ACMHAI
Association of Community Mental Health Authorities of Illinois

SENATE MEDICAID REFORM COMMITTEE HEARING

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ACMHAI Testimony

Written Testimony provided by:
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Dear Chairs Steans and Righter, and Members of the Senate Medicaid Reform Committee,

Thank you for inviting the Association of Community Mental Health Authorities to provide testimony on Medicaid reform in Illinois. We appreciate the opportunity to share the local governmental payer point of view. Responses to your questions follow:

1. What is your role in the Medicaid system?

The Association of Community Mental Health Authorities of Illinois (ACMHAI) represents mental health boards that plan, fund and coordinate services for people with mental illness, substance use disorders, and developmental disabilities. Local mental health authorities (LMHAs) fund over $60,000,000 in services to thousands of individuals in our communities through property tax levies.

Until the Medicaid cap was lifted in the last session, the local mental health authority role had been to cover Medicaid clients when the providers' state caps were met. Last year LMHAs that participated in billing for Medicaid reimbursement received over $1 million in FFP to reinvest in their communities' behavioral health system of care. Given the sharp decline in state funding of non-Medicaid eligible clients, local mental health authorities have generally shifted the majority of their funding to this population, with most LMHAs allocating less than 10% of their total budget for Medicaid eligible individuals. Communities with mental health boards have benefitted from immediate reimbursement for services provided, whether they are Medicaid or non-Medicaid, and from direct receipt of FFP to be used for much needed behavioral health services.

As local planners and governmental funders of community behavioral health services, local mental health authorities provide a unique perspective on the implications of expanding Medicaid programs and should be included in its

overall planning and implementation. Because all health care is local, the State of Illinois must work with local governmental entities and community based organizations to craft a set of local solutions that address the needs of individuals with mental illness and substance use disorders. Given the prevalence of co-morbid conditions, coordination and linkage with primary care can no longer be optional.

We are positioned to assist the state with accountability measures by designing local care management entities which would provide more multi-system planning and outcome measurement of state and locally-funded services. We also have been working with the State and other stakeholders to make system changes that will help Illinois ensure that it is in compliance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT), a federal Medicaid program for children, as it was designed to be implemented. At the same time we are looking for the most cost effective delivery of services in the home, schools and community.

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

Medicaid costs can be reduced by analyzing and promoting good health from a systemic level - that is, manage the highest utilizers of care through a chronic disease model and promote recovery and prevention by providing care predominantly in community-based settings rather than managing individuals in institutional settings. The savings can then be reinvested into the system to impact prevention.

Coordination of care is a must for reducing Medicaid costs, including better collaboration with local entities to monitor behavioral health service utilization and outcomes, and communication that includes access to records and corresponding with individuals and families on whether or not, and to what extent, services have been delivered. If there were local care management entities and there was more cooperation between state and local mental health authorities, there would be more transparency and assurance that services are delivered effectively.

If health/social services are integrated, as is happening with primary and behavioral health care, and with mental health services in the schools, the funding among federal, state, and county government also has to be intertwined. Blended or braided funding forces the elimination of silos with their duplicative eligibility and other tedious administrative requirements by supporting a streamlined comprehensive service system for individuals with complex health issues and their families. Changes in practice and payment to align quality and cost and to achieve desired client and system outcomes will greatly increase the likelihood for sustainability of the newly reformed system.

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

Several LMHAs continue to bill Medicaid for reimbursement to allow reinvestment in the community behavioral health system of care, and as the individuals who are newly eligible for Medicaid are enrolled and others are covered by the Health Insurance Exchange, LMHAs may be able to bill Medicaid more than they are currently. Several LMHAs are ensuring that providers have support to assist consumers on gaining eligibility for Medicaid benefits by funding benefit specialists or case manager positions. The need for this service will grow with expanded Medicaid eligibility, and LMHA support has the potential to increase as local funding that had previously been used for non-Medicaid clients is available.

ACMHAI is currently working with HFS to develop rules and procedures for psychiatric residential treatment facilities (PRTFs) in Illinois. PRTFs are the only Medicaid reimbursable out of home treatment entities that are viable options to acute (re)hospitalization, which is the most expensive and restrictive treatment modality. Short term PRTFs provide more appropriate treatment than Department of Juvenile Justice and Child Welfare placements that have been the unfortunate consequence of a gaping hole in the children's system of care.

Additionally, we could partner on more federal funding opportunities in which the state serves as the fiscal agent but require a local match. On a county or regional basis many of our LMHAs and their community partners are aggressively pursuing other federal funding sources (e.g., SAMHSA) and state/national foundations for supportive services not covered through Medicaid. We are also encouraging more coordination between behavioral health and primary health by: promoting Federally Qualified Health Center/Mental Health Clinic partnerships; funding patient navigator positions; and funding web based information and referral sites (network of care) and health fairs to bring forward information to the community. Information and referral networks will certainly be in demand as various aspects of Medicaid reform are implemented.

Payment reform and waiver demonstration programs would help us through state fiscal recovery and care integration waivers could be piloted in communities that have a strong infrastructure supported by local mental health authorities:

1) Health Homes and Chronic Care Management planning grant;

2) Moving toward a comprehensive case management and capitated systems;

3) 1115 and 1915 (i) Waiver demonstration programs in communities with mental health boards to implement health home pilots and to provide enhanced community support services to Medicaid beneficiaries who do not meet the institutional level of care criteria, respectively; As part of the waiver applications, revise the IMD exclusion, and redirect funding from institutional care (currently 80% of total funding for long-term care in Illinois) to community-based care. The 1915 (b), (c), or (i) waivers also serve as tools to meet obligations under ADA and Olmstead.

4) Payment incentives to reward quality and outcomes rather than volume;

5) Moving from behavioral health carve-outs to integrated care across all systems (we are watching the integrated care pilot with interest, an area in which several LMHAs are located).

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

As local governmental payers, it would be much more efficient if all payers were able to share service information and leverage resources to better serve individuals with mental illness, substance use disorders and developmental disabilities. One central database that combines all public funders' revenue and expense data by clients to be able to track services, costs, and outcomes would truly enable us to cost analyze care. We need to do a better job of inventorying services, analyzing costs, utilization, and outcomes across all the systems of care.

Local mental health authorities could be integral in the collection, storing and reporting of group level utilization and outcomes data to further improve the system. Many of our members are already collecting data to analyze the effectiveness of their funded programs in order to improve outcomes and to discern whether they should continue funding a particular program or pursue a different initiative for a better result.

Other ideas to rid the State's Medicaid system of inefficiencies that prevent individuals from being served by Medicaid are:

- Reduce the lag time in approving Medicaid applications.
- Eliminate barriers for Medicaid approval for those with co-morbid conditions - especially substance use disorders and mental illness.
- Ensure that EPSDT services are accessible to those with behavioral health conditions/developmental delays in children and youth by clearly describing allowable services and how to access those services through every child-serving state agency (DMH, DD, DASA, ISBE, DCFS, HFS). Multi-system planning and care management must be coordinated through these agencies and with corresponding local entities.

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

Currently, auditing for behavioral health services is focused on checking the provider's case notes with the Medicaid billing, but not to assure that the services are actually provided as billed. In a recent Illinois Times article, Medicaid consumers were urged to check the billing statement, which is supposedly sent to their homes. HFS representatives countered this statement, however, reporting that consumers do not receive a billing statement. While it may be too costly or impossible to send statements to all consumers, sending statements periodically to a random sample of consumers to confirm whether or not the services were delivered might be enlightening as to overall costs, accessibility and utilization of services. This research would provide evidence that alternative courses of treatment that are cost effective and result in recovery, such as intensive community based supports, should be considered. By establishing clearer and consistently interpretive guidelines concerning billable services and by monitoring service utilization with a central database and consultation with service recipients any loopholes within state statute would be closed.