1st MTG
Monday 11-29-2010

Statement of the Illinois Hospital Association

November 29, 2010

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Senate Special Committee on Medicaid Reform
Room 400 Capitol, 1:00 p.m.

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TESTIMONY BY
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ILLINOIS SENATE SPECIAL COMMITTEE ON MEDICAID REFORM
MONDAY, NOVEMBER 29, 2010

INTRODUCTION

Committee co-chairs and members of the Illinois Senate Special Committee on Medicaid Reform, I am Howard Peters of the Illinois Hospital Association (IHA) here on behalf of our 200 member hospitals and health systems across the state of Illinois. We greatly appreciate the opportunity to speak to you about the Medicaid program, which is a vital part of our state's health care delivery system and our state and local economies.

The hospital community recognizes that the State faces significant fiscal challenges. This committee and the General Assembly have the difficult, but important task of identifying approaches to enable the State to be more fiscally responsible, efficient and accountable as a good steward of its resources for vital programs and services, including health care.

As you consider potential changes and reforms to the Medicaid program, it is important to remember that Medicaid not only ensures the health and well being of many of the state's residents, but just as importantly, provides a substantial stimulus to Illinois' economy and to the local economies of communities across the state that helps generate jobs and revenues and brings in substantial, additional non-State funding.

The Illinois Hospital Association supports a cost-efficient, effective Medicaid program that ensures that the right care is delivered in the right place at the right time. Illinois' hospitals have consistently collaborated with the State to identify and implement workable mechanisms and solutions to control Medicaid costs and improve care, including the development of Primary Care Case Management and Disease Management, promoting a medical home for Medicaid patients, and reducing inappropriate prescription drug utilization. Hospitals have also partnered with the State to bring in billions of dollars in federal funds for the Medicaid program, through the Hospital Assessment Program, which also significantly benefits patients served by non-hospital providers.

The hospital community looks forward to continue working with the General Assembly and the State as good partners in expanding existing approaches that are working well and developing new strategies to strengthen our health care delivery system, including the Medicaid program. We share the same goal – to make the Medicaid program as cost efficient and effective as possible while promoting timely access to quality care with the best possible outcomes. At the

same time, in considering strategies to control costs and achieve greater efficiencies in the Medicaid program, we urge you to "first, do no harm" to patients and the health care system. Implementing untested or flawed strategies or strategies based on faulty assumptions could have far-reaching negative consequences in the immediate future and in the years to come.

For our testimony today, we have been asked to focus on five areas related to the Medicaid program. We respectfully offer the following comments.

1) **What is your role in the Medicaid system?**

Hospitals: Serving Patients and Their Communities

Illinois' hospitals quietly do extraordinary work every day in communities all across the state. They are dedicated to serving the health care needs of every person in their communities whether or not they can pay. As part of their commitment, Illinois hospitals treat patients from every segment of society, 24 hours a day, seven days a week, 365 days a year. People turn to their local hospital in times of personal need and in times of crisis, and they depend on their hospital to be there.

Illinois hospitals provide a staggering amount of health care to Illinois' 12.8 million people. Every year, they care for approximately 1.6 million inpatients, deliver 171,000 babies, treat 29 million outpatients, and handle about 5 million emergency department visits, saving thousands of lives.

In partnership with state government, hospitals provide a safety net of essential services for all Illinoisans. In 2009, hospitals across the state delivered inpatient and outpatient services to hundreds of thousands of Medicaid recipients – providing 1.9 million days of care (excluding dual eligibles) and 2.6 million outpatient visits each year. Medicaid pays for half of all Illinois births and one out of six hospital admissions.

While hospitals are traditionally seen as providers of acute, inpatient care, they do much more to enhance the health and quality of life in their communities by identifying and addressing health, social and welfare needs. They not only provide compassionate care 24-7 and vital services – like emergency and trauma care, and neonatal intensive care, where their costs often far exceed the payment they receive – they also provide free and subsidized health services in the community, wellness programs, support groups, medical research, education and training for the next generation of doctors, nurses and other health care professionals, and neighborhood revitalization projects. Hospitals meet the pressing health care needs of their community, inside and outside their walls, and ultimately improve the long-term health of their communities.

Illinois hospitals continue to provide the state and their communities all these benefits and more, including care for the growing numbers of uninsured and underinsured – giving more charity care than ever before. The 109 hospitals that file annual community benefits reports with the State provided nearly $500 Million in charity care (at cost) alone for the hospitals' fiscal years ending Sept. 30, 2009 – an increase of about 100 percent since 2005 – as well as more than $4.9 billion annually in overall benefits to their communities.

Hospitals are also vital to the fiscal health of their communities and the state as major employers and economic engines. In nearly half of the State's counties, hospitals are among the top three

employers. Together, hospitals provide more than 425,000 direct and indirect jobs and generate a total economic impact on the State of more than $75 Billion annually.

Typically, when a new doctor comes to a community, it's generally the hospital that helped attract, if not outright recruit that doctor, leading to more jobs in the community. A recent Oregon study showed each physician's practice supported 12 to 48 jobs.

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

Care management, coordination and integration – focusing not just on primary care, but the entire spectrum of a patient's health care needs – can reduce hospitalizations, lower the rate of complications from chronic conditions, help eliminate health disparities, and **reduce costs.** Bringing together hospitals, primary care physicians, specialists, long-term care and social service providers to organize care around the needs of the patient in a structured, coordinated and appropriate approach can improve outcomes, reduce unnecessary and avoidable utilization, and reduce costs. At the same time, **improving the quality of patient care** and making sure that the right care is delivered in the right place at the right time is also critical to efforts to control and reduce costs.

It is important to note that a critical component needed for the success of care coordination approaches are the **patients** themselves. They have a **personal responsibility** for their health, in partnership with their providers, including taking preventative steps, following their providers' instructions, obtaining necessary prescriptions, keeping follow-up appointments, going to their primary care provider or medical home as needed and appropriate, and only going to a hospital emergency room in a true emergency. We need to enhance and develop strategies, including care management and coordination, to make sure that patients act in ways that ensure their health and well-being.

Improving Quality to Reduce Costs

IHA and the Illinois hospital community have long been engaged in the relentless pursuit to advance quality patient care and outcomes across the state that help reduce over-utilization and avoidable utilization of health care services and that reduce costs. We are stepping up those efforts.

In 2010, IHA created the Quality Care Institute, a statewide center, to promote excellence in performance improvement across Illinois' delivery systems. The Institute's dynamic efforts build upon existing quality and safety initiatives, engaging our organizations in shared learning networks and applying innovative strategies for strengthening the quality of health care delivery – with the ultimate objective of becoming national leaders in quality patient care.
Nearly 200 hospitals and health systems across Illinois are actively engaged in the Institute's "Raising the Bar" campaign to substantially reduce readmissions, and hospital-acquired conditions and infections. This initiative will not only **improve patient outcomes but reduce health care costs for everyone, including the Medicaid program.**

Enhance Primary Care Case Management and Disease Management Programs

The State has already taken some important steps in moving to integrate and better coordinate medical services into the Medicaid program. We commend the State and the Department of

Healthcare and Family Services for establishing the Primary Care Case Management (PCCM) and Disease Management (DM) programs. The programs have shown great promise and substantial savings in their first few years of operation.

The PCCM and DM programs keep people healthier and help keep costs in check by preventing inappropriate and costly emergency room visits and hospitalizations. Each client is assigned a "medical home" where they receive regular ongoing care and have access to primary care doctors who provide regular checkups and preventative care. Through extensive outreach efforts, Illinois Health Connect has more than 5,000 "medical homes," including physicians and Federal Qualified and Rural Health Centers across the state.

The disease management program provides an even more intensive and comprehensive approach to patients with chronic disease, such as coronary artery disease, asthma or depression. The program coordination includes the use of nurses and social workers to ensure that participants obtain the help they need for their health, food and housing issues to get better control of their situations and reduce the incidence of costly medical crises.

These programs are all about managing and coordinating care, making sure that people get the right care at the right time in the right place, so that they are not unnecessarily using the hospital emergency room and driving up costs. Through good PCCM and DM programs, the state is accomplishing those goals. The state should not abandon the PCCM or DM approaches.

We urge the state to **expand and refine the PCCM and DM programs to include other populations, other conditions, and other providers.** For example, the PCCM program could be enhanced to include long-term care services as part of the "medical home." It could also be expanded to include clinics, Federally Qualified Health Centers, physician groups, and Accountable Care Organizations. Through an enhanced PCCM program, the state should be able to achieve better integration of services, not just by individual physicians, but also by physician groups, clinics and hospitals, who should be included as strategic partners in this effort.

Several other states, including Arkansas, Indiana, North Carolina, Oklahoma, and Pennsylvania, have sought to enhance their basic PCCM programs with additional features. While each state uses different resources for care coordination and care management and uses different care coordination methods, common themes in their approaches include: more intensive care management and care coordination for high-need beneficiaries; improved primary care physician incentives; information sharing; and increased use of performance and quality measures. We urge the state to look at those approaches as well as other enhancements to the PCCM program, including:

- Tie per member per month payments to specific outcomes that require the physician to actively engage and provide appropriate primary care to the Medicaid beneficiary;
- Disciplines, incorporating provider risk-sharing such as reductions in per member per month payments, should be considered to encourage physicians to provide top care, including adequate hours and access to care;
- Focus on true incentives for the provider and patient to reward healthy lifestyles and ensure that primary care physicians are making only proper referrals; and
- Limit doctor shopping within the PCCM system to allow for proper care management.

We also recommend several changes in the DM program, which is currently voluntary for enrollees with chronic conditions, including:

- Participation in the existing disease management program by **all beneficiaries** who are in the high-cost category or at risk of joining the high-cost category should be pursued;
- Payment for service should be based on meeting reasonable performance metrics and improving health outcomes; and
- Mechanisms to tie payments to the program's vendor to savings and health outcomes should also be explored.

One prime example of a highly successful disease management approach that has been implemented in Illinois by a hospital is Sinai Children's Hospital/Sinai Urban Health Institute's "Healthy Home Healthy Child" program for pediatric asthma in the North Lawndale area of Chicago. One in four children in the largely African-American community, and one of the poorest areas of the city, suffers from the disease, one of the highest documented rates of asthma in the country. IHA data had indicated that children in that area are 1.5 times more likely to be hospitalized with asthma problems than their peers in other parts of Chicago.

Using evidence-based interventions, the Sinai program provides in-home visits and education to families. During the visits, community health educators and lay health educators help identify and eliminate asthma triggers in the home such as mold, mice, household pets, cigarette smoke, cockroaches and cleaning products. They also review the child's use of medications, inhalers and nebulizers to assure that the child benefits the most from his or her treatment. The program's efforts have led to a 200 percent drop in frequency of symptoms, **a 48 percent reduction in ED visits** and **50 percent decrease in hospitalizations,** decreased exposure to asthma triggers in the home and fewer nighttime home asthma emergencies. Cost savings from the program in recent years are on the order of $5 to $7 for each dollar spent.

Explore Care Coordination Approaches Through Demonstrations and Grants Under ACA

The federal health care reform legislation, the Affordable Care Act (ACA), includes a number of new demonstrations and grants focused on service delivery and payment reforms that promote greater care coordination. The hospital community welcomes the opportunity to work with the state and the Department of Healthcare and Family Services to assess the feasibility of various options available under the ACA, including:

- Medicaid Integrated Care Hospitalization Demonstration Program: Up to eight states will be selected to use bundled payments to promote integration of care around hospitalization;
- Medicaid Global Payment System Demonstration: Up to five states will be selected to test paying a safety net hospital system or network using a global capitated payment model;
- Pediatric Accountable Care Organization Demonstration Project: Will allow pediatric providers to organize as accountable care organizations (ACOs) and share in federal and state Medicaid cost savings;
- Medicaid Emergency Psychiatric Demonstration Project: Will provide Medicaid payments to institutions for mental diseases (IMDs) for adult enrollees requiring stabilization of an emergency condition;

- Medicaid Chronic Disease Incentive Payment Program: Will provide states grants to test approaches that encourage behavior modification for healthy lifestyles; and
- A new program to develop and advance quality measures for adults in Medicaid. A similar initiative for children was included in the Children's Health Insurance Program Reauthorization Act (CHIPRA).

Medicaid ACO Demonstration Projects & Grants
Beyond the ACA demonstration and grant opportunities listed above, we believe the State should consider the idea of pursuing an even bolder approach.

Although the wisdom of care management and coordination has never been questioned, our current volume-based payment systems have never adequately funded or incentivized this approach. To make care management and coordination a viable solution to inappropriate health care utilization, our payment systems need to incentivize such care. One of the most promising new payment ideas borne out of health care reform is the creation of Accountable Care Organizations (ACOs), which are designed precisely to incentivize care management.

IHA recommends that Illinois pursue the analysis and development of a multi-year, federal Medicaid waiver to bring substantial federal resources to the state to fundamentally restructure our Medicaid program toward accountable, value-based care. With these federal funds, the Illinois Medicaid program should support and fund a number of ACO pilots or demonstrations throughout Illinois to determine whether and how this care management approach can significantly improve the care of Medicaid beneficiaries and slow the rate of growth in the cost of covering this population.

To achieve meaningful results, the state will have to use these new federal monies for the up-front investment of resources required to give these pilots a realistic opportunity to succeed. Federal Medicaid waivers and grants offer a tremendous opportunity for Illinois to promote this initiative without having to fund it completely out of state revenue. The following elements would need to be included in this bold and innovative approach.

Start-up Funding:

1. **Investing in Delivery System Infrastructure Improvements.** ACOs must implement meaningful and identifiable reforms in care delivery, patient engagement, and other aspects of health care that will credibly improve health and reduce the growth in costs. The state should provide funding for the creation of an ACO provider network with an ACO management structure for administrative and care coordination support (e.g., claim adjudication; ACO provider network contracts; management of incentive payments to providers; provider relations and coordination; care and utilization management; and quality and efficiency measurement).

2. **Health Information Technology.** The State should fund health information technology for each ACO that connects all of the ACO providers and allows for proactive patient care management and the clinical tracking of patients throughout the delivery system.

ACO Elements of Success: The core elements of a successful Medicaid ACO pilot include the following:

3. **Primary Care Focus.** ACOs must be established on a strong foundation of primary care to promote preventive health care and to enhance patient wellness. Accordingly, the State must offer ACOs sufficient funding to attract primary care providers to serve in these demonstrations for primary care management of the Medicaid population that is enrolled in a participating ACO.

4. **Continuum Care Capacity.** The ACO must be able to manage the full continuum of care for all of its Medicaid beneficiaries, from primary care to end of life service.

5. **Sufficient Size in Patient Populations.** The state must assure enrollment of a sufficient number of Medicaid beneficiaries in each ACO to ensure that their quality and cost impacts can be reliably measured and evaluated.

6. **Data and Healthcare Analytics.** The state should assist the ACO in understanding the health risks of its Medicaid population and appropriately fund the analytical resources they will need to achieve the desired level of care coordination that improves quality and contains costs.

7. **Shared Savings.** Although the existing volume-based payment system may be the default approach for some services, the state should develop new ACO payments that provide incentives to avoid cost and create savings, such as medical home payments, care management fees, bundled payments, and other possibilities. The state should also offer ACOs performance bonuses for achieving measurable quality targets and reductions in overall spending growth for its Medicaid population.

8. **Provider Incentive Payments.** ACOs must offer realistic and achievable opportunities for their providers to share in the savings created from delivering higher-value care.

9. **Performance Measurement.** ACOs must participate in ongoing performance measurement that provides meaningful evidence of health and cost impacts. Results, including patient experience, clinical process and clinical outcomes, must be transparent and accessible to patients and the state.

10. **Time.** It will take each successful Medicaid ACO pilot applicant at least twelve months to establish the infrastructure and operational policies and procedures to implement the ACO-style of care. For the state to get a credible understanding of how well each of its Medicaid ACO pilots performs, it is recommended that each pilot be allowed to operate for at least three years beyond its first year start-up unless the ACO decides to withdraw from the demonstration because of financial or operational hardship.

IHA looks forward to working with the state to pursue the federal waiver and funding opportunity described above. The need to find better ways to treat our Medicaid population coupled with the possibility of doing so with federal financial assistance are compelling reasons for proceeding down this promising path. As we look ahead, we must seek to not only preserve

existing federal financial support for Medicaid, but also pursue new opportunities to enhance that support. IHA stands ready to assist and work with the state in this quest.

Integrate Behavioral Health Services with Primary Medical Care

Another innovative approach the state should consider is a **new model of care that integrates and coordinates behavioral health care with primary medical care**. Such an approach would **make behavioral health services available to a wider population** – especially to single adults without children. The state should pursue obtaining federal Medicaid matching funds to help pay for those services, which are currently funded with state funds only.

Over the past several years, hospitals in Illinois have been serving a large and steadily increasing number of persons with mental health and substance abuse illnesses – who did not qualify for Medicaid or Medicare – in their emergency departments, inpatient beds and specialty facilities. Individuals with mental illnesses often go to the hospital emergency room in crisis because treatment was not available to them sooner and in a more appropriate setting. This unnecessarily drives up health care costs.

The U.S. Surgeon General, the Institute of Medicine and the President's New Freedom Commission on Mental Health have all concluded that primary medical and specialty psychiatric care should be integrated. They note that mental illnesses are treatable diseases, and in many cases, occur concurrently with medical conditions. For example, one-fifth of persons hospitalized for cardiac conditions have depression. Persons with serious mental illnesses die at a much younger age than the general population because of untreated medical conditions.

The situation has only worsened over the past few years, as Illinois' community mental health and substance abuse systems have sustained major funding cuts, depleting the availability of services in communities across the state. The expansion of the Medicaid program presents an opportunity for the state to **enhance and rebuild community-based services**, thus reducing unnecessary utilization of hospital emergency rooms and inpatient psychiatric services, and costs.

Rebalance Long-term Care Services

The state should rebalance and reduce its reliance on institutional care in the Medicaid long-term care system. Individuals who are aged or living with a disability or serious mental illness should remain in the communities in which they live, with quality services provided to them on a medically practical and cost-effective basis. Specific strategies to achieve this goal might include:

- Enhancing the Community Care Program for Medicaid-eligible seniors;
- Enhancing community options for people with developmental disabilities who are living in state or privately-run institutions;
- Enhancing and expanding community-based programs for those with mental illnesses; and
- Managing admissions to ensure a short institutionalization period and facilitate rapid reintegration to a community setting.

Explore Payment Reforms to Improve Quality and Outcomes

We applaud the Department of Healthcare and Family Services for its efforts to transform itself from an agency that "simply pays bills for services after [its] clients get sick – to being a proactive agency that focuses on helping to keep people healthy." We note that the Department already offers **bonus payments to primary care providers for high performance** in *Illinois Health Connect* medical homes. In the 2010 General Assembly session, IHA supported legislation (SB3743/PA96-1130) that enhances payments to long-term acute care hospitals that choose to participate and meet certain quality standards.

The hospital community looks forward to continue working with the Department to consider and **test incentives for cost-effective, quality care, based on outcomes**. In the years to come, the Medicaid program expansion provides an opportunity to explore various payment reforms that could lead to more cost effectiveness and efficiencies, quality improvement and better outcomes. Such reforms might include the **bundling of payments** for an "episode of care" to various providers in different settings, such as the physician's office, the hospital and the nursing home, in an effort to increase patient care coordination among providers.

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

The Hospital Assessment Program: Helping Ensure the Fiscal Health of Medicaid

Illinois hospitals recognize that the State has faced and continues to face very difficult fiscal challenges, including finding the resources to support the Medicaid program.

In recognition of those challenges, Illinois hospitals have worked with the State to develop three Hospital Assessment Programs over the past six years to provide billions of dollars in new federal and hospital tax funds for the state's Medicaid program – to boost inadequate hospital rates and help everyone in the Medicaid program, including generating substantial funding for other Medicaid services, such as long-term care and developmental disability services.

Hospitals Are Not the Cause of Medicaid Spending Increases

It is important to understand how the hospital budget line in Illinois Medicaid program is financed and the fundamental pressures facing the program.

According to the General Assembly's Commission on Government Forecasting & Accountability, **Illinois' Medicaid enrollment has grown by more than 107% between FY1999 (1.35 million enrollees) and FY2009 (2.79 million enrollees)**. It should come as no surprise that Medicaid spending has also increased.

Despite covering substantially more people, hospital inpatient base rates have been frozen since 1995, and a majority of Medicaid hospital outpatient base rates are now lower than they were in 1998. Without the enhanced funding from the Hospital Assessment Program, on average, Medicaid covers only ***75%*** of Illinois hospitals' ***costs*** of treating Medicaid patients.

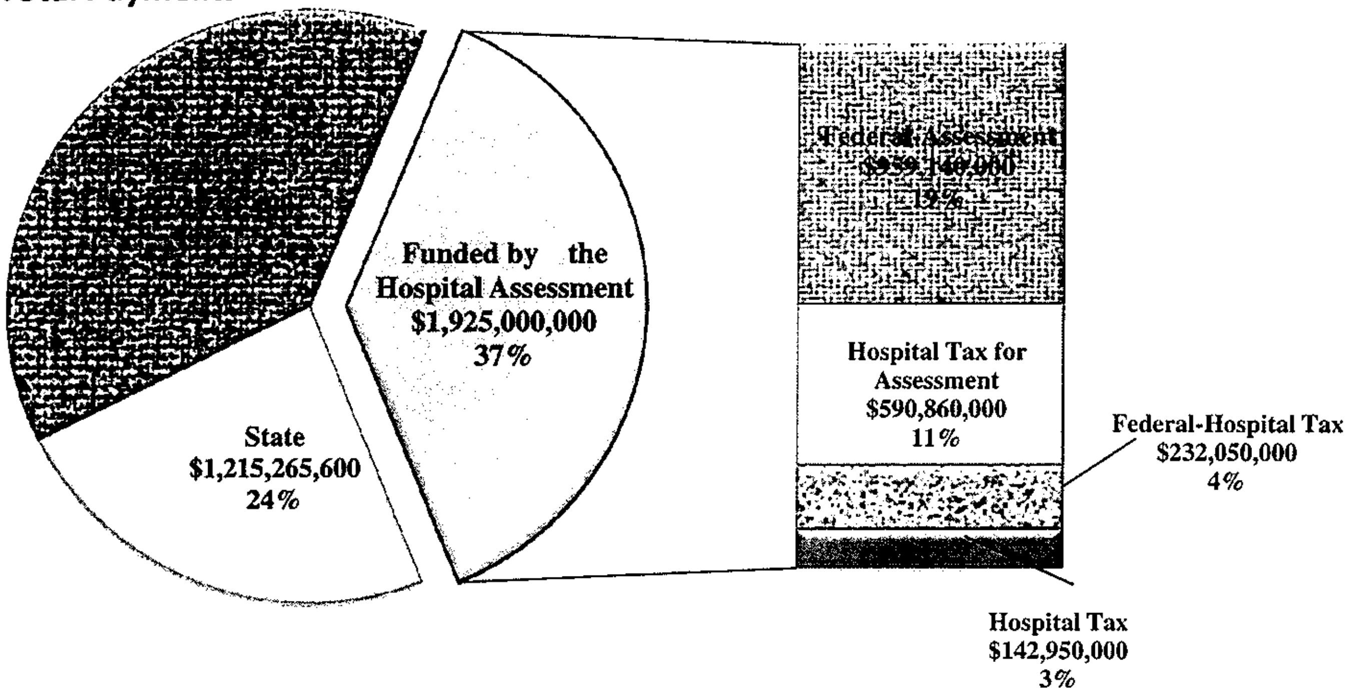
When you look at the total $5.1 Billion in Medicaid payments to hospitals in Illinois in state fiscal year 2011, the vast majority of funds used to make these payments are from NON-State sources:

- **<u>Three-quarters of Medicaid payments to hospitals in FY2011 are from NON-State funding sources</u>**: $733.8 Million paid by hospitals to the State for the assessment program, which triggers a federal match of $1.19 Billion, and $1.97 Billion in other federal funds;

- **<u>Less than 25 percent</u>** of Medicaid payments to hospitals, or $1.2 billion, **<u>are from state funding</u>**.

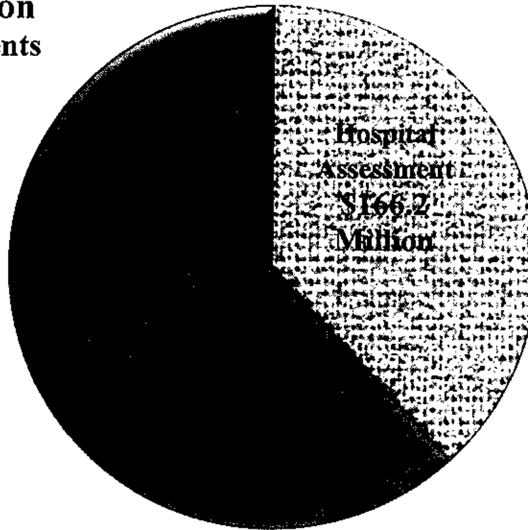
Sources of SFY 2011 Budget Medicaid Hospital Payments

$5.113 Billion
Total Payments



Just as importantly for the State, the Hospital Assessment Program is generating additional NON-State funds of approximately **$436 Million** for other Medicaid needs in the current fiscal year.

Additional Medical Assistance Payments Funded by the Hospital Assessment Program



Under the assessment program, in the current fiscal year, hospitals contribute substantial funds to the State: a total of $900 Million a year, with $733.8 Million of that contribution generating the federal match to pay hospitals.

The remaining $166.2 Million of hospitals' contributions go to the State to use for other Medicaid needs. Under the State's enhanced FMAP rate, that $166.2 Million generates another $269.8 Million in federal matching funds, for a total of $436 Million.

Over the five years of the current assessment program, the program will have brought the state $3.85 billion in federal Medicaid funds for hospitals, as well as provided the state another $650 million for other Medicaid needs, such as long-term care and developmental disability services. With the State receiving temporarily increased federal matching funds under the economic stimulus law, the $650 million, if matched, will net the state $2.5 billion over five years for other Medicaid needs.

Maximize Additional Federal Funding for Medicaid in the Short-Term and Long-Term
We urge the State and its various agencies, including the Departments of Healthcare and Family Services, Human Services, and Aging, to continue their efforts to **increase and maximize their claims for federal Medicaid reimbursement for as many qualifying services as possible**, now through the end of June, 2011, under the state's enhanced federal matching rate (FMAP).

To ensure that the state can adequately support the Medicaid program (and reduce its need for state funds), we strongly urge the Governor, General Assembly and Illinois Congressional Delegation to push for a **permanent increase in the state's federal Medicaid matching rate**. When the state's enhanced rate expires next June, Illinois will return to the lowest federal matching rate, even though it provides disproportionately more Medicaid services than many other states.

To explore other ways to obtain substantial federal funding for the Medicaid program, as we noted above under Question #2, we urge the State to consider pursuing appropriate **demonstration, grant and waiver opportunities** under the federal health care reform legislation. Given Illinois' geographic and demographic diversity, the State would be an excellent testing ground for the Midwest and the nation for Medicaid innovations and warrant federal funding support.

Also, as part of that exploration, HFS should analyze those populations where state-only dollars are spent to determine if these populations could be part of the Medicaid program's expansion under health reform and thus generate a federal match and reduce the amount of state general revenue that is needed. One such population would be childless adults who are using mental health services. Another potential population would be individuals who are currently in county jails and state correctional facilities.

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

We commend the General Assembly and HFS for taking several major steps in recent years to fight fraud, and to improve transparency and efficiency in the Medicaid system. In 2010, three major pieces of legislation in this area were enacted by the General Assembly:

- House Bill 5241: Creates the Medicaid Accountability Through Transparency Program, allowing the State to post Medicaid claims data online by county. This provides public access to information on how funds are used for the Medicaid program and enables people to report any irregularities or concerns they see in the data;

- House Bill 5242: Allows the State to contract with third parties to conduct audits to recover funds that are paid in error or through fraud and abuse; and

- House Bill 5054: Allows HFS to issue Medicaid cards on a permanent basis rather than monthly (eliminating wasteful printing and postage costs) and requires Medicaid providers to verify eligibility using an electronic verification system **before** providing services.

We also note that HFS has been engaged in an extensive review of its eligibility and enrollment procedures for the AllKids, FamilyCare, Moms and Babies and other Family Health Plans to ensure that those who receive Medicaid services meet all state and federal eligibility requirements.

In addition, as noted in our extensive comments under Question #2, the hospital community and the State have been taking many steps and are considering other steps to reduce over-utilization and unnecessary utilization of health care services, and reduce readmissions and hospital-acquired infections and conditions, which reduce inefficiencies and costs in the health care system, including the Medicaid program.

One area where there is potential for making the Medicaid program more efficient concerns the current Medicaid Management Information System (MMIS). Many of the system's edits and audits could be updated to ensure that claims are reviewed and paid accurately, especially as medical assistance programs grow under health care reform. That may require additional staff and resources within HFS as it works to streamline and improve claims processing and other processes, such as eligibility determination, to reduce the program's operational costs as well as avoid unnecessary or inappropriate expenditures.

The hospital community stands ready to continue working with the State and HFS to make the Medicaid program as efficient as possible.

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

As noted above under Question #4, the State and HFS have been taking appropriate steps to identify and close loopholes.

It should be noted that a major new program is being launched by the U.S. Centers for Medicare and Medicaid Services (CMS) to reduce the number of improper payments under state Medicaid plans. CMS recently issued a proposed new rule for the Medicaid Recovery Audit Contractor (RAC) Program.

Similar to the Medicare RAC Program, which was rolled out in all 50 states last year, under Medicaid RAC, independent contractors will seek out improper payments and overpayments. Under the Affordable Care Act, states must submit their plans to CMS by December 31 to establish their Medicaid RAC programs. Each state will choose Medicaid RAC contractors by the end of the year, and contractors will begin operations as early as April 1.

The proposed rule includes the payment methodology for identifying overpayments as well as the recovery of overpayments and the requirement that RACs report fraud or criminal activity whenever they have reasonable grounds to believe such activity has occurred. According to some estimates, Medicaid RACs aim to recover $9 billion a year across the country by 2012.

Conclusion

IHA and the hospital community are strongly committed to its partnership with the state to not only preserve and protect the health care delivery system in the short term to ensure its sustainability, but also to transform the health care system in the long term. We look forward to continue working with the state for a cost-effective, efficient and quality Medicaid program that focuses on good outcomes for patients and collaborating on ways to develop and maintain reliable, sustainable and predictable funding sources for Medicaid and the health care system.