December 31, 2010

Dear Illinois General Assembly Member,

On behalf of the four State of Illinois human services Departments – The Department of Human Services, the Department of Healthcare and Family Services, the Department of Children and Family Services and the Department of Public Health – I present the attached report in compliance with HB5124, signed into law as PA 96-1141. This report complies with the mandate by the General Assembly to:

- Summarize redundancies and duplication
- Propose recommendations to develop a streamlined auditing and accreditation system
- Streamline agency rules to reduce administrative costs associated with duplication of agency oversight

The Steering Committee charged with producing this report consists of representation from providers, trade associations, and the four Departments, and has been working together since October. While there is much discussion around the silos in which individual governmental units and the provider community work, this Steering Committee has served as a model for strong inter-organizational collaboration.

While producing the report is an initial step, significant gains will be made when the recommendations contained in this report are appropriately implemented within the human services Departments. This implementation will require:

- A structure that is able to implement the legislative/policy/procedural modifications needed
- An investment in IT infrastructure to support the modifications
- The continuation of this effort to analyze issues that were not fully addressed in this report

This structure will need continued support from the executive and legislative leadership in Illinois. While the Steering Committee was only charged with producing the report, it has also begun contemplating the implementation process, and is committed to working in a collaborative fashion with all parties necessary to bring the required changes to fruition. Looking ahead, we welcome participation from the Illinois Department on Aging, given their shared interests in the recommendations contained in this report.

Thank you for your time and attention to this important matter of helping our great state to operate more effectively and efficiently. I am pleased to present this report on behalf of the Illinois human services Departments, and feel free to contact me with questions or comments.

Sincerely,

Michelle R. B. Saddler
Acting Secretary, Illinois Department of Human Services

"Streamlined Auditing and Monitoring of Community Based Services:
First Steps Toward a More Efficient System for Providers, State Government, and the Community"

Report to the Illinois General Assembly as required by PA 96-1141

Submitted by:
Department of Human Services
Department of Children and Family Services
Department of Healthcare and Family Services
Department of Public Health

January 1, 2011

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Executive Summary

Governor Pat Quinn signed HB 5124 into law, as P.A. 96-1141 (The Act), on July 21, 2010. The Act specifically directs four State human service Departments – the Department of Human Services (DHS), the Department of Children and Family Services (DCFS), the Department of Healthcare and Family Services (HFS), and the Department of Public Health (DPH) – to perform internal reviews on provider contracts, auditing requirements, licensing and training requirements, and mandated reporting. Given the State's budget crisis, the need to recognize and address the redundant monitoring and reporting requirements, which divert time and resources away from client service delivery, is a priority of State government and the provider community.

There are seven (7) categories of recommendation that came out of the review conducted by the four Departments in partnership with the provider community. The categories, not listed in priority order, include the following:
- Deemed Status for Accreditation
- Fiscal Audits
- Centralized Repository
- Medicaid
- Technology
- Contracting
- Streamline Monitoring Procedures

The Steering Committee recognizes that the Departments may need to implement reviews necessary to address specific Federal requirements and that while consolidated reporting should be used when possible, the review and reporting processes should facilitate the ability to garner Federal funding. However, the analysis thus far confirms the need for change and a significant potential to reduce redundant monitoring and reporting. At the end of this Executive Summary, there is a summary presentation, including a timeline and progress indicators, that gives more details on these recommendations.

The methodology used to conduct this review consisted of the following:
- Public hearings
  - Mattoon, IL
  - Grayslake, IL
- Surveys
  - Issued to representatives of the four Departments
  - Issued to members of the provider community
- Research
  - Review of monitoring practices by other states
  - Best practices and other monitoring trends

      o   Analysis of the human services related contracts with providers

Although there were different methods used for collecting data, similar themes emerged related to redundancy and potential solutions, which are the basis for this report.

What the Act calls for in terms of addressing provider monitoring and redundancy parallels similar efforts that were found during the research process. In Illinois, these efforts include the *1996 Department of Human Services Virtual Case Manager Tactical Implementation Plan* and the October *1997 Illinois Department of Human Services Plan.* Publications such as the National Core Indicators highlight similar efforts around the country to reduce costs and increase efficiency.

The data for the provider contract analysis was primarily gathered from the Illinois Office of the Comptroller (IOC). According to IOC data, the four Departments made payments to over 150,000 providers, and many of these providers contract with multiple Departments. In addition, a number of these providers administer multiple programs under one contract. Further analysis is needed to more clearly identify the individual Department/provider/program relationships because there is not a centralized State grants management system and the different Departments utilize different contract documents.

There is a high level of frustration in the provider community involving the administration of State programs because of the various laws, administrative codes, and policies which govern the funding recipients. The complication is sometimes magnified because even within a single Department, there are multiple parties conducting monitoring activities in order to meet different purposes. The most pervasive areas where streamlining is needed to reduce redundancy involve the gathering of financial information, general administrative information, program information, and Medicaid reporting information.

The estimated cost to providers for each Department review is between $4,300 - $9,000. However, the real value in eliminating redundancy is not just in dollar savings, but also the fact that staff can be reallocated to focus more on their primary job - providing direct service to clients. Encouraging news is that significant change can be achieved through process modifications within the Departments, which should not require legislative mandates.

In moving forward, it will be important to conduct further research on the areas explored in this report to provide a more rigorous analysis, including a Return on Investment (ROI) calculation, which can accurately project real savings, along with the costs of:
- The required technology investment to support the new processes
- The training necessary for both the State staff and the provider community

There are also considerations that need to be contemplated beyond the writing of this report to turn the findings into positive action, and those include:

- Developing a government/community partnership structure which will facilitate implementation of the recommended solutions
- Synthesizing the work of implementing recommendations with the ongoing daily administrative and programmatic tasks that need to be achieved
- Maintaining accountability by incorporating the perspective of the provider community in developing new processes and requirements

The work ahead is substantial, but just as in the formulation and writing of this report, success will be achieved, both ultimately as well as in interim steps, with the dedication to fostering a strong collaborative approach among the executive, legislative and provider communities in Illinois. Without this strong sense of collaboration and advocacy from all three of the aforementioned sectors, the kind of progress needed to move our great state forward will not soon occur.

[THE EXECUTIVE SUMMARY CONTINUES ON THE FOLLOWING TWO PAGES WITH THE CHART OF RECOMMENDATIONS]

	PA 96-1141	Action		Preliminary Timeline		
	Recommendations (Subject to Federal Review/Approval)	Rule change	Statutory change	2011	2012	2015
1	**Accreditation**					
1.a	Examine the application of deemed status more closely to identify commonalities among financial, general administration and program specific components, between Department and accreditation requirements	x	x	x		
1.b	Fully operationalize P.A. 92-0755 and other relevant existing Department rules	x			x	
1.c	Convert the licensing periods for providers to match the accreditation cycles	x			x	
1.d	Expand deemed status for accredited organizations across state agencies and divisions to reduce/eliminate layers of licensure/certification	x	x		x	
2	**Financial Audits**					
2.a	Accept the provider agency's independent CPA audit in place of specific state agency audits, when the audit meet federal requirements and the funding received is tested as a major program			x		
2.b	Create a centralized unit for fiscal control review (133 desk reviews) for all Human Service Agencies			x		
2.c	Base fiscal reviews on findings from CPA audit, when the provider's audit includes an opinion on fiscal controls			x		
2.d	Standardize audit requirements across state agencies and divisions based on funding levels for providers who are not subject to OMB Circular A-133	x			x	
2.e	Standardized fiscal report formats across state agencies and divisions utilizing one single chart of accounts				x	
3	**Centralized Repository**					
3.a	Establish a centralized repository of all information required of providers with state contracts. Once "deposited" the provider agency does not need to resubmit that information for any type of state monitoring/auditing	x		x		
3.b	Accept electronic vault information from providers when providers participate in such a system on its own	x			x	
3.c	Establish an electronic repository or "electronic vault" for all information required of providers	x	x			x
4	**Medicaid**					
4.a	Bring all Medicaid compliance requirements into one document upon which compliance surveys should be based	x	x		x	
4.b	Establish a centralized location for consistent interpretation of technical questions regarding Medicaid across state agencies	x	x		x	

	PA 96-1141	Action		Preliminary Timeline		
	Recommendations (Subject to Federal Review/Approval)	Rule change	Statutory change	2011	2012	2015
4.c	Use a single billing platform for Medicaid so providers do not have to use multiple state agency systems to report Medicaid services	x	x			x
5	**Technology**					
5.a	Allow software costs to be capitalized		x	x		
5.b	Introduce a capital bill for technology for state and providers		x	x		
5.c	Develop databases with accessible platforms to interface with the reporting systems of provider agencies	x	x			x
5.d	Replace siloed electronic processes with electronic functions that are or can be integrated across state divisions and agencies, for non-Medicaid and other reporting	x	x			x
6	**Contracting**					
6.a	Streamline contracting process through use of a multi-year contracting approach			x		
6.b	Implement cross-agency prequalification and master service agreements structured around common service taxonomy for human service providers	x	x	x		
6.c	Streamline contracting process by making contract language and structure uniform				x	
6.d	Streamline contracting process by establishing a comprehensive schedule for coordinating contracting activities				x	
7	**Streamline processes**					
7.a	Create and implement inter-agency process to cross check potential new requirements to avoid creating additional redundancies			x		
7.b	Review the necessity of state fire marshal inspections if local fire authorities issue clearances of sites	x	x	x		
7.c	Standardize administrative requirements, consolidate forms and reporting processes, and apply them consistently across services. Priority should be placed on standardized documents under the Financial Review/Audits and General Administration categories				x	
7.d	Standardize monitoring protocols across state agencies, including specific protocols for on-site and desk reviews, and train monitors to implement consistently. Priority should be placed on standardized documents under the Financial Review/Audits and General Administration categories				x	
7.e	Incorporate a risk-based approach, focusing reviews on information that has changed and/or was previously out of compliance				x	
7.f	Create an integrated approach across agencies, divisions, and bureaus for surveys and licensures so that to the extent possible a single survey covers requirements for all departmental rules and regulations	x			x	
7.g	Train state monitors to properly to seek consistent information according to agreed-upon monitoring areas					x

Background

P.A. 96-1141 had its genesis in a series of meetings convened by Rep. Chapin Rose with a group of community providers and their Associations in Spring 2010. The purpose of the meetings was to raise awareness that in the absence of an agreed policy direction by Illinois government to make adjustments to the State's spending priorities, or to agree on increasing the State's reoccurring revenues, providers desperately needed relief from redundant monitoring, auditing and reporting requirements. Legislative liaison representatives and State staff from affected Departments were brought into the legislative process early on leading to the introduction of HB 5124 on January 27, 2010.

Representative Chapin Rose (R-110) and Senator Michael Bond (D-31), the lead sponsors in their respective Chambers, expressed the position that administrative relief should be granted for human service providers in a modernized, efficient and accountable system through the elimination of duplicative requirements and processes that all too often comprise unfunded State mandates. The bill passed both the Illinois House and Senate unanimously.

The bipartisan support garnered by the legislation underscored the broad recognition that steps must be taken to control unnecessary increases in the operating costs of these providers as a result of diverting their staff resources away from the actual provision of services and supports. Also, with declining State staff resources, processes that are too frequently repeated by other Departments, or divisions within the same Department, need to be reengineered.

The Governor signed HB 5124 into law, P.A. 96-1141, on July 21, 2010. This legislation represents collaboration between the Administration, the General Assembly and human service providers to prioritize efforts to untangle the complex and sometimes redundant web of contracting, auditing, monitoring and reporting requirements for both human services Departments and community providers.

PA 96 -1141 specifically directs four State human service Departments – the Department of Children and Family Services (DCFS), the Department of Healthcare and Family Services (HFS), the Department of Human Services (DHS), and the Department of Public Health (DPH) – to perform internal reviews on provider contracts, auditing requirements, licensing and training requirements, and mandated reporting. It further directs those Departments to identify the extent to which these requirements result in redundancies and duplication.

Following completion of the internal mandated review, the law requires that a unified report be issued to the General Assembly providing proposed actions to address the redundancy or duplication.

The results of these reviews led to the analyses and recommendations contained in this report, as stipulated by the Act:
- The development of a streamlined auditing and accreditation system
- The integration of Department rules to reduce administrative costs associated with multiple and duplicative program and accreditation audits and oversight activities
- Necessary changes
- Proposed statutory, rule and process changes

Recommendations

Providers, their trade associations, and the four Departments agree that the State needs a coordinated, non-redundant process for providing effective and efficient oversight of human service contracts, in a manner which insures client safety, quality treatment, and the limitation of fraud and abuse. There was a high level of convergence around the recommendations, with similar themes arising from the public hearings, Provider and Department Surveys, and brief review of previous Illinois efforts and national practices and trends. In addition, a review of issues specific to DHS resulted in comparable solutions (See Appendix F).

The following recommendations emerged in response to the redundancies described above. To operationalize them, each recommendation will require some combination of actions, including: change in procedures, organizational change, inter-Department agreements, administrative rule change, statutory change, and change in technology. Also it will be critical as new processes and technology is rolled out that the older manual and paper driven processes are modified and or eliminated. The process for moving forward anticipates that the specific path will be determined in the next phase. Regardless, these recommendations call for a high level of collaboration among Departments, and continued input from providers.

For purposes of this report, areas which may require administrative rule or statutory changes are identified. **(*=potential administrative rule change; **=potential statutory change)** There may be others which arise, but in large part many of the recommendations at least begin with process and organizational changes.

The Steering Committee recognizes that the Departments must analyze Federal regulations to maintain compliance as they pursue the recommendations, and in some cases conduct further study regarding the feasibility of implementation. However, the analysis thus far confirms the need for change and a significant potential to reduce redundant monitoring and reporting.

1. <u>Deemed Status for Accreditation:</u> Many Illinois human service providers seek and achieve national accreditation, which demonstrates that the provider is organized and managed according to accepted governance practices, is fiscally managed through sound accounting practices, and provides programs according to high standards of care. Conferring "deemed status" of compliance on accredited providers is a widely used method nationally to maintain standards and accountability while eliminating redundant regulatory processes. P.A.92-0755, enacted in 2002, requires DHS to accept accreditation of certain providers of mental health and substance abuse services in lieu of onsite review or monitoring, except when Federal or State regulations are to the contrary. DCFS rules also permit recognition of deemed status for accredited child welfare providers. However, P.A.92-0755 and additional State rules have not been fully implemented. As Illinois looks ahead for models that demonstrate the efficient utilization of resources, such as the potential expansion of managed care efforts, it is essential that there are no inconsistencies in how the State applies, and providers understand, accrediting standards.

   Recommendations:

   - Examine the application of "deemed status" more closely to identify commonalities among financial, general administration and program specific components, between Department and accreditation requirements. The goal of the examination should be to create the highest standard of consumer services through partnerships with National Accrediting Organizations, Departments and contracted organizations * **
   - Fully operationalize P.A. 92-0755, and any other currently existing rules related to deemed status for accredited providers*
   - Convert the licensing periods for providers to match the accreditation cycles*
   - Expand deemed status for accredited providers across Departments and divisions to reduce/eliminate layers of licensure/certification * **

2. <u>Fiscal Audits:</u> Most providers submit to an annual comprehensive independent audit, conducted by an external certified public accountant. Separately, Federal requirements typically require similar fiscal monitoring across a wide range of

programs. However, simply having standardized Federal requirements is not adequate to meet all Medicaid documentation standards.

Recommendations:

- Accept the provider's independent CPA audit in place of specific state Department audits, when the CPA audit meets federal requirements and the funding received is tested as a major program
- Create a centralized unit for fiscal control review (133 desk reviews) for all human service Departments
- To the extent feasible, base Department fiscal reviews on findings from CPA audit, when the provider's audit includes an opinion on fiscal controls
- Standardize audit requirements across state Departments and divisions based on funding levels for providers who are not subject to OMB Circular A-133*
- Standardize fiscal report formats across state Departments and divisions, utilizing a single chart of accounts

3. <u>Centralized Repository:</u> As indicated by the Provider and Department Surveys, much of the information Departments required as part of a contract review is requested multiple times by Departments and divisions, and year after year. Standard administrative documents in particular do not change frequently. Rather than requiring providers to repeatedly submit these materials, Departments should develop a system for maintaining them on an ongoing basis. This system might be implemented in stages, in terms of identifying shorter term solutions in advance of the long term fix, which would likely require a more significant investment in technology.

Recommendations:

- Establish a centralized repository of all information required of providers with contracts with the Departments. Once "deposited" the provider would not need to resubmit that information for any type of state monitoring*
- Establish an electronic repository or "electronic vault" for all information required of Providers* **
- Accept electronic vault information from Providers which participate in such a system on their own *

4. <u>Medicaid:</u> Providers recognize the need to maximize Medicaid billing. The Affordable Care Act provides an opportunity to revise the system to reduce

redundant billing and monitoring processes. It is important that the Medicaid revenue maximization legislation (SB3762/ P.A. 96-1405), the Governor's Health Care Reform Implementation Council, the Governor's Office of Health Information Technology, the Cross-Agency Medicaid Commission, the Revenue Commission for Community Services, along with the Illinois Healthcare and Human Services Framework Project, are all aligned to help increase efficiency of provider billing and monitoring processes.

Recommendations:
- Bring all Medicaid compliance requirements into one document upon which compliance surveys should be based* **
- Establish a centralized location for consistent interpretation of technical questions regarding Medicaid across Departments*
- Use a single billing platform for Medicaid so providers do not have to use multiple Department systems to report Medicaid services* **

5. <u>Technology:</u> In addition to Medicaid systems, updated technology is a common thread throughout all the categories of recommendations listed here, and capital is needed to invest in overhauling systems. To the extent that the scope of the Illinois Framework initiative encompasses provider reporting and monitoring processes, the recommendations in this report should be considered. As new systems are developed, they should minimize double-data entry by providers and facilitate information sharing across Departments.

Recommendations:
- Allow software costs to be capitalized**
- Introduce a capital bill for technology related to Departments and providers**
- Develop databases with accessible platforms to interface with the reporting systems of providers* **
- Replace stand-alone electronic systems with electronic functions that are integrated across Departments and divisions, for non-Medicaid and other reporting* **

6. <u>Contracting:</u> While contracting is technically a front-end process and monitoring contracts is the back-end, there are actions which can be taken in contracting which would make both processes more efficient. This would ultimately reduce repetitive submissions of paperwork and facilitate monitoring reviews.

Recommendations:

- Streamline contracting process by utilizing a multi-year contracting approach
- Implement cross-Department prequalification and master service agreements structured around common service taxonomy for providers* **
- Streamline contracting process by making contract language and structure uniform
- Streamline contracting process by establishing a comprehensive schedule for coordinating contracting activities

7. <u>Streamline Monitoring Procedures:</u> In gathering and beginning to analyze data for the purposes of this report, the Departments determined that beyond new legislation and investments in technology, they can reduce redundant monitoring by standardizing and integrating procedures. Even during the time of developing this report, while not intentionally, Departments were implementing new requirements which would increase redundant reporting and monitoring. Therefore, it is important to not only "fix" the existing problems, but develop processes for incorporating proposed requirements into the overall structure of monitoring procedures, in order to avoid creating new redundancies.

   Recommendations:

   - Create and implement inter-Departmental process to cross check potential new requirements to avoid creating additional redundancies
   - Review the necessity of state fire marshal inspections if local fire authorities issue clearances of sites* **
   - Standardize administrative requirements, consolidate forms and reporting processes, and apply them consistently across services. Priority should be placed on fiscal and general administration documents
   - Standardize monitoring protocols across state Departments, including specific protocols for on-site and desk reviews. Priority should be placed on standardized documents under the Financial Review/Audits and General Administration categories
   - Incorporate a risk-based approach, focusing reviews on information that has changed and/or was previously out of compliance.
   - Create an integrated approach across Departments, divisions, and bureaus for surveys and licensures so that to the extent possible a single survey covers requirements for all Departmental rules and regulations*
   - Train state monitors to properly to seek consistent information according to agreed-upon monitoring areas

Process for Moving Forward

There have been previous efforts in Illinois, such as P.A. 92-0755 for deemed status of accredited providers, aimed at reducing redundant monitoring. In fact, many of the recommendations presented in this report have been raised before. However, the State and its providers can no longer afford to offer potential solutions which are not realized. While the recommendations may seem apparent, the work is complex, and requires new ways of interacting across Departments/divisions and with providers. In order to facilitate implementation, there must be a structure established for that purpose.

Recommendations:

- Establish a Steering Committee consisting of Department Leadership Team members (see below) and organizations representing providers, charged with oversight for implementation and ensuring that the provider perspective is incorporated. Incorporate necessary expertise in technology/MIS on the Steering Committee. The Steering Committee would be co-chaired by someone representing the state and another person representing providers. Any sub-committees would have a similar leadership structure
- Place leadership responsibility in the Governor's office, in order to increase the priority and accountability for implementation of recommendations
- Designate a small Leadership Team of high-level Department leaders able to access available and necessary resources within their respective Departments, to set priorities, manage the overall implementation process, and ensure that any new monitoring/compliance activities are developed in the spirit of the recommendations. The Leadership Team would be responsible for drafting status report on the implementation of recommendations every six months
- Create inter-Departmental workgroups of subject matter experts around the recommendation categories. Where appropriate, integrate recommendations into appropriate existing initiatives, emphasizing the importance of incorporating HB5124. Examples include DHFS work on Medicaid as part of Affordable Care Act and Illinois Framework efforts around technology

High Level Action Plan

The following is a preliminary timeline of when the recommendations outlined above might be achieved, assuming that work begins in the short term, but is not completed for several years. Organizational benchmarks are identified as immediate next steps,

including the development of specific action plans for each work group charged with responsibility for implementing a set of recommendations.

Immediate next steps: January 2011-June 2011

- Designate lead responsibility and Leadership Team
- Determine workgroups and workgroup leaders
- Reconstitute and convene Steering Committee
- Identify and draft any necessary legislation for spring session
- Develop action plans for workgroups
- Conduct necessary cost analysis
- Develop performance indicators to measure improvement
- Examine the application of "deemed status" more closely to identify commonalities among financial, general administration and program specific components

Short term: July 2011-December 2011

- Accept the provider Department's independent CPA audit in place of specific state Department audits
- Create a centralized unit for fiscal control review
- Base fiscal reviews on findings from CPA audit, when the provider's audit includes an opinion on fiscal controls
- Establish a Centralized repository of all information required of providers with Department contracts
- Review the necessity of state fire marshal inspections if local fire authorities issue clearances of sites
- Allow software costs to be capitalized
- Introduce a capital bill for technology
- Implement a multi-year contracting approach
- Create and implement inter-Departmental process to cross check potential new requirements to avoid creating additional redundancies

Medium term: January 2012-December 2012

- Fully operationalize P.A. 92-0755, and any other currently existing rules related to deemed status for accredited providers
- Expand deemed status for accredited providers across Departments and divisions
- Convert the licensing periods for providers to match the accreditation cycles
- Standardize audit requirements across state Departments and divisions based on funding levels for providers who are not subject to OMB Circular A-133

- Standardized fiscal report formats across state Departments and divisions utilizing one single chart of accounts
- Accept electronic vault information from providers which participate in such a system on their own
- Bring all Medicaid compliance requirements into one document upon which compliance surveys should be based
- Establish a centralized location for consistent interpretation of technical questions regarding Medicaid across Departments
- Implement cross-Department prequalification and master service agreements structured around common service taxonomy for human service providers
- Streamline contracting process by making contract language and structure uniform
- Standardize administrative requirements, consolidate forms and reporting processes, and apply them consistently across services
- Standardize monitoring protocols across Departments, including specific protocols for on-site and desk reviews
- Create an integrated approach across Departments, divisions, and bureaus for surveys and licensures so that to the extent possible a single survey covers requirements for all Departmental rules and regulations
- Incorporate a risk-based approach, focusing reviews on information that has changed and/or was previously out of compliance

Long term: January 2013-December 2013
- Establish an electronic repository or "electronic vault" for all information required of providers
- Use a single billing platform for Medicaid so providers do not have to use multiple Department systems to report Medicaid services
- Develop databases with accessible platforms to interface with the reporting systems of providers
- Replace siloed electronic processes with electronic functions that are or can be integrated across state Departments/divisions, for non-Medicaid and other reporting
- Train state monitors to properly seek consistent information according to agreed-upon monitoring areas

Methodology

To gain a better understanding of the issues related to redundant monitoring, DHS, as lead Department, established a process to gather information from both providers and

State Departments. In a highly collaborative process, a Steering Committee consisting of provider and Departmental representatives carried out the activities described below. See Appendix A for additional information on the Steering Committee.

Public Hearings: Two hearings were convened on behalf of the bill sponsors, on August 27, 2010 and September 16, 2010, in Mattoon and Grayslake, respectively. Providers and advocates shared examples of their experiences with redundant reporting as well as their suggested solutions. A number of organizations provided oral or written testimony. See Appendix B for additional information on the public hearings.

Provider Survey: A committee of trade associations representing community providers designed a survey which was administered through Survey Monkey from September 24, 2010 – October 11, 2010. The survey questions focused on four types of information: Financial, Organizational/Governance, Administrative/Human Resources, and Programmatic. It sought to identify the overlaps in information required across Departments, between Departments and national accrediting bodies, and between Departments and local government funders. DHS and DCFS sent a link to the survey to their distribution lists, consisting of hundreds of providers. In addition, provider associations including the Child Care Association of Illinois, the Arc of Illinois, the Illinois Alcoholism and Drug Dependence Association, Community Behavioral Health Association and Illinois Association of Rehabilitation Facilities, as well as Illinois Partners for Human Service distributed the link to the survey to their human service provider members. Three hundred seventy-seven providers representing all areas of Illinois responded. The survey participants represented a range of organizational sizes, and respondents as a whole received funding from all four primary Departments highlighted in this report. A committee of provider and Department representatives analyzed the results, which are summarized in Appendix D of this report.

Department Survey: A group representing the four Departments developed a survey to identify duplication of provider monitoring, which administered through Survey Monkey from October 15-26. The survey was distributed to organizational areas within each Department which play a monitoring role. Responses representing a total 157 programs were received from all four Departments. The survey resulted in monitoring activities being categorized into three main components: financial review, general administration, and program specific reviews. In addition, the survey focused on monitoring format and frequency. A committee of provider and Department representatives analyzed the survey results (See Appendix E for more details).

Research: A committee representing a mix of provider associations and Department representatives conducted a limited review of previous reports in Illinois and similar efforts by other states directed at eliminating redundant contract monitoring. From this

review, the committee created a list of resources (Appendix G) as a starting place for future research beyond the scope of this report. In addition, the committee conducted several interviews to better understand experiences in other states. Finally, the committee raised the Affordable Care Act and other areas as current issues which will impact how certain of the redundancy issues are addressed.

Review of DHS-specific Concerns: A committee of provider and Department representatives conducted a targeted review of issues identified in the Act specific to DHS. The committee drew upon the testimony from the public hearings, information gathered through the Provider and Department surveys, and experience from their own organizations to make recommendations related to the seven areas outlined in the Act, which are outlined in Appendix F.

Provider Contracts Analysis: A committee of provider and Department representatives defined the criteria to analyze the number of contracts for human services across the four Departments. The data was sorted by Federal Employer Identification Number in order to identify those providers which have contracts with more than one of the four Departments.

Given time and resource constraints, the activities and the various sources of information described above were sufficient to affirm a significant level of redundancy in contract monitoring.

Previous Efforts and Current Trends

The analysis of previous efforts and current trends was necessarily limited to 'surface' reviews of previous reports in Illinois and similar efforts by other states. This approach ultimately led to identifying very specific instances in Illinois aimed at eliminating redundancy and duplication, as well as reviews of a select few reports from other states. These resources can be found listed in Appendix G and are included to provide a pathway for future research beyond the scope of this report.

This document is not the first effort to address the coordinated efforts to reduce redundancy and duplication of reporting/documentation requirements on human service providers in Illinois. Historical efforts, such as the *1996 Department of Human Services Virtual Case Manager Tactical Implementation Plan* and the October *1997 Illinois Department of Human Services Plan* were identified as resources for such previous efforts. In addition, a crosswalk of accreditation requirements against Illinois rules and

regulations developed in 1996 by the Commission on the Accreditation of Rehabilitation Facilities was identified as such a resource.

Current examples of Illinois government undertaking efforts to eliminate redundancy and duplication involve deemed status, the recent approval of Medicaid Revenue Maximization Act (SB 3762/P.A. 96-1405), and the Illinois Healthcare and Human Services Framework Project. These examples in Illinois are in line with similar efforts to reduce costs and increase efficiency by other states as reported by publications such as the National Core Indicators.

Provider Contracts Summary

Based on data from the Illinois Office of The Comptroller (IOC) Statewide Accounting Management System (SAMS), 11,897 providers were common to multiple Departments, while the vast majority of providers (161,520) were affiliated with one Department.

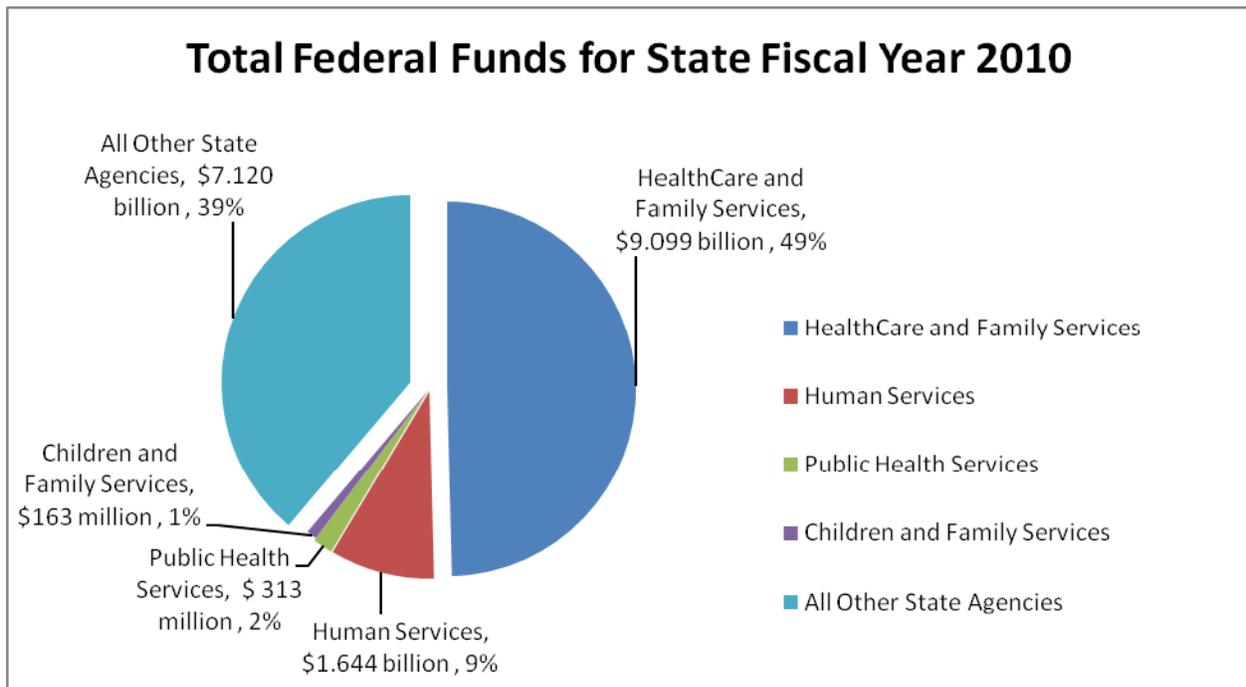|	Agreements (Contracts) Filed with IOC
Number of Providers at all 4 Departments	136
Number of Providers at 3 of 4 Departments	588
Number of Providers at 2 of 4 Departments	11,173
Total Number of Providers with Multiple Departments	11,897
Providers affiliated with one Department	161,520

Upon further analysis of the data, it was discovered that many providers administer one or more human service programs within a single contract. For example, the Department of Human Services may have one contract with a single provider which contains multiple attachments, detailing specific requirements for each program administered by that provider. In addition, each Department uses a different contract document for its providers. As noted in the "Nature and Impact of Redundancies" section below, even contracts for a single program may be subject to monitoring from multiple areas within a Department. Additional research is necessary in order to identify the specific programs associated with Department contracts, as well as the requirements (i.e., monitoring, reporting, auditing) of the programs incorporated into each contract.

The State of Illinois does not have a common grants management system that would have facilitated a more comprehensive analysis of the data. As a result, there were

limitations in using the analysis of payments through the IOC and Department surveys, as 'performance measure' or monitoring-related responsibilities can only be collected and assembled manually.

Role of Federal Funding

In order to get a proper perspective of the role the human services Departments play in Federal funding for Illinois, one need only look at State fiscal year 2010. During that year, forty-eight (48) State entities received more than $18 billion dollars in Federal funding. Of the total, 61% were within the four Departments, as displayed below.

Total Federal Funds for State Fiscal Year 2010

All Other State Agencies, $7.120 billion, 39%

HealthCare and Family Services, $9.099 billion, 49%

Children and Family Services, $163 million, 1%

Public Health Services, $ 313 million, 2%

Human Services, $1.644 billion, 9%

- HealthCare and Family Services
- Human Services
- Public Health Services
- Children and Family Services
- All Other State Agencies

Given the level of Federal funding, Federal requirements play a significant role in the auditing and monitoring that the State conducts of its contracts with providers.

Auditing requirements vary slightly among the various Federal programs. The reporting requirements for Federal funding has a uniform base requirement, however, other reporting varies by program to incorporate a number of unique programmatic factors. Reporting may require program reports, expenditure reports, performance reports, or a combination of the three report types. Currently, the State does not maintain a listing of

the unique reporting requirements by Federal or State program. This is a labor intensive endeavor that will require significant resources to determine.

OMB Circular Number A-133 applies to more than 90% of the Federal grants provided through the various Illinois entities, including the Departments. In accordance with the provisions of OMB Circular No. A-133 (Revised, June 27, 2003), "Audits of States, Local Governments, and Non-Profit Organizations," nonfederal entities that expend financial assistance of $500,000 or more in Federal awards will have a single or a program-specific audit conducted for that year. Nonfederal entities that expend less than $500,000 a year in Federal awards are exempt from Federal audit requirements for that year, except as noted in Circular No. A-133.

In 2006 the Federal government passed the Federal Funding Accountability and Transparency Act (FATA). However, it wasn't until FATA became part of the American Recovery and Reinvestment Act (ARRA) that the State fully realized the extent of the reporting requirements, as well as the limitations of its systems to gather and report the data for the grants. ARRA is coming to an end; but, as of October 1, 2010, State reporting for all Federal funds, including entitlement funds, must comply with ARRA requirements.

Nature and Impact of Redundancies

Providers and Departments recognize the need for contract monitoring to maintain accountability. However, the number of surveys, the time required to comply with monitoring requirements, and the approach to monitoring "defy logic" according to a participant in the public hearings. The high level of frustration which participants expressed in the public hearings was echoed in the Provider Survey. The Provider and Department Surveys offered glimpses of two sides of the same coin, and were consistent in the picture they portrayed of a system that requires providers to divert time and resources away from delivering services in order to comply with repeated requests for the same, or highly similar, information.

Each program funded by the State is subject to various laws, administrative codes, and policies which create requirements for funding recipients. The requirements represent a multitude of layers, potentially including Federal, State, Department, and division levels. Across Departments, many of the information requirements are the same. For instance, among 157 programs represented in the Department Survey, forty (40) require a desk review of fiscal policies and procedures. While this indicates a significant potential for

redundancy, further study is required to determine which changes can be made to reduce redundancy without jeopardizing Federal or State funding.

Even within a single Department, there are multiple parties conducting monitoring activities in order to meet different purposes, such as overall contract monitoring, program quality assurance monitoring, fiscal monitoring, program/provider certification, program/provider certification, and complaint investigations. For instance, within DHS, there is a Bureau of Accreditation, Licensure and Certification (BALC) and within the Division of Developmental Disabilities at DHS, a Bureau of Quality Management (BQM). While their purposes may be different, there appears to be a significant overlap of activities between these two Bureaus for community providers supporting persons with developmental disabilities and mental illness.

The frequency of monitoring varies across Departments and by program, with specific protocols developed based on program and auditing requirements. However, based on the number of programs a provider offers, and the different purposes for monitoring, the cumulative effect is a significant administrative burden for providers, which is typically not fully reimbursable, if at all.

For instance, one downstate provider of comprehensive services testified to experiencing fourteen monitoring visits in fourteen months. Another described five surveys in six months, some for the same Department and some for different Departments. Sometimes, a given program will require both desk (at the Department) and on-site (at the provider location) reviews, as a two-part process. In that case, it is not unusual for providers to sit with monitors on-site to review and provide paper copies of the same information that they previously submitted electronically for the desk review.

The provider and Department surveys offered insight on the type of information which is repeatedly reviewed, and potential areas for streamlining. Almost all Provider Survey respondents reported at least one annual monitoring visit, no matter the size of the program/contract or people served; this was confirmed by the Department survey. However, a majority of Provider Survey respondents referred to multiple monitoring contacts during a year.

<u>Financial information:</u> Among 377 respondents to the Provider Survey, 84% (n=317) indicated that they are required to submit CPA, A-133 audits, and consolidated financial reports. When asked about the level of similarity of information requested by Departments and divisions, 82% of survey respondents (n=158) indicated a high level of similarity for the CPA audit, 76% (n=104) for the A-133 audit, and 69% (n=120) for consolidated financial reports. The Department Survey confirmed that all four

Departments conduct financial monitoring through desk and/or on-site reviews, and that they do have common components in their reviews, in addition to those listed above.

Providers raised two concerns with respect to financial monitoring. The first is that identical information is required to be reported on different forms and in different formats by various Departments and DHS divisions. This may account for the somewhat lower level of "high similarity" identified for the consolidated financial reports. The second concern relates to the need to undergo a financial review by Departments, when a provider has already completed an independent audit. The Steering Committee concluded that there is significant potential to increase efficiency if all Departments move to monitoring standardized financial reporting.

General Administrative Information: All four Departments also monitor and collect multiple copies of information on the administration of provider organizations, including organizational, governance, and human resource-related information. In fact, administrative elements were found to be the most common review components among Departments, leading to a conclusion that significant efficiencies could be realized through sharing providers' administrative information among Departments.

Seventy-seven percent (n=291) of Provider Survey participants responded that they are required to submit by-laws, 501(c) 3 letters, and board of directors information for desk and/or on-site reviews. Among the respondents, over half have contracts with more than one Department or divisions within DHS. When asked about the level of similarity of information requested across Departments and divisions, 75% of these survey participants indicated a high level of similarity for by-laws, 78% for 501(c) 3 letters, and 72% for board information. (It should be noted that this question did not account for providers who do not have contracts with more than one Department or division, but are still subject to multiple reviews). Among these examples of organizational documents, the 501(c) 3 letter is unlikely to change over time and by-laws change infrequently. Yet providers are required to submit them multiple times per year, every year.

Seventy-three percent (n=277) of total Provider Survey respondents indicated that they are required to submit personnel handbooks, job descriptions, and staff licensure, certification, and credentialing information. When asked about the level of similarity of information requested by Departments and divisions, approximately 67% of survey respondents (n=142, n=163, n=171, respectively) indicated a high level of similarity for each of these types of information. Providers at the public hearings gave examples in this area that illustrate different issues related to monitoring protocols. For instance, monitors are required for some programs to randomly review a number of employee files to determine whether background checks were completed when they were hired. However, especially with smaller organizations, there is a likelihood that the same files

will be pulled for review. In fact, some employee files can be selected multiple times over the course of their employment, though the information would not change if the provider was in compliance the first time. The example below illustrates the challenges that arise when information required by one Department is in fact not exactly the same as another.

"Some of our direct care employees are also trained to work in our Children's Group home licensed by DCFS. For many years DCFS has required fingerprinting and a much more extensive background check. When DHS has come to survey, we have offered this more comprehensive background check as proof of meeting the background check requirement. This was not acceptable, "THE RULE SAYS" a State Police background check that is only based on name, birth date and social security number. That is the only background check that will be accepted. Although DHS is now moving towards fingerprinting this is just an example of the lack of coordination that has existed between Departments in setting requirements for community providers."

Program Information: Given the wide range of programs contracted through the Departments, it is not surprising that the greatest variance existed among program-specific reviews, driven by federal, state and individual program policies and procedures. However, both the Department and Provider Surveys found that there are common elements.

Seventy-two percent (n=270) of Provider Survey respondents indicated that they are required to submit quality assurance information, risk management/life safety plans, and client rights policies/client grievances. Among those survey participants which have contracts with multiple Departments and/or DHS divisions, more than 60% responded that there is a high level of similarity of information requested in these areas (n=130, n=113, and n=129, respectively).

While it appears that there are opportunities for streamlining of program information, a more in-depth analysis is needed in this area, given a greater complexity of program-specific requirements and the limited scope of the initial review. However, Medicaid reporting and monitoring is a program-related area which deserves a high priority, given the current Federal implementation of the Affordable Care Act and concerns identified below.

Medicaid Reporting and Monitoring: In recent years, maximizing the Medicaid federal match has increased in importance as each state human service department providing behavioral health services seeks to maximize federal revenues. However, redundant administrative requests for information from the departments administering Medicaid are a challenge. For instance, certain information entered for the Administrative Service

Organization (ASO) billing system overlaps with the state's Illinois Outcomes web-based system. The Illinois Mental Health Collaborative for Access and Choice is a partnership between the Division of Mental Health (DMH) and ValueOptions® to improve and advance mental health services.   An administrative services organization was (ASO) created to help DMH make the best use of limited resources to serve people in need of mental health assistance. Documentation of income is required from all consumers for the ASO, even when that information is already captured by DHS Medicaid eligibility databases, or when the client is already entitled to that eligibility (such as a foster child).

Each department has developed its own data collection and claiming systems. A provider serving clients from multiple state departments must submit claims into separate and unrelated state billing systems. As one provider stated in the public hearings, for providers that serve a large number of children for multiple Departments, Medicaid billing is "inefficient and cumbersome to administer, particularly when considering the tens of thousands of separate entries that have to be made in billing for individual service units, ranging from fifteen to forty-five minutes each."

In addition, external ASO, managed care, and Medicaid consultants give multiple interpretations of Medicaid rules to identical questions from providers. As a result, staff members at provider organizations spend much time trying to understand and meet the requirements of all entities, and potentially receive penalties as they are unable to do so.

New federal requirements related to the Affordable Care Act and opportunities for federal support of required technology are likely to drive necessary changes in this area, which would be a welcome relief to providers. However, one of the concerns identified from previous experiences in implementing Medicaid billing systems was the requirement for multiple software programming updates at additional unreimbursed cost for the providers.

Additional Redundancies

There are several important factors which are technically outside state monitoring of providers, but are part of the overall picture of identifying redundancies and potential solutions. These include accreditation by national professional organizations, monitoring by local government entities, and providers' own information systems.

Accreditation: Many providers seek accreditation by national, bodies to assure they operate according to the highest national standards of care and to assure they continually seek to improve their services and operations. Accreditation by national entities such as Council on Accreditation, CARF International (originally the Commission

on Accreditation of Rehabilitation Facilities), and the Joint Commission on Accreditation of Healthcare Organizations, are required by some state agencies and encouraged by others. Accreditation is a lengthy and comprehensive review process, in which a provider must show through a self-study that provides documentation and through a peer review site process that they meet such national standards. Standards include criteria for the governance, program operation and fiscal management of the agency as well as adherence to various professionally accepted standards for the individual social and program services they provide. Accreditation is provided at regular intervals and is generally renewed at 4-5 year cycles.

Accreditation is also an expensive process. Fees depend on the size of organization, but can be in the tens of thousands of dollars. Through the public hearings and Provider Survey, providers identified state monitoring as redundant with accreditation. For example, 76% (n=118) of accredited providers who responded to a question about financial information requested by accrediting bodies and Departments indicated that there was high similarity in the CPA audits requested, 66% (n=61) for A-133 audits, and 58% (n=82) for consolidated financial reports.

Enacted in 2002, Illinois P.A. 92-0755, was designed to address redundancy between state monitoring and accreditation. It created the opportunity for deemed status of compliance for accredited providers for identified programs, except when contrary to federal requirements. *Deemed status means that if a provider is accredited, such accreditation is deemed to indicate that the provider meets specific Department criteria.* Various Departments also have adopted rules that recognize "deemed status." However, neither P.A. 92-0755 nor other existing Department rules for deemed status have been fully operationalized. The Steering Committee recognized the vital role accreditation plays in creating high standards for service delivery, the need for a dynamic partnership between accrediting organizations, state Departments, and providers, and the opportunities for increased efficiency by operationalizing deemed status provisions for accredited providers.

Local Government: In addition to contracts with the four Departments, many providers have contracts with other Departments and local government entities. Some providers also provide Medicaid funded services for county probation clients in the same facilities that serve state-referred clients. Those individual counties also require their own billing systems. Even though the state is ultimately responsible for the tracking and accountability of Medicaid services, there is little coordination between Departments and counties. For this and other reasons, it is understandable that providers report duplication between monitoring at state and local government levels.

Again, using financial information as an example, 69% (n=185) of providers responding to a survey question about CPA audits said there was a high level of similarity between state and municipal funding sources. Fifty-eight percent (n=99) said there was a high level of similarity for A-133 audits. While it may be more difficult for the Departments to coordinate monitoring requirements with local government entities, the reality is that providers are subject to multiple levels of review.

Provider Systems: Finally, an issue that was raised in both public testimony and the Provider Survey is that providers have invested significant resources in their own systems for tracking information. In most instances, the Department systems do not interface with provider systems; this has resulted in the necessity of providers to input the same data multiple times in order to meet reporting requirements. Doing the same data entry on multiple occasions is a waste of time and resources, which could be allocated towards delivering service.

Costs of Redundant Reporting and Monitoring

The issues and examples identified above point to an uncoordinated system of duplicative monitoring by Departments and redundant reporting by providers. What is the cost of inefficiency?

Anecdotally, a small provider reported hiring an office worker at $24,000 to keep up with compliance requirements. Another estimated "tens of thousands" of duplicative billing entries. Accreditation fees were quoted at $6,000-$40,000, with an on-site review process of three to four days, in addition to numerous people preparing over a period of months for the review.

Attributing a financial cost of redundant audits across the system is difficult, and a detailed cost analysis was not possible for this report. Analysis from the Provider Survey indicated that provider agencies spend anywhere from 36 to 75 hours preparing for each audit/program review. As a result, the direct staff cost per provider per Department review ranges between $4,300-$9,000. This does not reflect Department costs. Streamlining and eliminating redundant contract monitoring has the potential to return millions of dollars in direct client service to providers. However, a more rigorous cost analysis is needed to quantify potential benefits in hard dollars.

The Steering Committee cautions that there should be no assumption that any dollars can be immediately eliminated from Departments because of efficiencies and savings in duplicate monitoring. The benefits of creating more streamlined monitoring should be realized through higher-quality service to clients. The time saved across all providers in

the system would be significant in total and most likely reflect freeing up days for designated staff that would be able to re-allocate the time to client service and outcomes.   In order to achieve the increased efficiency, the State will need to invest in new technology. In addition, the Affordable Care Act and other anticipated mandates such as the Federal Funding and Transparency Act will require significant resources to develop and implement.

Yet creating a more streamlined and coordinated system for monitoring contracts is a win-win for providers and the Departments, as it will create opportunities for both to focus on quality and results, both in delivering services and in monitoring them.

Conclusion

Departments recognize the critical role that community organizations play in the provision of direct service to the citizens of Illinois; but, these providers get very frustrated about the resources wasted on redundant monitoring. Departments and providers alike are jointly committed to quality service provision and the efficient use of taxpayer dollars.

It is tempting to assume that significant dollars can be pulled out of the system simply by eliminating redundant contract monitoring. However, the benefits would not all be realized in dollars, especially in the immediate years. While the time saved across all providers in the system would be significant in total, for most individual organizations, the dollars saved from inefficient administrative costs would need to be reinvested in the system to offer a higher level of direct service to human services customers.

The process for developing this report has demonstrated that there is an appetite for collaborating to increase the effectiveness and efficiency of the system. The successful implementation of recommendations will require leadership, creativity, persistence, and investment. While some recommendations will take several years to operationalize, there are some short term opportunities—now is the time to start the work.

APPENDIX

A. Steering Committee

In order to address the issues raised in P.A. 96-1141, Acting Secretary of DHS, Grace Hong Duffin, convened a Steering Committee consisting of representatives from the four Departments and organizations representing a range of human services providers. The charge of the Steering Committee was to draft the required report to the General Assembly, by collecting and analyzing relevant information, and developing recommendations in response to identified issues. The Steering Committee was organized into six subcommittees, each responsible for gathering, analyzing, and summarizing information for a specific area of focus. The overall Steering Committee synthesized the findings of the sub-committees to develop the recommendations for this report. The Steering Committee members are listed below:

Carol Kraus, Chair
IL Dept. of Human Services

Miller Anderson
IL Dept. of Children and Family Services

Frank Anselmo
Community Behavioral Health
Association

Bill Bell
IL Dept. of Public Health

Margaret Berglind
Child Care Association of Illinois

Chris Burnett
IARF

Theresa Eagleson
IL Healthcare & Family Service

Josh Evans
IARF

Cheryl Francis
Chicago Area Project

Judith Gethner
Illinois Partners for Human Service

Matthew Grady
IL Dept. of Human Services

Jim Hobbs
IL Dept. of Human Services

Brenda Hanbury
IL Dept. of Human Services

Jack Kaplan
United Way of Metropolitan Chicago

Lorraine Kopczynski
Pioneer Center for Human Services

Suzie Lewis
IL Dept. of Children and Family Services

Lyla McGuire
CCAR Industries/The Institute on Public Policy

Don Moss
Don Moss & Associates

Mike Moss
IL Healthcare & Family Service

Nancy Kim Phillips
NKP Consulting/Donors Forum

Peggie Powers
Illinois Alcoholism and Drug Dependence Association

Gary Robinson
IL Dept. of Public Health

Steven E. Shaw
IL Dept. of Human Services

Tim Sheehan
Lutheran Social Services of Illinois

Dan Strick
South STAR Services/The Arc of Illinois

Leanne Urbina
IL Dept. of Human Services

Maria Whalen
Action for Children

Mark Valentine
Ounce of Prevention Fund

B. Public Hearings Summary

The hearings in Mattoon and Grayslake afforded providers the opportunity to share experiences, which often included the frustrations they encounter with the duplication of state monitoring efforts. There were some common themes in many of the complaints which encompass the majority of the report. Problems with specific Departments are also mentioned as well as suggestions for solutions.

Another section details concerns and possible reforms mentioned that while not specifically mentioned in the bill comply with the intent of it. The Steering Committee should benefit from the testimonies from these providers because they give more detail than some of the online surveys. We heard from providers in various parts of the state and the most beneficial part may be that while frequently many problems were reiterated, many unique points of view were presented.

The most often heard grievance and the one most frequently mentioned by the sponsor when urging passage of the bill was that visits from monitoring Departments are uncoordinated and take up a great deal of provider time and resources that could otherwise be utilized for clinical and therapeutic purposes.

To illustrate the fiscal impact, one small provider stated that it had to hire an office worker and pay them $24,000 a year to stay in compliance. Another provider indicated that just from the Division of Developmental Disabilities at DHS, there were two visits in December and another in March and June. There were Mental Health and Public Health surveys interspersed within this timeframe as well. Other Provider Survey respondents commented that accreditation surveys take his administrative and some treatment staff away from their regular duties for three to four days.

Another aspect of the visits that is problematic is that they are most often unannounced. Whereas Departments realize that in some circumstances unannounced inspections are mandated, if there are situations where it is not a mandate it would alleviate the pressure it puts on already understaffed providers, which may have "staff who are unfamiliar with required policy and procedure, scrambling and searching for the requested policies for the reviewer."

There were also questions about the frequency of visits. It was pointed out that more intensive residential programs were surveyed every three years by certain programs and conversely day training programs with lesser requirements were visited yearly. Also, organizations with consistently high reviews had the same monitoring timeframes.

Another often heard message was the extent of information requested every year by several entities although the same information had been obtained in previous audits.

One provider listed examples of the large amounts of redundant documentation requested of it, such as:

- Program Policies and Procedures
- Application for License
- Financial Reports and Budgets
- HR Policies and Procedures
- Staff Training Plans
- Staff Training Records/CEU Reports
- Clients Right/Consumer Handbooks
- Foster Parent Implementation Plan
- Civil Rights Compliance Checklist
- List of Clients Served
- List of Employees and Organizational Charts
- List of Board and Board Minutes
- Financial Audit and Management Letter
- IRS Forms
- Copies of Payroll Taxes
- In Kind Match Contributions
- Inventory List
- Fee Schedules
- Copies of Licenses & Certifications
- Proof of Liability Insurance
- Copies of Inter-Departmental Agreements
- Accreditation Letters
- Sub-Contractor reports
- Articles of Incorporation and By-Laws
- List of Lawsuits
- Incident and Client Grievance Reports
- Corrective Action Reports from Previous Monitoring
- Corrective Action Reports from Other Funders/Regulator Departments
- Personnel Records
- Background Screening
- Staff Credentials/Certification
- Staff Credentials/Compliance and Certification with statutes
- Facility Inspection Reports

Billing problems was an often mentioned theme. The lack of coordination between the Healthcare and Family Services (HFS) Medicaid billing system with the other state Departments is a burden because Medicaid eligibility is a common denominator of most of the providers' clientele. Testimony revealed that "Currently, DCFS, DHS and county probation Departments each have their own separate methods and/or software programs for collecting this very detailed information, which for providers that serve a

large number of children from multiple Departments is inefficient and cumbersome to administer, particularly when considering the tens of thousands of separate entries that have to be made in billing for individual service units, ranging from 15 to 45 minutes each. " There were many who spoke of problems with the ASO, or Collaborative as it is also referred to which is the new Mental Health system that replace ROCS.

Deemed status is another galvanizing force behind the legislation. It was noted in written testimony submitted by one provider Association that Public Act 92-755 "required DHS to accept accreditation of providers of mental health or substance abuse services in lieu of the Department's onsite review or monitoring requirements 'except when the federal or State statutes authorizing a program, or the federal regulations implementing a program, are to the contrary.'"

Providers have been grappling with intensive accreditation reviews, as mentioned previously about the provider who had staff detained from their regular tasks for three to four days, *in addition to numerous people preparing for the review over a period of months based on an estimated timeframe for the review*. Many providers stressed that they choose national accreditation for the benefit of their organization and clientele. However, they believe that meeting the stringent requirements of accreditation should reduce some of the monitoring efforts on the state's part. As one provider stated, "It seems that complying with the extensive CARF standards should eliminate many of the Medicaid review requirements" and another stated, "CARF covers a wide range of clinical and record keeping standards." Also, a mention was made that has been thematic in previous reports regarding state rules and regulations, which are more specific and detailed in comparison to the regulations of national organizations.

Other problems illustrated by service providers are those for which they are cited as violating state law. One provider gave an example during testimony that it was required to send letters to clients who left their facilities to make them aware of potential services to them. As deceased clients met that definition they decided to "take the hit" rather than burden the family with a letter regarding their deceased family member. Another example is when the Office of the State Guardian refused to sign off on a financial self-sufficiency form for a client to whom it would never be applicable. The provider took the citation for that as well.

The majority of the testimony was about problems experienced with all Departments. There were, however, specific Departments mentioned and the final report should address the problems in their recommendations. It was stated that the Department of Public Health makes providers repeat the same data collection process as Medicaid. Also, a provider, in written testimony, referred to the structure of fines at the Department of Public Health. A Public Health representative said the fines had increased in recent

years because "it hadn't been done for a long time." The DHS Division of Mental Health makes clients provide financial information every six months even if the client is Medicaid eligible and the information is already obtained through that process.

There were many solutions suggested by various providers; a single unified Medicaid billing system was one of the most common. Elvin Lay from HFS responded that a unified Medicaid system will happen as part of national healthcare reform. IARF mentioned the development of a cross-disability database. Other examples of suggestions include:

- An organizational chart for all Department divisions so new providers can better navigate the State system

- Introducing legislation to update the client side of the database

- The State establishing an electronic document vault and/or a centralized document repository for each provider

- Departments that already have provisions for deemed status should develop a calendar of licensing renewals to coordinate with the same time frames as accreditation cycles

- Full implementation of deemed status

C. Sample of Public Hearing Testimony

PUBLIC HEARING TESTIMONY RELATED TO THE IMPLEMENTATION OF HB 5124
SARAH BUSH LINCOLN HEALTH CENTER
AUGUST 27, 2010

Good afternoon I am Lyla McGuire, the executive director of CCAR Industries in Charleston.   I have been the Executive Director for twelve years and have worked in the field for 30 years in a variety of positions.

Before I go forward I want to take this opportunity to thank Representative Rose for listening to our concerns over the last few years and working to find a way to address them. I sincerely appreciate his willingness to be involved as well as everyone on this committee in the effort to seriously look for ways to streamline the survey processes and reduce the duplications and inefficiencies within the Developmental disability system.

To give you a little background CCAR Industries has provided a comprehensive array of services for children and adults with developmental disabilities and their Families since 1969 and last year served 455 individuals. During these years CCAR Industries staff have been surveyed by CARF, a national accreditation body, Department of Children and Family Services, Department of Aging, Illinois State Board of Education, Department of Human Services through the Bureau of Accreditation, Licensure, and Certification, the Bureau of Quality Management, the Office of Rehabilitative Services, and Early Intervention monitoring, State Fire Marshall, the Department of Labor, OSHA, EEOC, as well as local city inspectors, fire inspections and local public health.   So I can assure that we have a great deal of experience with going through surveys successfully. Today my concerns are specifically about the duplication in surveys performed by the Department of Human Services through the Bureau of Accreditation, Licensure and certification and the Bureau of Quality Management.

We have all experienced very stressful times in recent years with funding being so restricted and that I appreciate your efforts to try and put some common sense back into the survey process. I can't stress enough how frustrating it is when staff are asked over and over for the same documents and required to spend days sitting right with surveyors to make sure that they can find everything. All of this time is time that could be utilized to better provide services for the individuals we serve.

Please understand that it is not my intention to be overly critical; my only hope is bring some very basic issues to your attention as you work toward completing your challenge. I must say that I have provided most of these comments to Michael Hurt at the Department of Human Services while serving on a quality committee around the same time that I sent them to Representative Rose and that I have witnessed some recent movement in trying to make some of these changes.

The staff and I have prepared a written document that goes into specific detail regarding our issues as well as our recommended suggestion for improvement which I have provided for each of you to review.   This afternoon I will just a share a few examples of our personal experiences.

Persons hired to provide direct service to persons with developmental disabilities are required to have background checks to make sure they have no disqualifying convictions that would prevent them from working in this field. We are fortunate to have many staff who have been with us 10 or more years. Each year DHS come to our organization to survey our day program, Developmental Training.   A random number of employees are selected and we have to show that we completed this initial background check. Employees can be selected 2, 3, 4 or more times over their course of employment. We still have to pull their background check and show it to the surveyor. Some of our direct care employees also are trained to work in our Children's Group home licensed by DCFS.   DCFS requires fingerprinting and a much more extensive background check. When DHS has come to survey, we have offered this more comprehensive background check as proof of meeting the background check requirement. This was not acceptable, "THE RULE SAYS" a State Police background check that is only based on name, birth-date, and social security number. That is the only background check that will be accepted.   Although, DHS is now moving towards fingerprinting this is just an example of the lack of coordination that has existed between departments in setting requirements for community providers.

Even within the Department of Human Services we see redundancy. Every two years our agency must submit a proposed training curriculum for direct care staff that includes a minimum of 40 hours of classroom and 80 hours of on-the-job training. Each training plan is carefully reviewed to make sure it has the correct number of hours in each subject category. We are issued a letter stating our curriculum has been accepted. The DHS surveyor comes to our agency and asks to see our training curriculum. One year the surveyor questioned the number of training hours. She was offered a copy of our approval letter. Her response was "No, I have to count them myself." Two administrative staff sat with her counting up the hours to try and get her to understand that not only did we meet, but we exceed the number of hours of training.

This waste in resources occurred because one group within DHS would not accept the opinion of another group regarding our training plan. This extra time is in addition to driving them around, arranging for them to meet with staff and bringing them all the information they need.

Some requests made of us even defy logic. Here are some examples that we have experienced over the years:

Direct care employees are required to have a high school diploma or its equivalent. Since we are located in a college town, many of our direct care employees are college students or graduates. During a survey we offered a college transcript to prove level of education. No, the "rule says" a high school diploma then we must have a copy of the high school diploma in the personnel file.

We were once told that we needed to contact persons who leave our agency as a follow-up process to make sure they are linked to any needed services. A letter would suffice, however persons leaving our agency in the last year included only those who had died. Families would be very offended and upset if we were to send them a letter of this nature. We decided we would just have to take a hit.

When a person enters our programs we must provide them with an explanation of their rights. One person who was randomly selected for the survey had been in our program over 20 years. After a staff member spent considerable time in the basement going though the boxes and boxes looking for this 20 year old document we decided to just take the citation. The required terminology in the rights statement was not even worded in a way this person could understand.

Then there are the ever changing interpretations of the rules or as we call them "rules by memo."

One example of this is the definition of annual. Is it 365 days from the last event or do we have a one or two week grace period to be in compliance. In one case a person was in the hospital at the time his annual physical was due. Agency [Department] staff members were not really thinking about his physical exam, since his prognosis for recovery was very poor. He did end up getting discharged from the hospital and went to a rehabilitation facility for a short period of time before returning to the CILA home. We were cited for not having the physical exam "annually" even when showing the discharge papers indicating he was in the hospital. The surveyor was not concerned that he had been seriously ill or if he was getting appropriate medical care,

but rather did we have a piece of paper that said "annual physical" in his file that had the appropriate date ("appropriate" meaning the timeline in the most recent memo).

My most recent example happened just this week. Service planning and training goals are typically based upon consumer wants, needs and preferences. However, DHS has written into the CILA rule that each consumer must have a goal in the areas of independence in daily living, community integration and economic self-sufficiency. May survey citations are based upon changes in interpretations as to whether a goal falls within one of these categories. Persons with severe disabilities may require lifelong assistance in managing their money, constant supervision in the community, and staff completing their bathing, feeding, and dressing activities. Staff members spend a considerable amount of time trying to be creative and develop a goal in each of these areas in addition to goals that are more relevant to the persons served. Some guardians actually laugh when they are asked for input on developing a economic self-sufficiency goal. Not only is it time spent on these mandated goal areas, but they have to be implemented, and documented. This week a staff member with the Office of State Guardian actually refused to sign the individual service plan because of how ridiculous it was to have an economic self sufficiency goal for this person. At that point staff had to spend time figuring out how to deal with this. Because it would be a hit on a survey to not have the plan signed. We determined that it was less of a hit to not have the goal; but what a waste of time for staff. We can no longer afford to not use common sense in our survey process.

I hope through these examples you can see that staff find themselves in a fragmented and chaotic situation where they spend too much of their time trying to understand and please all the entities and little time to focus on the needs of the individual and actually providing them services. I just don't think those involved in surveys understand how their actions can dramatically impact the difficulty in delivering services. Especially at a time which is extremely hard with concerns over funding, etc.

In closing I would ask that serious effort be made in streamlining the DHS surveys by defining specific rolls of a survey and not rechecking on each other. If one group is checking then other DHS staff should accept their colleagues work. In addition, the surveys have to change from a total focus on process and very little interest in outcome. In addition, there needs to be some recognition for agencies that have vast years of experience and very good surveys year after year. So much time is spent rechecking on these agencies that there can't possibly by adequate time to devote to newer providers and those who have significant issues in their surveys. With the lack of money available and the loss of staff positions in the Department over the years it is imperative to use staff effectively in order to achieve quality.

In addition, at a time when we have to do more with less it is imperative that we work together and use common sense in our processes and decisions. Many times I find that staff at DHS is so narrowly focused on specific rules even when they don't make sense and there doesn't seem to be anyone that can use their judgment to rectify these.

I know that I have provided you with a lot of information and I again, thank you for your attention and willingness to listen. If you would like any additional information I have included by business card and would be more than willing to answer questions and/or provide additional information. If nothing else I know that Representative Rose can find me.

D. Summary of Provider Survey

A work group consisting of staff from several member associations, a statewide multi-service provider, DHS and Illinois Partners for Human Service developed a Provider Survey. The goal of the Survey was to ensure that the human service provider viewpoint was included, from the beginning, in the interpretation, planning and implementation of PA 96-1141.The intent was to collect concrete data from providers about the actual number and type of audits and program reviews.

To facilitate data collection and analysis, Survey Monkey was used to develop and implement the provider version of the Survey.

The Survey was sent out by DHS and DCFS to State providers. Provider associations Child Care Association of Illinois, Community Behavioral Health Association and Illinois Association of Rehabilitation Facilities, as well as Illinois Partners for Human Service supported the process by encouraging membership to complete the Survey. Providers had three weeks to complete the survey. 377 providers responded to the survey with an overall response rate of 35%. Providers from every county responded with the highest percentage from Cook County. Providers of all sizes participated from those with budgets under $200,000 to those with budgets over $20 million. The State funding sources for these providers included DHS, DCFS, DHFS and DPH.

Major Findings

What is the nature of redundancy?

Departments request information from providers to satisfy monitoring requirements (Federal and State) over program and service delivery, as well as provider organizational management. The Provider Questionnaire requested feedback on Departmental (including some divisions within larger Departments) information on:

- organizational/governance
- financial information
- administrative/human resources
- programs

Feedback on each of these queries indicates there are duplicative requests for the same/similar information for each of the categories queried, and that this duplication occurs both across Departments and across divisions within Departments.

Organizational/Governance

Providers were asked whether they submit By-Laws, 501(c)3 letters, and Board of Directors information. A total of 291 providers responded to this initial query.

The following responses indicate there is a high similarity of duplicative information requested across Departments/divisions:

- By-Laws – 75.3% (119/158)
- 501(c)3 letters – 78.1% (121/155)
- Board Information – 71.9% (115/150)

A total of 201 providers identified as having contracts with multiple Departments/divisions responded to the question as to the extent with which the requested organizational/governance information requested occurred across Departments/divisions.

Financial Information

Providers were asked on whether they submit CPA and A-133 audits, consolidated financial reports, and financial statements. Those queries were drilled down further by asking whether this information was requested for purposes of a desk review, on-site review, licensure, oversight, and other. A total of 317 providers responded to both of the above queries.

A total of 219 respondents identified as having contracts with multiple Departments and/or divisions responded to the question as to the extent financial information requested is the same across Departments/divisions. The following responses indicate there is a high similarity of duplicative information requested across Departments/divisions:

- CPA audit – 82.3% (158/192)
- A-133 audit – 75.9% (104/137)
- Consolidated financial reports – 69.4% (120/173)

In addition, 172 respondents indicate there is a high similarity of duplicative information requested by accrediting bodies:

- CPA audit – 76.1% (118/155)
- A-133 Audit 65.6% (61/93)
- Consolidated Financial Reports – 57.7% (82/142)

Furthermore, 317 respondents indicate there is a high similarity of duplicative information requested by other municipal funding sources:

- CPA audit – 68.5% (185/270)
- A-133 audit – 57.6% (99/172)

Administrative/Human Resources

Providers were asked whether they submit personnel handbooks, job descriptions, and staff licensure, certification, and credentialing information. A total of 277 providers responded to this query.

A total of 279 respondents identified as having contracts with multiple Departments and/or divisions responded to the question as to the extent the requested administrative/human resources information is the same across State Departments/divisions. The following responses indicate there is a high similarity of duplicative information requested across Departments/divisions:

- Personnel handbooks – 67.3% (142/211)
- Job descriptions – 67.1% (163/243)
- Staff information – 67.6% (171/253)

Program Information

Providers were asked whether they submit quality assurance information, risk management/life safety plans, and client rights policies/client grievances. A total of 270 providers responded to this query.

A total of 218 providers identified as having contracts with multiple Departments and/or divisions responded to the question as to the extent the requested program information is the same across Departments/divisions. The following responses indicate there is a high similarity of duplicative information requested across Departments/divisions:

- Quality assurance information- 64.4% (130/202)
- Risk management/life safety plans – 61.1% (113/185)
- Client rights policies/client grievances – 64.2% (129/20)

What is the cost of redundancy?

Analysis of the Provider Survey indicates that provider organizations spend anywhere from 36 hours to 74.8 hours, or an average of 49 hours preparing for each audit/program review. Those same providers indicated they must prepare for an average of 4.40 audits/program reviews per year.

The association members of the sub-committee indicate that member providers typically assign a program director/QA director level staff person to provide oversight and management of audit/program review requirements. The average hourly rate for program director/QA director staff in member organizations of the Child Care Association of Illinois and Illinois Association of Rehabilitation Facilities is $27.35/hour.

Attributing a financial cost of numerous/duplicate audits is difficult. However, it is possible to attribute an average cost for a provider per audit based on this data. This cost reflects only direct salary costs, and does not reflect the costs of copying, duplicating materials or mailing materials to multiple offices.

The average direct staff cost per provider organization per audit/program review is $5,906.66, with a range of costs from $4,332.24 to $9,001.43. The survey yielded responses from 377 providers. The average cost of audit/program reviews for the total of providers responding, based on these averages, is $2,226,810.82. This does not take into account the Department costs per audit/program review.

Streamlining and eliminating redundant audits/program reviews has the potential to return millions of dollars to direct client care for providers. Time eliminated in preparing for multiple audits/reviews can be spent in delivering care and assuring program outcomes are achieved.

Accreditation

Many Illinois human service providers seek and achieve national accreditation. Such accreditation shows that the organization is organized and managed according to accepted governance practices, is fiscally managed through sound accounting practices and provides programs according to standards of care excellence.

A major concern cited by providers through the survey is that there is little practical recognition of accreditation by State auditing and monitoring processes. Even when a "deemed status" provision is contained in state rules, there is little operational application by the Departments.

The sub-committee suggests that one way to approach necessary monitoring needed by Departments is to operationalize deemed status for accreditation. Such accreditation

is an excellent barometer that the provider is assuring patient/client safety, providing quality treatment and care and limiting fraud and abuse.

Once the accreditation process is recognized, a monitoring system can be developed that focuses on what the Department must specifically know, beyond what accreditation requires. Such a system should also recognize that frequently expectations of accrediting bodies and Departments regarding provider organization and care are the same.

- Departments should accept accreditation as a way to avoid duplicate information requests and avoid multiple monitoring visits from Departments and divisions
- Departments should fully operationalize deemed status consistently for accredited providers
- Licensing periods for providers should be converted to match the accreditation cycles
- Program-related audits should interface with accredited program standards, leaving state monitors to look for specific contractual areas
- State monitors should be trained properly to seek consistent information according to agreed-upon monitoring areas for providers

Independent Audits

Provider organizations submit to an annual comprehensive independent audit, conducted by an external CPA. The audit comes at considerable cost and is often recognized as a cost of the contract; so the State, in essence, is already paying for part of that independent audit.

- Accept the provider's independent CPA audit in place of specific Department audits

Duplicate Information Requests

Much of the information required by Departments in the course of monitoring/auditing is requested multiple times by multiple Departments.

Materials such as board bylaws, human resource manuals, client rights statements do not frequently change. They can easily be consolidated into one standardized packet and posted in a central location.

- Establish a Centralized repository of all information required of providers with state contracts. Once "deposited" the provider does not need to resubmit that information for any type of state monitoring/auditing

- Work to establish an electronic repository or "electronic vault" for all information required of providers. There are models already developed that can be easily adapted for state use without the cost of new development
- Accept electronic vault information from providers when providers participate in such a system on its own

Databases

Providers frequently directly enter data on various Department data systems. Those same providers also develop and run their own data systems to assure quality care. The multiplicity of databases in use, and the lack of bridge systems that allow exchange of identical data across and between Departments and with providers, is a huge challenge.

- Development of a single central database
- Develop databases that are compatible with the reporting systems of providers

Medicaid

Providers understand the state's need to leverage as much federal funding for human services as possible. As providers, however, they are frequently required to use different Medicaid billing systems/platforms for different Departments – even when the population served is identical and served within the same provider program. This lack of coordination across Departments translates into a huge cost for providers as they attempt to help the state draw down Federal funds.

- Establish a centralized location for consistent interpretation of technical questions regarding Medicaid across state Departments
- Use a single billing platform for Medicaid so providers do not have to use multiple Department systems to report Medicaid services
- Seek consistent information for Medicaid across state Departments

E. Summary of Department Survey Findings

Survey responses were received from all four Departments. There were 157 responses by program area were received including 108 programs at IDHS, 28 programs at DPH, 15 programs at DCFS and 6 programs at HFS.   The chart below identifies the primary reason why the Departments are engaged in monitoring activities. The main reason identified was contract monitoring.

The committee's outcome was to recommend a coordinated and streamlined system for

Please identify the reasons your area engages in monitoring activities
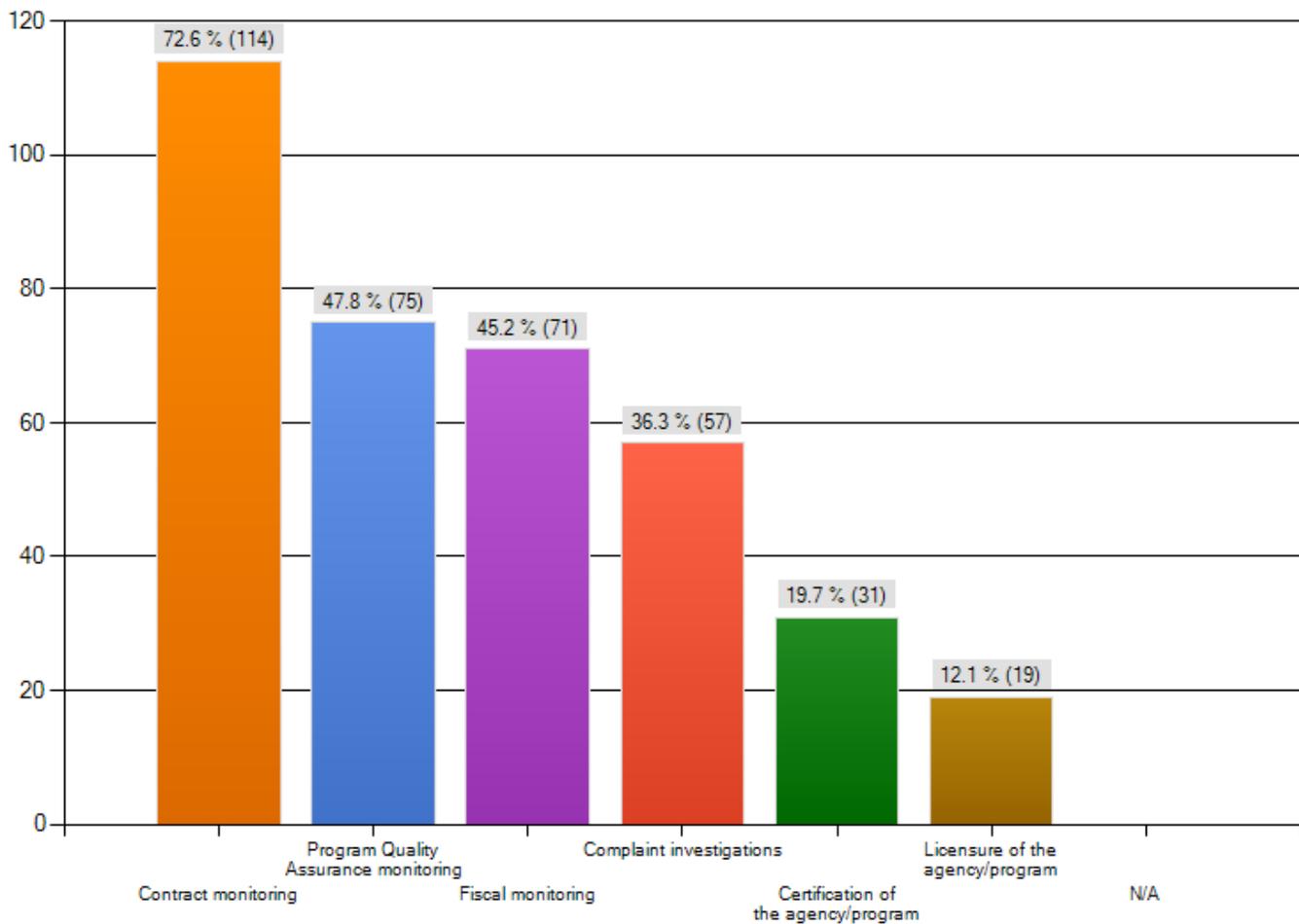
oversight and accreditation. This committee's focus was to identify redundancies and improve efficiencies among state agencies.

Upon analysis of agency monitoring operations, the committee identified and categorized activities into three main components. The components are: Financial Review/Audits, General Administration and Program Specific reviews.

Financial Review/Audits

The committee concluded that all Departments covered by Public Act 96-1141 conduct financial monitoring either through desk or on-site reviews. However, financial monitoring varied depending on several factors. The factors included specific Federal financial requirements, mandated reporting of specific programs administered by Departments, external and internal audit findings, and policies and procedures employed by individual Departments.

In general, the analysis found that Departments do have common components in their reviews. The primary components of financial reviews/audits conducted by Departments included contractor's oversight of:

- Fiscal policies and procedures manuals
- Financial audits conducted by Certified Public Accountants
- A-133 audits according to federal regulations (if involving federal funds)
- Reviews of consolidated financial reports
- Financial statement reviews
- Quarterly financial reports
- Budget reviews
- Submissions of IRS form 990 and AG 990-IL

General conclusions drawn from the analysis of financial reviews/audits indicated the potential for reducing duplication of monitoring and improving efficiencies when dealing with standardized financial reporting. In particular, the potential exists for sharing information among Departments to include reviews of Federal financial reporting requirements as mandated by A-133, financial audits submitted by Certified Public Accountants, consolidated financial reports, financial statements and submissions of IRS form 990 and AG 990-IL.   Efficiencies and benefits can be realized through a reduction of state agency staff conducting the reviews and duplication of information submitted by contractors.

General Administration

In addition to financial reviews/audits, all Departments conducted monitoring reviews of the general administration of contractors. Reviews varied among Departments, depending on the nature and type of funding allocated to the contractors.   Typically, reviews contained the following common administrative elements as identified by the survey:

- Board composition and minutes of Board meetings
- Board policies
- Personnel handbook containing specific language such as equal opportunity, sexual harassment and so forth
- Staff Job Descriptions
- Documentation of criminal background checks
- Client/Participant Grievance policies
- By-laws
- 501 C 3 status
- Credentials of staff
- If applicable, facility compliance to include fire marshal, health department inspections, building and zoning code enforcement

Administrative elements were the most common review components among state agencies and their contractors. Significant efficiencies could be realized through sharing contractor's administrative information among Department.

Program Specific Reviews

While common elements existed among administrative and financial components, the greatest variance existed among program specific reviews. The program specific reviews were driven by federal, state and individual program policies and procedures. For example, child care funds were directed to a specific service with mandated policies and procedures dictated by federal and state statute. However, the committee identified some common elements such as:

- Service reporting, typically on a quarterly basis
- Medicaid reporting, if applicable
- Individual service planning
- Consumer case records review
- Quality assurance
- Contract deliverables

- Accreditation status, if applicable
- Medication management, if applicable

The committee concluded that a more in-depth analysis is needed to fully address the program specific reviews conducted by Departments. Since hundreds of programs existed among the state agencies a more thorough analysis is needed. Program specific components were more complex, involved a variety of different federal and state requirements and were beyond the limited scope of an initial review.
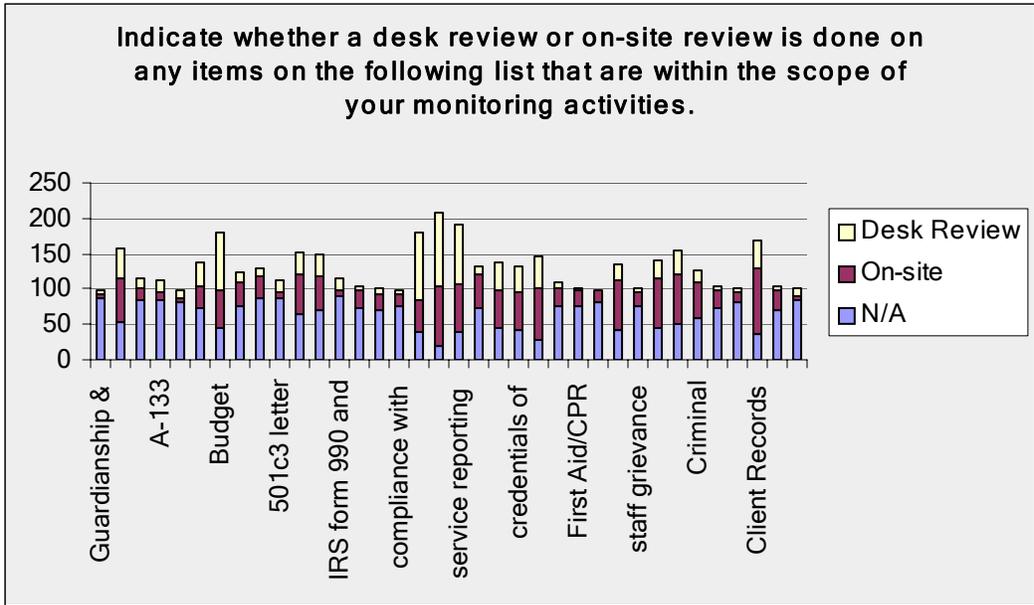
<u>Accreditation</u>

The committee examined the role and value of accreditation. Accreditation plays a vital role in the service delivery system implemented through Departments and their partner contractors. National Accrediting Organizations establish high standards for consumer services. The committee recognized the dynamic partnership that needs to exist among National Accrediting Organizations, Departments and contracting organizations. The over-arching goal continues to be the highest standards of service delivery. As a result, the concept of "deemed status" should be examined more closely to identify commonalities among the above-mentioned components.

<u>Frequency of Monitoring</u>

The committee surveyed Departments regarding the frequency and type of contractor monitoring activities. Desk review and on-site monitoring review were identified as the two most likely forms of monitoring. Depending on the specific program, desk and/or on-site monitoring occur within all Departments.

The following chart details the most common types of both on-site and desk monitoring as compiled from the Department information survey:

Indicate whether a desk review or on-site review is done on any items on the following list that are within the scope of your monitoring activities.

Other notable elements included reviews of:

- Formal Assessment Instruments
- Implementation of Individual Service Plan
- Confidentiality standards
- Abuse, neglect prevention and reporting
- Individual rights
- Documentation of agency (contractor) training plan

The frequency of monitoring varied among Departments. Depending on program and auditing requirements, Departments developed specific protocols for on-site and desk review monitoring. For example, the U.S. Department of Agriculture requires that all food banks receiving Emergency Food Program funds be monitored by DHS staff yearly. The committee found that monitoring reviews are conducted across a wide range of time periods with the most frequent time period as one time per year. However, the committee found that monitoring protocols vary significantly among and within Departments. The opportunity exists to examine monitoring protocols and develop a standardized protocol for minimum on-site and desk reviews.

F. 10 (c) Elements

The committee reviewed the seven elements that comprised the Act and determined that several items were specific to two DHS divisions. The divisions were Division of Developmental Disabilities and Division of Mental Health and are addressed in the Elements numbered 3, 4, and 5. The committee also reviewed the summary of public hearings, survey results, and identified recommendations from both the Provider and Department Survey committees to ensure that the total Act was addressed.

The public hearings and survey results show a great deal of redundancy through all state Departments. However, Section 10(c) elements appear to be some specific examples of concerns found in these hearings. They appear to be examples of:

- Lack of collaboration and acceptance of other state monitoring entities which appears to go to a lack of agreement/acceptance of deemed status from either national accreditation bodies or within their own Departments
- The need to resubmit information numerous times with no central place to keep data that could be used by all
- Inadequate information technology capabilities at state level causing monitors to look at items repeatedly

(1) Addressing redundant checks of policies and procedures which have already been reviewed for a particular provider, with the focus of the review instead on any changes which may have been made to policies or procedures.

- Accreditation as a way to avoid duplicate information requests and avoid multiple monitoring visits
- Work to establish an electronic repository or "electronic vault" for information required of Providers. There are models already developed that can be easily adapted for state use without the cost of new development
- Use a single billing platform for Medicaid so Providers do not have to use multiple Departments' systems to report Medicaid services
- Development of a single central database
- A more in-depth analysis is needed to fully address the program specific reviews conducted by Departments because of the multiple programs
- A minimum level of monitoring protocols should be established within the four Departments. The process should include specific protocols for on-site review and desk reviews. All contracted providers should be made aware of the minimum protocols as well as any additional protocols established by state and/or federal statute
- Form a workgroup to investigate the feasibility of centralizing the fiscal reporting, monitoring and accountability function with the intent to reduce redundancy at the provider and State level

(2) The use of consumer rights statements with terminology that is not consumer friendly and the need for a statewide, standardized consumer rights statement.

- A working group should be formed that will investigate the numerous consumer report statements and make a recommendation that will limit the number used

(3) Streamlining of review of individualized service plan requirements to ensure that sufficient review of plans occurs while eliminating the need for redundant reviews.

- Divisions within DHS should collaborate on the development of standardized review protocols for Case Management including Individual Service Plans (ISP) and Cash Assessments. Furthermore, evaluation of the protocols to be completed to avoid imposing different criteria on the same standard

(4) The need for flexibility in scheduling service plan meetings to allow for time extensions in circumstances where a guardian may not be able to attend due to illness or other temporary reasons.

- DHS should schedule training opportunities for Bureau of Accreditation, Licensure, and Certification; Bureau of Quality Management; and community providers of Community Integrated Living Arrangements and Developmental Training to clarify the protocol for monitoring time frames for the completion of annual ISP's. To the extent possible the protocols should be flexible enough to reasonably address unexpected circumstances which interfere with a timely schedule

(5) Standardization of staff training curriculum to expedite the review of curriculum and training previously approved by the Department of Human Services.

- DHS Divisions should collaborate on standardizing staff training curriculum's across DHS and program areas to the extent possible. Furthermore, collaboration should ensure that the same training requirement not impose different interpretations on the same standard

(6) The current use of random review of staff training documents instead of focusing reviews on newly hired individuals, which results in multiple reviews of the same file year after year.

- The Bureau of Accreditation, Licensure, and Certification should investigate the protocol used by DCFS, or others, to track training and to provide a single location for training documentation

(7) The use of redundant surveys for providers who consistently demonstrate compliance in previous surveys instead of focusing survey efforts on Departments with on-going compliance issues.

- Standardize administrative elements for program monitoring review. This process should be done in collaboration with service providers and provider trade associations. Consideration need to be made to the following areas.
  - Define the purpose and target area(s) for monitoring review
  - Provide clarity and consistency on the method of monitoring review [desk audit, on-site visit, etc.]
  - Utilize technology to share Department survey across appropriate divisions with the four Departments (A-133 and certified audit report, annual financial reports, Board governance information and Department administration data)
  - Maintain a central electronic repository for organizational and other commonly requested documents as feasible, as suggested by the Provider Survey and Department Survey Committees

- Develop a process for using and/or incorporating Department accreditation (deemed status) into the monitoring review process to avoid duplication

  - DHS, DPH, and DCFS collaborate on the concept of "deemed status" to improve the efficiency of surveys
  - Standardized administrative elements for program monitoring acknowledge/cross reference data collection requirements for accreditation

- Minimize the burden of routine program monitoring review on the Providers that demonstrate a history and track record of compliance.

  - Utilize existing manual records, available technology and the proposed central electronic repository to streamline the submission and review of relevant program monitoring requirements
  - Prioritize compliant providers for desk review vs. on-site monitoring visits, unless mandated by federal or state program guidelines
  - Develop templates for specific program remediation plans to address Department's concerns or issues identified through monitoring review)
  - Provide training and technical assistance to non-compliant Providers to support progress toward compliance

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H. Glossary of Terms Used in the Report

501c3 Letter – A document issued by the Internal Revenue Service (IRS) certifying the applicant organization as a charitable entity organized and operated exclusively for purposes set forth in section 501(c)(3) of the IRS Code. The letter also states that contributions to the organization are deductible under Section 170 of the code. The organization is also qualified to receive tax deductible bequests, devises, transfers or gifts under section 2016, 2055 or 2522 of the code.

A-133 – A specific certified audit which includes both the provider's financial statements and the Federal award documentation when a provider expends $500,000 or more of Federal funds in a given year.

Audit – A formal and systematic process of objectively obtaining and evaluating evidence regarding assertions about economic actions and events to ascertain the degree of correspondence between those assertions and established criteria.

Deemed Status – A status conferred on a provider by a Department in formal recognition of successful completion of an accreditation process by a national professional standards review organization. This Status should be sufficient in meeting applicable compliance requirements without further monitoring by the Department. A provider needs to maintain agreed upon accreditation to ensure that applicable programs meet certain recognized standards.

Department – A public sector organization that is an administrative unit of government which has "authority in law to make decisions" within the State of Illinois. In this report, a Department specifically refers to the Department of Human Services (DHS), Department of Children and Family Services (DCFS), Department of Healthcare and Family Services (DHFS) or Department of Public Health (DPH).

Financial Report – A report with statements that are expected to summarize what fiscal events took place within an organization during a given reporting period. Financial statements should indicate sources of revenue, use of the organization's resources and give a clear picture of the financial condition of the organization and indication of future potential for continued operation. Complete financial statements include an income statement (or statement of financial activity), balance sheet (or statement of financial position/condition) and cash flow statement. All financial statements should be audited and signed off on by a licensed accountant. A **consolidated financial report** combines an organization's balance sheet with its primary and subsidiary operating accounts to show a single reporting entity. This consolidated statement is designed to identify the allowable expenses associated with each program for which a rate must be calculated.

Monitoring – A process preformed by management to obtain and evaluate information to oversee and track provider performance.

Non-profit Organization – Any corporation, trust, association, cooperative, or other organization which: 1.) Is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; 2.) Is not organized primarily for profit; and 3.) Uses its net proceeds to maintain, improve, and/or expand its operations.

Provider – A non-Department enity that expends Federal and/or State funds to carry out a designated program, but does not include an individual that is a beneficiary of such a program. For the purppose of this report, the providers referred to are generally structured as non-profit organizations.

Survey – Instruments utilized by the Departments to obtain information from the providers.