance.

The Commission recommends that the assignment of all waiver enrollment be centralized in one location.

REDESIGNED SERVICE DELIVERY SYSTEM

Public Act 96-1501 (2011 Illinois Medicaid Reform law) requires that HFS have at least 50% of its clients enrolled in coordinated care programs by 2015. Pursuant to this goal, HFS has, in collaboration with other state agencies and community partners developed the “Innovations Project.” The Innovations Project is designed to meet the state’s goal by testing community interest and capacity to provide alternative models of delivering care; aligning with the federal CMS Affordable Care Act initiatives; incorporating feedback from stakeholders; and building on interagency collaborations. The first step in reaching that goal will be contracts with Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs) in response to the solicitation to provide care coordination services to Seniors and Persons with Disabilities (SPD).

This Solicitation fulfills a goal to allow Providers to design and offer care coordination models other than traditional Health Maintenance Organizations (HMOs). HFS is seeking innovative proposals that demonstrate that Providers can organize networks of

care around clients with complex health/behavioral health needs, provide quality care coordination services, produce health outcomes and render measurable savings.

Coordinated care in Illinois is contemplated to include a mix of care coordination arrangements that include traditional, fully capitated HMOs, along with CCEs and MCCNs organized by hospitals, physician groups, FQHCs or social service organizations.

Along with maximizing federal Medicaid funds and better coordinating efforts between agencies, the way in which Medicaid funds are budgeted should also be made more transparent. Finally, agencies should continue to work in an on-going process to address new obstacles to claiming as they arise.

RECOMMENDATION

The Commission recommends that the Medicaid budgeting process be revised to increase transparency and account for differences in claiming mechanisms. Such budgeting should create an emphasis on reporting true expenditures to better reflect the actual dollars, including the state expenditures, as well as the receipt of FFP at its various claiming rates.

The Commission also recommends the on-going coordination of claiming between the several social service agencies with current claiming mechanisms. Such on-going coordination should be charged with addressing new claiming issues as they become identified.