



John K. Holton, Ph.D., Director

One Natural Resources Way, Suite 100, Springfield, Illinois 62702-1271
Phone: 217-785-3356, Fax: 217-785-4477, Web: www.state.il.us/aging

March 1, 2014

To: The Governor of the State of Illinois
The Honorable Members of the Illinois General Assembly

The Illinois Department on Aging (IDoA) is pleased to offer the March 1, 2014, bi-monthly report as required by HB 2275 (Public Act 98-0008). The report describes in detail the progress-to-date by amended ILCS statute, pertaining to IDoA's Community Care Program (CCP) goals outlined in the legislation. This report also highlights IDoA policy changes and notifications required to implement this amendatory Act, in addition to federal waiver requests and State administrative rule changes, although no amendment to the Illinois Title XIX State plan has been made or offered. Finally, the quarterly report regarding Service Authorization Guidelines is reflected as an addendum to this document.

20 ILCS 105/4.01(2-a) (provide data sharing and requested employment information verification for CCP providers)

- ✓ **All interagency agreements have been agreed upon and signed. The department is currently working to establish the secure transfer of information.**

20 ILCS 105/4.02(7) (Balance Incentive Payment Program (BIP)) - CCP effectiveness under Medicaid Waiver)

- ✓ **This requirement has been met. The Illinois Department of Healthcare and Family Services (HFS) submitted the BIP application to the federal Centers for Medicare and Medicaid Services (CMS) on March 27, 2013. On June 12, 2013, the State of Illinois received official notification from CMS regarding the awarding of the BIP grant. The project period is July 1, 2013, through September 30, 2015. Illinois will receive an enhanced 2% match on non-institutional long-term services and supports, estimated at \$90.3 million during the project period.**

20 ILCS 105/4.02 (quarterly reporting on CCU's (Care Coordination Units) performance and adherence to service authorization guidelines)

- ✓ **The Department has established a review process to ensure that the eligibility and services authorized are consistent with CCP policies and procedures. The first quarterly report, which established a baseline for this analysis, covered the first three**

month period following the effective date of the policy (May 1 – July 31, 2013), and was submitted in our November 1, 2013 report. This report covers the first six-month period following the effective date of the policy (i.e., May 1 through October 31, 2013), as compared to the same Six-month period in 2012, and can be found at the end of this report.

20 ILCS 105/4.02(10) (Medicaid waiver enrollment and claiming improvements)

- ✓ **The Department has established a stakeholder group that includes representatives from DHS, DHS-OIG, CCUs, HFS, and AAAs (Area Agencies on Aging). The stakeholder group has met four times. The dates were November 1, 2013, November 14, 2013, December 19, 2013, and February 27, 2014. The group has provided recommendations on improving the Medicaid claiming process and the Medicaid enrollment process. Recommendations include 1) establishing a process to review and update IDoA income/asset rules and procedures as compared to the new HFS rules 7-2012; 2) policy/rule changes for enrollment of Medicaid process to increase Medicaid reimbursements; 3) training of Department staff and sister agency staff on latest policy and rule changes in Medicaid; 4) streamline the Home and Community Base Services work flow process for the Community Care Program; 5) to establish two processing centers in Illinois (Macon and Cook counties) to specifically address Medicaid applications; 6) to develop an implementation plan for the above mentioned recommendations; and 7) to continue to meet monthly.**

20 ILCS 105/4.02(11) (seven-minute rounding policy clarification)

- ✓ **This requirement has been met. As of April 1, 2013, IDoA has developed a policy that requires implementation of rounding from seven minutes up or down to the nearest quarter hour as a new method for calculating CCP units for in-home service providers. The Department has been monitoring for rounding of hours on reviews and agencies reviewed have been in compliance.**

20 ILCS 105/4.02(12) (coordinated (i.e., managed care) enrollment)

- ✓ **Policies for the Integrated Care Program (ICP) have been finalized to ensure the smooth transition of CCP clients to managed care entities (MCEs). The Department continues to meet on a regular basis with the Department of Healthcare and Family Services, as well as the MCEs to address issues that arise to ensure that care provided is consistent with federal waiver requirements.**

20 ILCS 105/4.02(13) (maintain existing (FY13) CCP rate increase in FY14)

- ✓ **All current CCP fee-for-service rates remain unchanged at the FY13 level.**

20 ILCS 105/4.02 (Electronic Visit Verification (EVV))

- ✓ **Public Act 097-0689 (or the S.M.A.R.T. Act) mandates the Community Care Program (CCP) to implement electronic visit verification (EVV). The purpose of this mandate is to secure error rate reductions in billings, safeguard against fraud, and improve program oversight. The Department's EVV requirement became effective on July 1, 2013. It is predicated on a "standards-based model" that allows providers flexibility to employ an EVV system of their choice and at their own expense, as long as it meets the Department's standards which are promulgated in administrative rule. The Department requires 100% compliance with the EVV mandate by providers. As of February 28, 2014, the Department had 107 In-Home Service provider agencies of which 105 agencies were compliant with the Electronic Visit Verification (EVV) requirements. Of the remaining two agencies, one recently entered into a contract with an EVV provider and is currently in the testing phase and had their intake of new clients temporarily suspended by the Department on January 1, 2014, until EVV is fully operational. The Department recently took added contract against the remaining provider agency; issuing a termination notice to take effect on March 31, 2014, for failure to comply with the EVV certification requirements and for other material contract matters.**

20 ILCS 105/4.02 (reporting requirements /bi-monthly reporting)

- ✓ **This report will satisfy the intended requirement of HB 2275. Reports have been filed on a bi-monthly basis.**

20 ILCS 105/4.02 (CCP providers submission of bills or invoices)

- ✓ **This provision has been met. The Department's online billing system for Vendor Requests for Payment was modified to contain certification language referring to a physical notarized statement (Notarized Certification Form).**

30 ILCS 105/25 (prior CCP liability payment cap)

- ✓ **This provision has been met. Aging does not have a re-appropriated line in the FY 14 budget. The General Assembly approved two supplemental appropriations for the**

Community Care Program to resolve liability issues. The first supplemental appropriation was for \$173,000,000 which allowed IDoA to pay prior years liability through FY 12. The second supplemental appropriation of \$142,000,000 provided the Department sufficient funds to pay for services provided through June 30, 2013.

We will be happy to provide any further documentation you require. Please do not hesitate to contact me if you have any questions regarding this report.

Sincerely,

A handwritten signature in blue ink, appearing to read "John K. Holton".

John K. Holton, PhD
Director
Illinois Department on Aging

cc: Mary Killough, Deputy Director
Deb Shipley, Chief of Staff-Operations

ADDENDUM

Illinois Department on Aging Community Care Program Service Authorization Guidelines Analysis February 28, 2014

Introduction: Public Act 98-0008 (or HB2275) requires the Department to report on the reinforcement of service authorization guidelines for Plan of Care assessments done by Illinois Department on Aging's Care Coordination Units (CCUs) for Community Care Program applicants and participants. Specifically, the Act requires the department to "conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The Department shall collect and report longitudinal data on the performance of each care coordination unit. Nothing in this paragraph shall be construed to require the Department to identify specific care coordination units."

Background: The Department implemented the Service Authorization Guidelines (SAG) policy for Case Coordination Units (CCUs) statewide in May 2013. The overall intent of re-issuing guidelines was to strengthen consistent application of service tasks approvals across the state in developing clients' Plan of Care, and to assure that services are approved according to an individual's need while promoting the participant's health, safety and welfare. The guidelines do not impact access or eligibility to the CCP; change the Determination of Need (DON) tool or the Service Cost Maximums. Statewide training was provided to Care Coordinators in April 2013. The Department has established a review process to ensure that the eligibility and services authorized are consistent with CCP policies and procedures, and has initiated the process to begin reviews by requesting records from affected CCUs. Staff also complete onsite CCU reviews monthly since November 2013, as a part of the increased efforts to ensure compliance monitoring and improved quality assurance outcomes.

Methodology: In order to establish a baseline for the Department's analysis and ongoing monitoring of the Service Authorization Guidelines (SAG) and the impact on CCP activities and resources, the Department reviewed caseload, DON scores, service authorization and utilization levels for CCP participants who received redetermination and initial assessment for the first Six-month period following the effective date of the policy (i.e., May 1 through October 31, 2013), as compared to the same Six-month period in 2012.

Findings

Overall In-home Service Caseload: Using baseline data from May 2013, the Department examined the authorized and delivered units for the entire caseload receiving in-home service (only) and Determination of Need (DON) scores during which had the following results:

1. The monthly average INH caseload increased by almost 3,748 clients to 76,354 or 5.2%
2. The monthly average DON score decreased by 1.6 points to 48, or 1.2%
3. The monthly average authorized units increased from 58.7 to 59.3, or 1.6 units, or 2.7%

4. The monthly average delivered units increased from 46.9 to 47.9 or 1.0 unit, or 2.3%

INH Clients who received a Redetermination: The data for the six-month period from May 2013 to October 2013, compared with the same period in 2012 also revealed the following findings:

1. Clients are required to receive a re-determination annually to determine their continued eligibility for service and to timely monitor changes in the client's condition. However, a re-de may be conducted earlier if there is a change in the participant's health or a situation that warrants a re-determination. The average number of re-determinations increased by over 283 assessments to an average of almost 5,700 monthly re-determinations or 5.2%. An average of 8% of the caseload received a re-determination during the specified period for 2013, compared to 7.0% during the prior year.
2. The monthly average DON score decreased to 48 by 1 point or 2%.
3. The monthly average authorized units increased to 59 units a month, or 1 unit, or 1.7%
4. The monthly average delivered units remained fairly level at 42 units.

Initial Assessments: The decreasing trend(s) for initial assessments that were observed and reported in the first quarterly report were maintained this quarter as well, or for the six-month period of May thru October 2013. An average of 1,600 initial assessments were conducted monthly, compared to almost 1,900 during the previous year during the same time period. Due to billing data lag, the Department is still continuing its in-depth analysis that will include an examination by CCUs along with field review data. Notwithstanding, the SAG analysis is showing encouraging results when comparing the initial client assessments. The average authorized monthly number of units was 48 (11 units less or -19%), compared to 59 units on average for existing clients in 2013 for the period examined. There was also a notable difference in the average DON score of 43 for new client initials, compared to 48 for existing clients, which is different of 5 points less (-10%). The reduction in initial assessments has a positive effect on slowing the rate of growth, contributing to managing a more sustainable program, and staying with existing FY14 enacted budget.

Conclusion: The early changes observed regarding the Service Authorization Guidelines is a direct correlation to the efforts to improve care coordination; exercise greater control and consistency in developing clients' Plan of Care, and enhanced training. It also demonstrates both the benefits of and the need for increased and ongoing field monitoring presence along with more field staff to maintain reliable quality assurance and oversight of the CCP provider network statewide, and as contractually required. The Community Care Program is still experiencing the expected growth curve in clients. The observed trends with the recent initial assessments, coupled with implementation of Electronic Visit Verification, and clients being transferred to managed care are just some of the major policy initiatives which combined are critical to improve clients care options, enhancing accountability, managing risk, and containing costs, while balancing demand with limited financial resources.