State of Illinois
Illinois Department on Aging

Older Adult Services Act

(P. A. 093-1031)

2016 Report To The General Assembly

Illinois Department on Aging

A MESSAGE FROM
ACTING DIRECTOR KRISTINE A. SMITH

To The Honorable Members of the Illinois General Assembly:

The following report is submitted as mandated by Public Act 93-1031, the Older Adult Services Act. This Act requires the Illinois Department on Aging to notify the General Assembly of its progress toward compliance with the Act on January 1, 2006, and every January thereafter. This report summarizes the work completed during calendar year 2015 towards fulfillment of the goals and objectives established by the Older Adults Services Advisory Committee, as well as impediments to such progress, and makes recommendations including legislative action if appropriate.

The Department on Aging gratefully acknowledges the members of the Older Adult Services Advisory Committee (OASAC) as well as the many visitors and frequent guests who participate in meetings and contribute to the process of restructuring the State of Illinois' long term care delivery system for older adults. The overarching goal for these efforts is to assure that older adults across Illinois have accurate information and timely access to high quality services in the community so that they and their families can find the right community-based service at the right time, place and price to continue to live safely in their own homes and neighborhoods.

The Department on Aging also acknowledges and thanks the Department of Healthcare and Family Services, Department of Human Services, Department of Public Health, and the Illinois Housing Development Authority for their thoughtful participation and contributions to the Committee. I am pleased to report that these agencies fully support the goals of the Older Adult Services Act and are assuring that State policies and practices promote the long term care transformation as required in the Act.

Please do not hesitate to contact me if you have any questions regarding this report.

Sincerely,

Kristine A. Smith
Acting Director

Illinois Department on Aging

2016 OASAC Report to the General Assembly

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Executive Summary

The Older Adult Services Advisory Committee (OASAC) met four times during 2015: February 23, May 18, August 24 and November 16. The Executive Committee also met four times: January 12, April 20, July 20 and October 19. A list of OASAC Committee members, meeting agendas, minutes, handouts and materials that were presented at each OASAC meeting are posted to the Illinois Department on Aging website and are listed beginning on page 19 of this report..

Members continued to engage in dialogue about the rebalancing priority areas identified for 2014 and 2015 through presentations at meetings and by reviewing and discussing program evaluations, research and reports on rebalancing activities from both a national and State perspective. Members discussed revisions to the priority areas for 2015 and prepared a concept paper that refined last year's activities to focus primarily on ongoing rebalancing initiatives. This report provides an update on the State's progress with regard to the ongoing rebalancing initiatives that are listed below:

1. Balancing Incentive Program
2. Care Coordination & Managed Care Entities for the Long Term Care Population
3. Institutions to Community Transitions
4. Home and Community Based Services & Aging Waiver Renewal

During the OASAC Executive Committee meeting on January 12, the OASAC Personal Assistant (PA) Consumer Directed Workgroup provided an update on their recommendations regarding the implementation of a PA model across all populations under an 1115 Waiver approval. During the February 23, 2015 full OASAC meeting the finalized recommendations were discussed. A motion was passed to approve the recommendations of the workgroup as advice to the Department on Aging, pursuant to the approval of an 1115 Waiver and when and if a PA Self-Directed Model becomes available.

Ongoing Rebalancing Initiatives

Balancing Incentive Program (BIP)

The Balancing Incentive Program (BIP) was authorized under the Affordable Care Act (Section 10202) to assist states with improving access to Medicaid-funded home and community-based (HCBS) long term services and supports (LTSS) and to streamline program eligibility and service delivery to consumers between state agency programs. Participating states received an enhanced federal match funds to increase access to non-institutional LTSS. Illinois received an enhanced (2%) federal match to participate in the BIP to further rebalance the State's long term care delivery toward increased HCBS. States are required to implement three structural changes:

- Implement a Core Standardized Assessment
- Provide assurance of the provision of Conflict Free Case Management across LTSS
- Establish a No Wrong Door system for LTSS that is coordinated across all disability populations

Illinois was projected to receive $90.3M in enhanced match over the award period from July 2013 through September 2015. In 2015, several of the grants were extended through September 2017 to fully implement the BIP pilot projects. BIP was authorized to incentivize states to rebalance their LTSS system where at least an equal amount of Medicaid funding is paying LTSS for individuals in the community versus a nursing facility or other types of institutional care. The 50% benchmark of LTSS expenditures being directed to the community system was to be met by September 2015. In 2009, Illinois was at the 27.8% benchmark of LTSS expenditures directed to the community-based supports and services. In 2014, that number had increased to 45.4% (Mathematica, 2015). As of September 2015 Illinois was at 45.6% of its benchmark of LTSS expenditures directed to the community and continues to works towards the goal of 50%.

Uniform Assessment Tool (UAT)

BIP required the development of a core standardized assessment tool that assesses consumers across ***five domains*** in a uniform manner throughout the State:

- Activities of Daily Living (ADLs)
- Instrumental Activities of Daily Living (IADLs)
- Medical Conditions/Diagnosis
- Cognitive Functioning and Memory/Learning
- Behavioral Concerns

BIP supports a holistic and person-centered approach to the assessment process and service planning including an individual's needs for training, support services, medical care, transportation, and other services.

In 2015, Illinois began work to develop a Uniform Assessment Tool (UAT) to satisfy the BIP's core standardized assessment requirement. The UAT creates a streamlined/standardized intake process that will reduce existing fragmentation and duplication while improving Statewide coordination and ensuring consumers experience the same process regardless of how they access services. The UAT involves two levels of assessment:

The UAT Level I (initial screen) will help to identify individuals likely to be eligible for Long Term Services and Supports (LTSS) by asking holistic questions using the ***five domains*** noted on page 2. Interested individuals will be able to complete and submit the UAT Level I by accessing any No Wrong Door/Coordinated Entry Point agency. Interested individuals may also contact the expanded Senior HelpLine/BIP Call Center for additional information on completing and submitting the Level I screen. The questions in the Level I are designed to identify the State agency most suited to take the lead in assisting the individual with the completion of the Level II.

The UAT Level II (comprehensive assessment) is being designed to determine functional eligibility for LTSS programs currently covered by the Determination of Need (DON) including Activities of Daily Living (ADLs), Instrumental Activities of Daily Living (IADLs) and the other three of ***five domains*** as required by the BIP. This improved assessment process will view individuals more holistically and lead to the development of a comprehensive person-centered plan. The UAT, including both Level I and Level II, will be piloted in early 2016.

Conflict Free Case Management (CFCM)

BIP regulation defines "conflict free" as the separation of case management and eligibility determination from direct service provision; as case managers not being able to establish funding levels for the beneficiary; and as case managers not being able to be related to the beneficiary or their caregivers. BIP requires states to establish firewalls and appropriate safeguards where conflict risks exist to assure consumer choice and protect consumer rights. The State of Illinois' case management systems are currently unique to each of the disability populations served under each of the Home and Community Based Services (HCBS) Waivers and the Medicaid Rehabilitation Option. Four of the eight programs/service areas included in Illinois' BIP application are conflict free because the entities that provide case management services are separate from the entities that provide direct services. While State oversight of

case management functions exists in the remaining four programs/service areas (Supportive Living Program, Adult Developmental Disabilities Waiver and services provided by the Illinois Department of Human Services' Division of Mental Health and Division of Alcoholism and Substance Abuse), the State has developed several new cross-agency policies as part of its BIP Conflict-Free Case Management (CFCM) protocol to strengthen and standardize existing oversight. In addition, the State is currently developing additional policies to comply with the conflict of interest provisions in the new federal CMS HCBS regulations.

Given the variance in the depth and scope of these activities across programs, the State is strengthening its LTSS oversight and monitoring functions by implementing the six administrative standardization policies across agencies and programs identified below. As described in the State's CFCM protocol, these policies will apply to all five LTSS agencies in Illinois: Department of Healthcare and Family Services, Department on Aging, Department of Human Services' Division of Rehabilitation Services, Division of Mental Health, and Division of Developmental Disabilities; and for services paid for under a fee-for-service or a managed care model. To the extent possible, these changes will build on existing processes and State infrastructure.

1. Establish a common method to inform consumers about filing grievances and requesting appeals.
2. Develop and implement a uniform consumer's rights document. The State is in the process of developing this document via an interagency workgroup and with input from an external stakeholder workgroup.
3. Develop and implement a core set of review elements for State record reviews, building on existing review processes. This will allow the State to better assess the performance of its LTSS system, particularly as it relates to case management and quality.
4. Identify standard survey questions about consumer satisfaction for all LTSS populations; and create new surveys or add questions to existing surveys as appropriate.
5. Establish a cross-agency written policy that prohibits a person who (1) is related by blood/marriage to a consumer or his/her caregiver and/or (2) acts as a guardian to a consumer from performing case management or being responsible for evaluating a consumer's need for services.
6. Begin development of a process to collect/analyze data on results of record reviews, complaints/grievances, etc. across agencies so that the State may better understand and address challenges in its LTSS system.

No Wrong Door (NWD)

BIP required the development of a statewide system to enable consumers to access all long term supports and services (LTSS) through a coordinated network or portal that:

1. Reduces existing fragmentation and duplication, improves coordination and provides a standardized intake process;
2. Provides application assistance;
3. Provides referrals for services and supports available in the community; and
4. Enables functional eligibility assessments.

In November 2015, through guidance from the Administration of Community Living, Illinois formed a NWD Executive Committee including high level administrative staff from the Department of Healthcare and Family Services, Department of Human Services, and the Department on Aging. Based upon a recommendation from the NWD Executive Committee, the Department on Aging is in the process of adding Housing and Veteran representatives. The interagency Executive Committee was formed to ensure that the NWD/Coordinated Entry Point system in Illinois is being designed around a coordinated system of multiple entry points across the State and across agencies. Additionally, in 2015 Illinois has expanded the Senior Helpline with additional staff to assist individuals accessing the BIP NWD Call Center. It is anticipated that the BIP NWD Call Center will begin taking calls in mid-2016. The creation of consistent, Statewide NWD "branding" and an LTSS website continue to be developed.

Beginning in December, 2014 through September 2015 the Illinois Department on Aging in collaboration with its consultants the Lewin Group and its State Department partners conducted six NWD listening sessions:

- Chicago (December 14, 2015); 100 estimated participants.
- Peoria (July 21, 2015); 54 participants
- Mt. Vernon (July 22); 62 participants
- Chicago (August 6 – a.m.); 49 participants
- Chicago (August 6 – p.m.); 67 participants
- Online (September 22); 158 participants
    - 490 total participants

The listening sessions gave consumers, family members and providers the opportunity to provide feedback on the current status of the Aging and Disability Resource Center (ADRC) network and share their thoughts on building a system that serves people of all ages and types of disabilities. Additionally, the listening sessions allowed the State to gather input about how

partnerships in ADRC networks are working now, and what opportunities exist to strengthen them.

Nursing Home Diversion Pilot

In 2015 the Illinois Department on Aging received an extension from federal CMS for the Nursing Home Diversion pilot through September 2016. An additional seven partners were funded, bringing the total number of lead agencies to 14. Funds for the Nursing Home Diversion pilot were adjusted to $3.8 million to support the ongoing implementation and evaluation. In addition to the 14 lead agencies, other partner agencies include Centers for Independent Living, Community Mental Health Centers, Area Agencies on Aging, Care Coordination Units, and housing partners.

The purpose of the Nursing Home Diversion pilot is to reduce the number of initial nursing facility placements at the time of hospital discharge, and to reduce the average length of stay in nursing facilities for short-term placements. The pilot serves individuals eligible for Medicaid, Medicare, and other publicly funded long term services and support (LTSS) programs as well as those who are ineligible for publicly funded LTSS programs.

The core service package includes:

1. A pre-discharge intervention at time of hospital admission that includes the use of a standardized person-centered planning/screening process to identify appropriate candidates and who are interested in receiving assistance.
2. The use of Options/Person-Centered Counseling to work with participants to develop a person-centered plan for connection to services, referrals and follow-up.
3. Mental health assistance is provided to determine eligibility, access, and linkage to community mental health services, rehabilitation services, and to private providers.
4. Rapid response home modifications are available to program participants.
5. Housing coordination supports clients in identifying and accessing available transitional housing options in the person's own community to: 1) secure housing vouchers for their community-based housing needs; and 2) assist with negotiations with landlords and/or facilities to maintain existing community housing during the time that individuals are in short-term rehabilitation.

The Lewin Group provides the Department on Aging with technical assistance and supports the ongoing implementation and evaluation of the pilot. At the November 16th, 2015 meeting of the full OASAC, members were provided with a presentation by representatives from The Lewin Group to learn about the pilot and to provide feedback. Data compiled from the beginning of

the pilot through September 2015 demonstrate that the 14 lead agencies and their partners had completed 610 screens and that 380 individuals had enrolled in the program. Individuals age 60 and over comprised 84% of the enrollees with the average age of 71 (Lewin Group, 2015). The most common disabilities listed were orthopedic impairments and dementia. A self-report on satisfaction showed that 95% of enrolled participants felt the program helped the participant meet their goals and 93% responded positively when asked if they were able to move to their desired setting (Lewin Group, 2015). Further reports on outcomes will be compiled and provided for review throughout the duration of the pilot.

Care Coordination & Managed Care Entities for the Long Term Care Population

Public Act 96-1501 ("Medicaid Reform") required that 50% of Illinois Medicaid clients be enrolled in some type of care coordination program by January 1, 2015. Illinois met this requirement by enrolling more than 60% of the Medicaid population into a care coordination program. Care Coordination manages the care needs of an individual by providing the client a medical home with a primary care physician, referrals to specialists, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, dental services, and when appropriate, rehabilitation and long term care services. The benefits of care coordination include better health for the member and a better quality of life for the member at a reduced cost. The Department of Healthcare and Family Services (HFS) has implemented three care coordination programs: the Integrated Care Program (ICP), the Medicare Medicaid Alignment Initiative (MMAI), and the Family Health Plan Program (FHP).

In Illinois, Care Coordination through these programs is provided to many Medicaid clients by a variety of "managed care entities," which includes Managed Care Organizations (MCOs), Managed Care Community Networks (MCCNs), Coordinated Care Entities (CCEs), and Accountable Care Entities (ACEs). All of these managed care entities are funded by and monitored by HFS, the State Medicaid agency. A description of MCOs, MCCNs, CCEs, and ACEs follows below.

Managed Care Organizations (MCOs) are HMOs licensed by the Illinois Department of Insurance; they utilize a comprehensive network of providers. Individuals that enroll in an MCO receive all of their Medicaid covered services from the providers that are affiliated with the MCO and must receive prior approval from the MCO to see a nonaffiliated provider. MCOs are health delivery systems designed to provide coordinated care that will reduce unnecessary utilization of services, control costs, and increase and maximize quality.

Managed Care Community Networks (MCCNs) are provider sponsored organizations that contracts to provide Medicaid covered services through a risk based capitation fee. MCCNs

must be certified by HFS rather than licensed by the Illinois Department of Insurance. MCCNs must be owned, operated, managed, or governed by providers. They cover the same services as an MCO, and their contract requirements with HFS are very similar to the contract requirements for an MCO.

Integrated Care Program (ICP)

The *Integrated Care Program (ICP)* is a mandatory program for older adults and adults with disabilities (age 19 and over) who have full Medicaid benefits but are not enrolled in Medicare. As of October 1, 2015, HFS holds contracts with ten Managed Care Organizations/Managed Care Community Networks (MCO/MCCN) and three Care Coordination Entities (CCEs) to serve the ICP population. ICP began as a pilot in suburban Chicago and the collar counties. It now covers 30 counties in Illinois, including the entire Greater Chicago Region, Rockford Region, Central Illinois Region, Metro East Region and the Quad Cities Region. As of October 1, 2015, the enrollment for ICP was just over 120,500. Enrollment for Elderly Waiver enrollees in ICP totaled 5,669 (5,465 enrolled in MCOs/MCCNs and 209 enrolled in CCEs).

ICP brings together local primary care providers, specialists, hospitals, and other providers to provide more coordinated care around the participant's needs. ICP members have a choice of at least two plans, and they select their primary care provider. ICP consists of two (2) service packages:

- Service Package 1 includes all standard Medicaid medical services, such as physician and specialist care, emergency care, laboratory and X-rays, pharmacy, transportation, dental services, mental health and substance abuse services.

- Service Package 2 includes long term services and supports (LTSS) for nursing facility care or for individuals enrolled in the following five Home and Community Based Services (HCBS) Waivers:
    - Persons with Physical Disabilities
    - Persons with HIV/AIDS
    - Persons with Brain Injuries
    - Persons who are Elderly
    - Persons in a Supported Living Facility.

At the August 24, 2105 full OASAC meeting staff from the Department of Healthcare and Family Services (HFS) presented on recent findings from the July 9, 2015 3rd Quarterly report of "HCBS Waivers – CMS Performance Measures Record Review of ICP Summary of Findings and Recommendations" prepared for HFS by the Health Services Advisory Group (HSAG, 2015). It included a review of seven ICP MCOs/MCCNs. Using a sample size of 2,545 HCBS members,

HSAG conducted record reviews of 12 CMS Performance Measures. The reviews determined if the enrollees' most recent care/service plan included: Goals, needs, risks as identified in the comprehensive assessment; required signatures; documentation that the enrollee was contacted and the care/service plan was completed in a timely fashion and updated as necessary; documentation that the enrollee was given the opportunity in choosing types of services and providers; and documentation that the enrollee is informed how and to whom to report abuse, neglect and exploitation at the time of assessment/reassessment.

Overall findings from the Health Services Advisory Group included data from seven ICP MCO/MCCNs (HSAG, 2015). Compliance averages of the 12 CMS performance measures ranged from 84%-100% with four MCOs scoring 90% or above. There were no immediate concerns related to health, safety, or welfare discovered during the on-site record reviews during the 3rd quarter (HSAG, 2015, p. 3-1). There was little difference (88% to 91%) in compliance among the five Waivers identified in Service Package 2 above. CMS performance measures that showed the highest levels of non-compliance were: the most recent care plan includes all enrollees goals as identified in the comprehensive assessment (30.02% non-compliance); and the case manager made timely contact (per Waiver requirements) with the enrollee, or valid justification is documented in the enrollee's record (17.65% non-compliance) (HSAG, 2015, p. 3-15). Eight MCOs were reviewed between the 1st and 3rd quarters. Overall performance demonstrated a statistically significant increase across quarters (81% to 90%) (HSAG, 2015, p. 4-1).

Medicare/Medicaid Alignment Initiative (MMAI)

On February 22, 2013, Illinois and the federal Centers for Medicare and Medicaid Services (CMS) signed a Memorandum of Understanding that approved the *Medicare/Medicaid Alignment Initiative* (MMAI). MMAI is an effort to reform the way care is delivered to client's eligible for Medicare and Medicaid services (dual eligible) by providing coordinated care.

In 2015 MMAI was operational in 21 counties, including the Greater Chicago Region and the Central Illinois Region. Only Managed Care Organizations (MCOs) were approved to provide services under MMAI. As of October 1, 2015, the enrollment under MMAI was 48,779. Enrollment for Elderly Waiver enrollees in MMAI totaled 5,669.

MCOs providing services under MMAI are responsible for covering all Medicare and Medicaid services, including Long Term Services and Supports (LTSS). Enrollees can opt out of MMAI at any time, as well as re-enroll at any time. Enrollees that receive LTSS will be required to participate in the Managed Long Term Services and Supports (MLTSS) program, a State only program with an anticipated begin date of summer 2016.

Family Health Plan Program (FHP)

The *Family Health Plan (FHP)* Program is for children, their families, and Affordable Care Act Adults who have full Medicaid benefits and are not enrolled in Medicare. FHP is currently operating in 45 counties including the Greater Chicago Region, Rockford Region, Quad Cities Region, Central Illinois Region and Metro East Region (15 additional counties outside the mandatory Regions have one MCO operating FHP in that county. Participation is optional in those 15 counties for enrollees). Current enrollment for FHP is over 1.9 million. Enrollment for Elderly Waiver enrollees in FHP was 752 (653 enrollees in MCOs/MCCNs and 79 enrollees in Accountable Care Entities (ACEs).

Accountable Care Entities (ACEs) are provider-based organizations (e.g. hospital groups) created to integrate delivery systems and coordinate care in the Medicaid program. ACEs manage populations that include children and their family members and the "newly eligible" adults under the Affordable Care Act. They include a minimum of the following types of providers (primary care, specialty care, hospitals and behavioral healthcare). As of October 1, 2015, there are six ACEs serving Medicaid clients. ACEs are being phased out in 2015/2016 and the individuals enrolled in this program are being transferred to an existing MCO.

Care Coordinated Entities (CCEs) are a collaboration of providers (including hospitals, primary care providers, mental and substance abuse providers) that develop and implement a Care Coordination model that meets State requirements. CCEs provide case management services. Some CCEs specialize in providing care to specific populations such as Children with Special Needs (CSN), and some CCEs provide risk assessments and care plans specific to individuals with severe mental illness. CCEs do not authorize services or pay claims to providers. Individuals may be enrolled in CCE and receive Community Care Program (CCP) services. As of October 1, 2015 there were three CCEs still in operation. CCEs are being phased out in 2015/2016 and the individuals enrolled in this program are being transferred to an existing MCO.

Institution to Community Transitions

<u>Pathways to Community Living/Money Follows the Person</u>

Illinois was approved for a Money Follows the Person rebalancing demonstration award from the federal Centers for Medicare and Medicaid Services (CMS) in May 2007. Following development on an Operational Protocol, policies and forms, the first transition began in 2009. It was re-branded as the Pathways to Community Living/Money Follows the Person (Pathways/MFP) in 2013. The program is designed to help older adults and persons with all

disability groups and ages move out of nursing facilities and back into the community with the necessary supports. The program goals are to increase the use of home and community-based services (HCBS); to eliminate barriers that prevent or restrict flexible use of Medicaid funds for necessary long term supports and services (LTSS) in the settings reflecting individual choice; to increase ability to assure continued HCBS LTSS to eligible individuals after transition; and to ensure quality assurance and improvement continuously occurs for HCBS LTSS.

Sustainability: When the Affordable Care Act was signed into law, Section 2403 extended MFP through September 30, 2016. In April, 2015 the Department of Healthcare and Family Services (HFS) submitted to CMS a Sustainability Plan that will authorize MFP-funded transitions through December 31, 2017. Illinois' plan outlines a key role of MCOs in assisting the State in rebalancing its LTSS system. All transitions completed prior to or on December 31, 2017 must have completed their MFP post-transition eligibility by December 31, 2018. The Department on Aging will be working with HFS on possible additional Waiver services to continue MFP-type activities beyond the Sustainability Plan timeframe.

Monitoring: On July 20-22, 2015 federal CMS came to Illinois for a monitoring site visit. The three-day agenda included meetings with State Department/Division executive staff and management, Pathways/MFP Department/Division leads, Transition Coordinators, and a panel of transitioned Colbert participants. The second day included CMS and HFS staff making home visits to three different transitioned participants living in DuPage County. Feedback from CMS following the site visit highlighted four "promising practices" that are going to be shared on the national MFP technical assistance website: 1) the Department on Aging developed tables and graphs to show on a step-by-step basis the number of individuals considering enrollment, actual enrollment and transitions; 2) the State has taken a multi-pronged approach to addressing unmet housing needs; 3) the University of Illinois at Chicago – College of Nursing has provided an additional level of program monitoring and quality assurance, and 4) the Colbert transitioned participants' peer engagement and mentoring roles were recognized for assisting new participants with the transition process.

New Initiatives: Two initiatives were implemented in 2015 aimed at increasing transitions. Effective August 27, 2015 all of the State Department/Division Pathways/MFP-funded agencies became eligible to receive Incentive Payments of $1,000 for participants enrolled with a Managed Care Organization (MCO) at both the 3-month post-transition and 12 month post-transition thresholds. In addition, the Department on Aging revised its policies to authorize equal Incentive Payments for Care Coordination Units who transition participants who are not enrolled in an MCO. The second initiative is a pilot project designed to provide a timely response to residents living in nursing facilities (NFs) who answer positively to a discharge-planning question found in the federal CMS Nursing Home Minimum Data Set (MDS), Section Q.

Facility residents are asked at the time of their admission, and quarterly, about their interest in talking to someone regarding moving into a community-based residence. A listing of those NF residents who have answered, "Yes" to the MDS-Q question will be sent to the pilot sites in a secured/encrypted format. Pilot sites include selected ADRCs which employ Transition Engagement Specialists under contract with HFS, selected CCUs and the two MCOs working with class members of the Colbert Consent Decree.

Outcomes: As of December 8, 2015 the total number of Pathways/MFP transitions across all State Departments/Divisions since the beginning of the program was 2,287 individuals. To avoid corrective action by federal CMS, states are required to meet at least 85% of the calendar year's projected transition goals. As of December 8, 2015 the State had met 90.9% of its transition goal. Transitions by Aging/Disability population: Elderly (50), Physically Disabled (44), Serious Mental Illness (25), Intellectually Disabled (58), Colbert Class [MFP eligible] (403); total of 580 individuals.

Colbert Consent Decree

The Colbert Consent Decree was filed on August 22, 2007 on behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook county Illinois. The class members alleged that they were being unnecessarily segregated and institutionalized in nursing facilities and forced to live with numerous other people with disabilities and in situations in violation of the Americans with Disabilities Act (ADA) and Rehabilitation Act. And they were denied the opportunity to live in an appropriate community integrated setting where they could lead more independent and productive lives. The consent decree was settled on December 20, 2011 and required the Defendants (Office of the Governor, Department of Human Services, Department of Public Health, Department of Healthcare and Family Services) to provide the necessary supports and services to:

1. Move 1,100 Colbert Class members to the least restrictive community-based setting by November 30, 2015 and;
2. Collect and compare data regarding the costs of maintaining Colbert Class members in the nursing facility and in the community-based setting, the results of which to be used to create a plan for moving interested and appropriate class members to the most integrated community-based settings appropriate to their needs.

Transition planning and implementation for Colbert class members began in February 2013 under the lead of the Department of Healthcare and Family Services (HFS). Effective January 22, 2014, oversight of the Colbert Consent Decree Implementation was transferred from HFS to the Department on Aging.

Implementation processes include outreach and education, evaluation, service plan development, transition services and post-transition monitoring. Initially, all referrals were made through the Pathways/MFP website with two MCOs (Aetna Better Health and Illinicare) providing evaluation and transition services in collaboration with three housing locator agencies and 10 Community Mental Health Centers (CMHCs). Several pilot processes have been initiated to maximize evaluation efforts and ensure the interests of certain disability groups, including: 1) evaluation and transition services of class members age 60 and over by three selected Care Coordination Units; 2) outreach, evaluation and transition services for class members diagnosed with a serious mental illness by two selected CMHCs and; 3) evaluation services only for persons diagnosed with serious mental illness by mental health professionals.

On November 30, 2015, the Consent Decree's requirement that 1,100 Colbert Class members be transitioned was met by the State with a total 1,101 Colbert Class members moved to the least restrictive community-based settings appropriate to their needs. Cost data is being collected for Colbert Class members that have been in the community for 12 months or more for comparison to the cost of living in the nursing facility for 12 months. It is anticipated that the final cost analysis report will be completed by April 1, 2016 and the cost neutral plan that will provide guidance for the State's future community reintegration efforts will be completed May 8, 2016.

Home and Community Based Services & Aging Waiver Renewal

Home and Community-Based Services (HCBS) Waivers provide Medicaid recipients with the opportunity to remain in the community through the provision of HCBS services and supports. Individuals must meet specific eligibility criteria to be eligible for an HCBS Waiver which includes that the individual must require an institution level of care (specified by each Waiver) and service needs must be cost effective. The Department on Aging currently offers the following services under the HCBS Aging Waiver:

- Adult Day Service
- Adult Day Service Transportation
- In Home Services
- Emergency Home Response Service
- *Automated Medication Dispenser
    - This service has been approved in the Waiver and the Department on Aging is exploring plans for its implementation.

On November 20, 2015 the Department of Healthcare and Family Services (HFS) submitted a renewal of the Aging Waiver to federal CMS. Significant changes included: 1) adding language to comply with federal HCBS regulations specific to person-centered planning, 2) ensuring the provision of services in integrated settings, and 3) an increase in the number of individuals served under the Waiver.

The Department on Aging has collaborated with HFS and the Department of Human Services as well as stakeholders on the development of the Statewide Transition Plan as required by federal CMS. In March, 2015 HFS submitted the Statewide Transition Plan to federal CMS for approval. States are provided with five years to come into compliance with the new HCBS regulations pending CMS approval of the Plan. The Department on Aging anticipates initiating the site validation process for its Adult Day Service providers in early 2016.

Impediments to Progress

During 2015 Illinois continued to work through the existing challenges in rebalancing Long Term Supports and Services (LTSS) that were identified in 2014 in addition to new challenges. Primary challenges include:

- The settlement of three *Olmstead* lawsuits (Ligas, Williams, Colbert) within two years of each other created a huge demand on the community infrastructure. The capacity of the community infrastructure needs to be strengthened to respond to the increased demand for services and gaps in the current delivery model need to addressed.

- The implementation of the Balancing Incentive Program (BIP) requires significant coordination amongst the State Departments. The change in the Administration at the beginning of 2015, including key personnel at the State Department level and other unanticipated challenges, slowed the implementation process down.

- The Aging and Disability community infrastructure is undergoing massive change simultaneously. While many of these changes are positive and address some of the shortfalls of the current structure; the provider community is adjusting to how they fit into the new system; specifically, the expansion of managed care models for LTSS, the rebalancing initiatives that are underway, and the expansion of Medicaid resulting from the implementation of the Affordable Care Act.

- The shift towards viewing individuals in a holistic manner, outside of the traditional silos and funding streams, will require additional training of the State's workforce. The movement away from fee-for-service reimbursement towards performance based contracting models and funding based on outcomes will require additional training for the provider community.

- The FY 2016 budget impasse has impacted many community-based Human Services agencies in maintaining their ability to fully operate and provide their full level of services. Numerous agencies have reduced services, hours of operation and have furloughed or laid-off staff.

Successes & Recommendations

Successes:

Increased Investment in the Community Long Term Services and Supports (LTSS) System: Over the past several years, Illinois has made significant progress towards increasing its spending on community-based services and supports as evidenced by the most recent HFS Report which notes Illinois spent 45.6% on community-based services (September, 2015). The enhanced federal match ($90.3 M) acquired through the BIP has been re-invested into community-based services to further strengthen Illinois' rebalancing efforts. As of September, 2015 $69.9 M of the $90.3 M has been allocated to support innovative and existing community-based programs, including two rebalancing initiatives; the Nursing Home Deflection Pilot and the expansion of Pathways/MFP to individuals with serious mental illness.

Progress on Transitions: Illinois continues to make significant strides in transitioning individuals from institutional settings to the community. The State met its transition benchmark under the Colbert Consent Decree which required 1,100 individuals residing in Cook County nursing facilities to be transitioned to the community by November 30, 2015. The transitions that were achieved under Colbert assisted the State with meeting its federal Pathways/MFP benchmark which requires the State to meet at a minimum of 85% of its overall annual transition goal. As of December 8, 2015 there have been 580 Pathways/MFP transitions (90.9% of the goal).

Coordination of No Wrong Door (NWD) Planning Efforts: The Department on Aging received a three year NWD planning grant from the Administration on Community Living and the State is also implementing the NWD requirements under the BIP. The six NWD listening sessions provided 490 stakeholders with an opportunity to provide State agency staff with key feedback on how these processes should be coordinated to improve access and outreach for consumers that are in need of community-based LTSS. The feedback provided at the NWD listening sessions will be included in the NWD Plan as part of the assessment of Illinois' current NWD system.

Home Care Ombudsman Expansion: In 2013, Public Act 098-0380 amended the Illinois Act on Aging giving additional authority to the Long Term Care Ombudsman Program, subject to appropriation, authority to advocate on behalf of older adults and persons with disabilities residing in their own homes or other HCBS settings. Expansion has included serving individuals age 18 and over who are receiving assistance under one of the State's Medicaid Waivers or MCOs providing care coordination under the Medicare-Medicaid Alignment Initiative (MMAI). The program expansion began in the summer of 2014 with 10 Regional Ombudsman Programs (ROPs) in the Greater Chicago Region and Central Illinois Region. In January 2015, the program expanded by including the remaining seven ROPs in the State.

Recommendations:

- During the February 23, 2015 full OASAC meeting it was noted that the proposed 1115 Waiver was submitted to federal CMS included a high level of stakeholder involvement. In 2016, the OASAC will implement a stakeholder engagement process that could be applied in Illinois to provide opportunities for the Aging and Disability network of consumers, providers and advocates to give meaningful feedback to the on the many long-term care initiatives were being introduced.

- OASAC recommends enhanced inter-agency collaboration and sharing of data concerning the ”lessons learned” from the implementation of the State’s three Olmstead Consent Decrees and Pathways/MFP; as well as the nursing facility deflection initiatives, including the Bridge Program and the BIP-funded Nursing Home Deflection Pilot.

- As managed care for the LTSS populations continues to expand, OASAC recommends an increased emphasis on the evaluation of MCO recipient’s quality of life and other measures that are non-medical in nature.

- OASAC recommends that the State should increase its efforts to address the need for identifying and training a growing workforce of paid and non-paid caregivers to meet the anticipated growth in the aging population in particular, including the need for additional supports for family caregivers.

- As the State continues to emphasize rebalancing efforts, the need for continued funding of existing community capacity is critical to the ongoing success of State/Federal initiatives, including the BIP, Pathways/MFP, and implementation of deflection programs.

Legislation

Following are several pieces of enrolled legislation the OASAC believes will have a positive impact on the State's rebalancing efforts:

Public Act 99-272

House Bill 1588 removes the 60 day wait period after criminal charges are made before a victim of financial exploitation may file civil charges, and expressly states that no criminal charge or conviction is required to file civil charges. This will not interfere with any other laws or precedents arising out of financial exploitation of an elderly person or person with a disability. Effective date: January 1, 2016.

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0272

Public Act 99-181

House Bill 2812 limits disclosures by Medicaid managed care entities relating to "sensitive health services", defined to include mental health, substance abuse treatment, reproductive health, family planning, STD treatment, and sexual assault/domestic abuse treatment. Effective date: Immediate.

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0181

Public Act 99-184

House Bill 3753 gives the Department on Aging rulemaking authority to provide grants, subject to appropriation, for programs which integrate mental health services for older adults in primary health care settings. This includes federally qualified health centers, primary care clinics, and private practice sites. While the Department on Aging does have a broad ability to give grants, this offers an alternative to other Departments who would normally provide mental health services. The Aging network, with 13 local Area Agencies on Aging, Adult Protective Services, the Long Term Care Ombudsman and its Regional Ombudsman, and associations with vendors and providers across the state, has a strong capacity to provide substantive contributions toward innovation in this area. Effective date: January 1, 2016.

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0184

Public Act 99-163

Senate Bill 689 expands the list of people able to pick up a prescription order for a patient to include advanced practice nurses, practical nurses, registered nurses, or physician assistants who provides hospice services to a hospice patient or who provides home health services to a person. Effective date: January 1, 2016.

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0163

Public Act 99-222

Senate Bill 1298, also known as the "CARE Act", would require hospitals, upon request, to provide designated caregivers "after-care assistance" training based on a patient's discharge plan. Discharge plans are created by the hospital in consultation with the designated caregiver prior to a patient's discharge and are intended to shorten a patient's hospital stay and reduce the chance of unexpected readmission. The after-care training may be provided either in person or from a recorded demonstration, and caregivers must also be permitted an opportunity to ask questions about the training. Effective date: 180 days after becoming law.

http://www.ilga.gov/legislation/publicacts/fulltext.asp?Name=099-0222

Older Adult Services Advisory Committee Members

The Department on Aging, Department of Healthcare and Family Services, Department of Human Serves, Department of Public Health and Illinois Housing and Development Authority gratefully acknowledge the service of the Older Adult Services Advisory Committee (OASAC). The State of Illinois benefits from the broad representation of the OASAC membership and their commitment to advise the Departments on all matters pertinent to the Older Adults Services Act and the delivery of services to older adults. OASAC has been instrumental in the support of a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system. The following individuals served as the current OASAC members effective December 31, 2015. (**Denotes members of the Executive Committee).

**Darby Anderson – *Community Care Program Homemaker Services*
**Carol Aronson – *Case Management*
Sherry Barter Hamlin – *Nursing Home or assisted living Establishments*
John Becker – *Statewide senior centers associations*
Jennifer Belkov – *Alzheimer's disease and Related Disorders*
June Benedick – *Parish Nurse*
Jean Bohnhoff – *Municipality*
Andy Chusid – *Nursing Home or assisted living Establishments*
Thomas Cornwell, M.D. – *MD specializing in Gerontology*
Cindy Cunningham – *Adult Day Services*
Frank Daigh – *Citizen Member over the age of 60*
Kelly Fischer – *Hospice Care*
Robyn Golden – *Health care facilities licensed under the Hospital Licensing Act*
Jan Grimes – *Home Health Agency*
**Terri Harkin – *Trade or union member*
Mike Hughes – *Nutrition Representative*
Lori Hendren – *Statewide organization in advocacy or legal representation on behalf of the senior population*
Susan L. Hughes, Ph.D. – *Gerontology Health Policy Analyst*
**Myrtle Klauer – *Nursing Home or assisted living Establishments*
Michael Koronkowski – *Pharmacist*
Jonathan Lavin – *Illinois Area Agencies on Aging*
Dave Lowitzki – *Trade or union member*
**Phyllis B. Mitzen - *Citizen Member over the age of 60*
Patricia O' Dea-Evans – *Family Caregivers*
Samantha Olds Frey – *Primary Care Service Provider*
**Susan Real – *Family Caregiver*
Geraldine C. Simmons – *Legal Representative on behalf of the Senior Population*
Jason Speaks – *Nursing Home or assisted living Establishments*
**Cathy Weightman-Moore – *Illinois Long Term Care Ombudsman*
Ancy Zacharia – *Advanced Practice Nurse with experience in Gerontological nursing*

OASAC State Department Members (Ex-officio)
(Denotes **Executive Committee)
**Kristine A. Smith, Acting Director, *Department on Aging*
**Kelly Cunningham, *Department of Healthcare and Family Services*
**Debra D. Bryars, *Department of Public Health*
**Linda Gonulsen, *Department of Human Services*
**Megan Spitz, *Illinois Housing Development Authority*
Jamie Freschi, *Department on Aging*
Doree Vetter, *Department of Veterans Affairs*

OASAC Workgroup Members

Personal Attendant/Consumer Directed Service Workgroup

Phyllis B. Mitzen – Health and Medicine Policy Research Group
Susan L. Hughes – University of Illinois at Chicago
Darby Anderson – Addus HealthCare
Carol Aronson – Shawnee Alliance for Seniors
Frank Daigh
Jonathan Lavin – AgeOptions
Dave Lowitzki – SEIU Healthcare Illinois and Indiana
Patricia O' Dea-Evans
Susan Real – East Central Illinois Area Agency on Aging
Charlotte Cronin – Family Support Network
Ann Ford – Illinois Network of Centers for Independent Living
Inga Lund
Sharon Post – HMPRG
Tameshia Bridges – PHI Midwest
Marsha Nelson – Shawnee Alliance for Seniors

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The Lewin Group, Inc. (October 8, 2015) Illinois Nursing Home Deflection Pilot Project Evaluation. (*Prepared for the Illinois Department on Aging*). PowerPoint of Data Extracted September 30th, 2015.

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(This report was prepared for OASAC by the Illinois Department on Aging, Division of Planning, Research and Development).

2016 Report to the General Assembly

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Senior HelpLine: 1-800-252-8966, 1-888-206-1327 (TTY)
8:30 a.m. to 5:00 p.m. Monday through Friday

24-Hour Adult Protective Services Hotline: 1-866-800-1409, 1-888-206-1327 (TTY)
http://www.illinois.gov/aging

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in compliance with appropriate State and Federal statutes. If you feel you have been discriminated against, call the Senior HelpLine at 1-800-252-8966, 1-888-206-1327 (TTY).
Printed by Authority State of Illinois IOCI 16-345 (75, 12/15)