



STATE OF ILLINOIS

OFFICE OF THE AUDITOR GENERAL

REVIEW OF
DEPARTMENT ON AGING'S
COMMUNITY CARE PROGRAM REFORM
IMPLEMENTATION REPORT

MARCH 2014

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OFFICE OF THE AUDITOR GENERAL
WILLIAM G. HOLLAND

To the Legislative Audit Commission, the Speaker and Minority Leader of the House of Representatives, the President and Minority Leader of the Senate, the members of the General Assembly, and the Governor:

This is our Review of the Department on Aging's Community Care Program Reform Implementation Report.

The review was conducted pursuant to Public Act 98-0008 which amended the Illinois State Auditing Act by adding a requirement for the Department on Aging to file a report with the Auditor General no later than July 1, 2013 listing the actions it was planning to take to implement the provisions of Public Act 98-0008. No later than February 1, 2014, the Department was required to submit evidence to the Auditor General showing that it had taken the actions detailed in its July 1, 2013 report. The Auditor General was then required to review the evidence submitted and issue a report by April 1, 2014 as to whether the Department had undertaken the actions listed in its July 1, 2013 report.

The report for this review is transmitted in conformance with Section 5/2-27(c) of the Illinois State Auditing Act.

A handwritten signature in blue ink that reads "William G. Holland". A blue line is drawn from the end of the signature towards the text below it.

WILLIAM G. HOLLAND
Auditor General

Springfield, Illinois
March 2014



STATE OF ILLINOIS
**OFFICE OF THE
AUDITOR GENERAL**

William G. Holland, Auditor General

SUMMARY REPORT DIGEST

**REVIEW OF THE DEPARTMENT ON AGING'S COMMUNITY CARE
PROGRAM REFORM IMPLEMENTATION REPORT**

REVIEW

Release Date: March 26, 2014

SYNOPSIS

Public Act 98-0008 made several changes to the Illinois Act on the Aging to increase the effectiveness of the Community Care Program (CCP) administered by the Department on Aging (Aging). The Act required Aging to file an implementation report with the Auditor General, the Governor, and leaders of the General Assembly by July 1, 2013 identifying actions Aging needed to take to implement the reforms mandated by Public Act 98-0008. The Act further required Aging to provide evidence to the Auditor General by February 1, 2014 that it has undertaken the actions listed in its implementation report. Finally, the Act required the Office of the Auditor General (OAG) to review the evidence submitted by Aging and issue a report to the Governor and legislative leaders no later than April 1, 2014 as to whether Aging took the actions listed in its implementation report.

Aging submitted its required implementation report with the Auditor General on June 27, 2013. The June 27 Report identified 11 provisions of Public Act 98-0008 where Aging officials concluded they needed to take some action to implement. The Report noted that no amendments to the Illinois Title XIX State plan had been made or offered.

As required by Public Act 98-0008, Aging submitted its February 1, 2014 report along with the evidence which it identified as documenting the actions delineated in its June 27, 2013 report. The evidence consisted of 100 documents, including new or revised policies, proposed rules, meeting attendee information and agendas, training presentations, federal approval of payment initiative, etc.

The OAG reviewed the evidence provided by Aging to determine whether it was supportive of the actions that Aging said it had taken. On February 14, 18, and 28, the OAG followed up with Aging with questions concerning the evidence provided and requested additional evidence to support actions taken. Aging provided responses to the OAG's questions, providing over 45 pieces of additional documentation.

Our review concluded that the evidence submitted by Aging generally supported the actions reported by the Department. This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

CONCLUSIONS

BACKGROUND

Public Act 98-0008 required the Department on Aging to file a report with the Auditor General, the Governor, and leaders of the General Assembly by July 1, 2013 that listed any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State policy changes and notifications required to implement the Act.

On April 25, 2013, the General Assembly passed House Bill 2275 which was signed into law by the Governor on May 3, 2013 as Public Act 98-0008. The Act made several changes to the Illinois Act on the Aging to increase the effectiveness of the Community Care Program (CCP) administered by the Department on Aging (Aging).

Public Act 98-0008 also amended the Illinois State Auditing Act adding a section titled “Certification of Community Care Program reform implementation” that required Aging to file an implementation report with the Auditor General, the Governor, and leaders of the General Assembly by July 1, 2013. The report was to list any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State policy changes and notifications required to implement the Act.

The Act further required Aging to provide evidence to the Auditor General by February 1, 2014 that it has undertaken the actions listed in its implementation report. Finally, the Act required the Office of the Auditor General (OAG) to review the evidence submitted by Aging and issue a report to the Governor and legislative leaders no later than April 1, 2014 as to whether Aging took the actions listed in its implementation report. (pages 1-3)

AGING'S JUNE 27, 2013 CCP REFORM IMPLEMENTATION REPORT

Aging submitted its required implementation report with the Auditor General on June 27, 2013.

Aging submitted its required implementation report with the Auditor General on June 27, 2013. The June 27 Report identified 11 provisions of Public Act 98-0008 where Aging officials concluded they needed to take some action to implement. The Report noted that no amendments to the Illinois Title XIX State plan had been made or offered.

The 11 provisions in Public Act 98-0008 for which Aging determined it needed to take some action were as follows:

- 20 ILCS 105/4.01(2-a): Provide data sharing and requested employment information verification for CCP providers;
- 20 ILCS 105/4.02(7): Balance Incentive Payment Program (BIP) – CCP effectiveness under Medicaid waiver;
- 20 ILCS 105/4.02(9): Service authorization guidelines for in-home service;

- 20 ILCS 105/4.02(10): Medicaid waiver enrollment and claiming improvements;
- 20 ILCS 105/4.02(11): Seven-minute rounding policy clarification;
- 20 ILCS 105/4.02(12): Coordinated (i.e., managed care) enrollment;
- 20 ILCS 105/4.02(13): Maintain existing (FY13) CCP rate in FY14;
- 20 ILCS 105/4.02(new): Electronic visit verification (EVV);
- 20 ILCS 105/4.02(new): Reporting requirements/bi-monthly reporting;
- 20 ILCS 105/4.02(new): CCP providers non-compliance; and
- 30 ILCS 5/2-27(new): Certification of CCP reforms. (pages 3, 4)

OAG REVIEW OF AGING'S FEBRUARY 1, 2014 SUBMISSION

As required by Public Act 98-0008, Aging submitted its February 1, 2014 report along with the evidence which it identified as documenting the actions delineated in its June 27, 2013 report.

As required by Public Act 98-0008, Aging submitted its February 1, 2014 report along with the evidence which it identified as documenting the actions delineated in its June 27, 2013 report. The evidence consisted of 100 documents, including new or revised policies, proposed rules, meeting attendee information and agendas, training presentations, federal approval of payment initiative, etc.

The OAG reviewed the specific evidence provided by Aging to determine whether it was supportive of the actions that Aging said it had taken. On February 14, 18, and 28, the OAG followed up with Aging with questions concerning the evidence provided and requested additional evidence to support actions taken. Aging provided responses to the OAG's questions on February 25 and March 5, providing over 45 pieces of additional documentation.

Our review concluded that the evidence submitted by Aging generally supported the actions reported by the Department.

Our review concluded that the evidence submitted by Aging generally supported the actions reported by the Department. (pages 4-16)

SCOPE OF REVIEW

The Office of the Auditor General conducted this review pursuant to the Illinois State Auditing Act (30 ILCS 5/2-27). This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

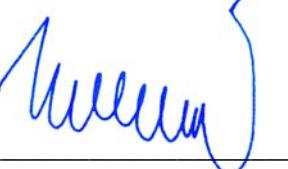
Our review of the information provided by the Department on Aging in conjunction with its February 1, 2014 Report consisted of the following:

- Verified that the statutory provisions that Aging identified as requiring action in its June 27, 2013 Report were addressed in its February 1 Report; and
- Determined whether the evidence provided supported the actions Aging reported taking for each of the Community Care Program reform provisions to which it was referenced.

The scope of our review focused on reviewing the information submitted by the Department and not conducting direct audit tests of such information. We did not make a determination as to whether there were additional provisions in the CCP reform legislation that required further action by the Department.

(page 16)

Aging was provided a draft of this report for their review.



WILLIAM G. HOLLAND
Auditor General

WGH:JS

This Review was conducted by OAG staff.

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Review

Department on Aging's Community Care Program Reform Implementation Report

REPORT CONCLUSIONS

On April 25, 2013, the General Assembly passed House Bill 2275 which was signed into law by the Governor on May 3, 2013 as Public Act 98-0008. The Act made several changes to the Illinois Act on the Aging to increase the effectiveness of the Community Care Program (CCP) administered by the Department on Aging (Aging).

Public Act 98-0008 also amended the Illinois State Auditing Act adding a section titled “Certification of Community Care Program reform implementation” that required Aging to file an implementation report with the Auditor General, the Governor, and leaders of the General Assembly by July 1, 2013. The report was to list any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State policy changes and notifications required to implement the Act. The Act further required Aging to provide evidence to the Auditor General by February 1, 2014 that it has undertaken the actions listed in its implementation report. Finally, the Act required the Office of the Auditor General (OAG) to review the evidence submitted by Aging and issue a report to the Governor and legislative leaders no later than April 1, 2014 as to whether Aging took the actions listed in its implementation report.

Aging submitted its required implementation report with the Auditor General on June 27, 2013. The June 27 Report identified 11 provisions of Public Act 98-0008 where Aging officials concluded they needed to take some action to implement. As required by Public Act 98-0008, Aging filed a report with the OAG dated February 1, 2014 which summarized actions taken to implement the requirements of Public Act 98-0008. Along with the Report, Aging provided 100 documents as evidence of the actions taken.

We reviewed the evidence submitted and followed up with Aging, asking for additional evidence to support the actions listed in the June 27 and February 1 Reports. Our review concluded that the evidence submitted by Aging generally supported the actions reported by the Department. This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

BACKGROUND

On April 25, 2013, the General Assembly passed House Bill 2275 which was signed into law by the Governor on May 3, 2013 as Public Act 98-0008. The Act made several changes to the Illinois Act on the Aging to increase the effectiveness of the

Community Care Program administered by the Department on Aging (Aging). Some of the changes required by Public Act 98-0008 included:

- Improve the sharing of data among agencies that is useful in establishing and verifying the initial and continued eligibility of older adults to participate in programs administered by the Department on Aging;
- Implement a Service Authorization policy that ensures eligibility and services are authorized accurately and consistently in the Community Care Program;
- Implement electronic service verification technology to help improve controls over the in-home services provided; and
- Work to bring about improvements in Medicaid claiming processes and Medicaid enrollment procedures.

Public Act 98-0008 also amended the Illinois State Auditing Act adding a section titled “Certification of Community Care Program reform implementation” that required Aging to file a report with the Auditor General, the Governor, and leaders of the General Assembly by July 1, 2013. The report was to list any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State Policy changes and notifications required to implement the Act (see inset). Aging filed its required report with the Auditor General on June 27, 2013, in compliance with the Act [June 27 Report].

The Act further required Aging to provide evidence to the Auditor General by February 1, 2014 that it has undertaken the actions listed in its June 27 Report. Aging filed the report required by February 1, 2014 [February 1 Report], which summarized actions taken to implement the requirements of Public Act 98-0008 and provided 100 documents as evidence of the actions taken. Finally, the Act required the Auditor General to review the evidence submitted by Aging

PUBLIC ACT 98-0008 REVISION TO THE ILLINOIS STATE AUDITING ACT

Section 9. The Illinois State Auditing Act is amended by adding Section 2-27 as follows:

Sec. 2-27. Certification of Community Care Program reform implementation.

(a) No later than July 1, 2013, the Department on Aging shall file a report with the Auditor General, the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate listing any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State Policy changes and notifications required to implement this amendatory Act of the 98th General Assembly.

(b) No later than February 1, 2014, the Department on Aging shall provide evidence to the Auditor General that it has undertaken the required actions listed in the report required by subsection (a).

(c) No later than April 1, 2014, the Auditor General shall submit a report to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate as to whether the Department on Aging has undertaken the required actions listed in the report required by subsection (a).

Source: Illinois State Auditing Act (30 ILCS 5/2-27)

and issue a report to the Governor and legislative leaders no later than April 1, 2014 as to whether Aging took the actions listed in its June 27, 2013 Report.

AGING’S JUNE 27, 2013 COMMUNITY CARE PROGRAM REFORM IMPLEMENTATION REPORT

Aging submitted the Report required by Public Act 98-0008 to the Office of the Auditor General on June 27, 2013 (see Appendix B). The June 27 Report identified provisions of Public Act 98-0008 that Aging determined required it to take action to implement the Act’s new requirements. The Report noted that no amendments to the Illinois Title XIX State plan had been made or offered.

The June 27 Report listed 11 provisions in Public Act 98-0008 where Aging determined it needed to take some action. The 11 provisions were as follows:

- 20 ILCS 105/4.01(2-a): Provide data sharing and requested employment information verification for CCP providers;
- 20 ILCS 105/4.02(7): Balance Incentive Payment Program (BIP) – CCP effectiveness under Medicaid waiver;
- 20 ILCS 105/4.02(9): Service authorization guidelines for in-home service;
- 20 ILCS 105/4.02(10): Medicaid waiver enrollment and claiming improvements;
- 20 ILCS 105/4.02(11): Seven-minute rounding policy clarification;
- 20 ILCS 105/4.02(12): Coordinated (i.e., managed care) enrollment;
- 20 ILCS 105/4.02(13): Maintain existing (FY13) CCP rate in FY14;
- 20 ILCS 105/4.02(new): Electronic visit verification (EVV);
- 20 ILCS 105/4.02(new): Reporting requirements/bi-monthly reporting;
- 20 ILCS 105/4.02(new): CCP providers non-compliance; and
- 30 ILCS 5/2-27(new): Certification of CCP reforms.

On January 31, 2014, Aging filed the report required by February 1, 2014 (see Appendix C). For 10 of the 11 provisions included in the June 27 Report, Aging provided a summary of actions taken and submitted evidence to document such actions. There was one provision in the June 27 Report that was not included in the February 1 Report -- Certification of CCP reforms. We followed up with Aging as to why that provision was not addressed. Aging officials responded that its filing of the June 27, 2013 Report, which listed the actions it determined were necessary to implement Public Act 98-0008, satisfied the Act’s requirement regarding the certification of the Community Care Program reform implementation. Therefore, since the requirement was satisfied, it was not repeated in the February 1 report.

The February 1, 2014 Report contained two provisions that were not on the June 27 Report. The first one dealt with quarterly reporting on Care Coordination Unit’s

(CCU) performance and adherence to service guidelines; the second dealt with the prior CCP liability payment cap. We will review those two provisions in the following section.

OAG REVIEW OF EVIDENCE SUBMITTED BY AGING

As required by Public Act 98-0008, on January 31, 2014 Aging submitted evidence which it identified as documenting the actions delineated in its June 27, 2013 report. The evidence consisted of 100 documents, including new or revised policies, proposed rules, meeting attendee information and agendas, training presentations, federal approval of payment initiative, etc.

As part of our review, we examined the February 1, 2014 Report to determine whether Aging made significant changes in the “required actions” from those that were delineated in its June 27 Report. The OAG reviewed the specific evidence provided by Aging to determine whether it was supportive of the actions that Aging said it had taken. On February 14, 18, and 28, the OAG followed up with Aging with questions concerning the evidence provided and requested additional evidence to support actions taken. Aging provided responses to the OAG’s questions on February 25 and March 5, providing over 45 pieces of additional documentation.

Our review concluded that the evidence submitted by Aging generally supported the actions reported by the Department. This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

OAG Review of Evidence Submitted

For each of the provisions identified by Aging in its February 1 Report as requiring action, the following section summarizes the relevant statutory requirement in Public Act 98-0008, the actions Aging stated in its February 1 Report it took to implement the requirement, and the OAG’s review of the evidence provided by Aging to determine whether it supported the actions Aging reported taking.

Data Sharing

Requirement: (20 ILCS 105/4.01(2-a) *To request, receive, and share information electronically through the use of data-sharing agreements for the purpose of (i) establishing and verifying the initial and continuing eligibility of older adults to participate in programs administered by the Department; (ii) maximizing federal financial participation in State assistance expenditures; and (iii) investigating allegations of fraud or other abuse of publicly funded benefits. The Act expressly authorizes the exchanges of income, identification, and other pertinent eligibility information by and among the Department on Aging, the Social Security Administration, the Departments of Employment Security, Healthcare and Family Services, Human Services, and Revenue, the Secretary of State, U.S. Dept. of Veterans Affairs, and any other governmental entity.*

The Act also requires Aging to verify employment information at the request of a community care provider for the purpose of ensuring program integrity.

Actions listed by Aging in February 1 Report: Aging reported that the interagency data sharing agreements it determined to be necessary to enhance the verification and eligibility determination processes have been signed, with the exception of two agreements – one with the Social Security Administration and one with the Department of Revenue. However, the same day Aging submitted its February 1 report, the Social Security Administration signed an agreement with Aging, which was subsequently provided to the OAG. Regarding an agreement with Revenue, Aging reported that repeated attempts have been made requesting the Director of the Department of Revenue to sign the intergovernmental agreement between the Departments on Aging, Healthcare and Family Services, and Human Services with unsuccessful results to-date.

OAG Review of Evidence Submitted: Aging submitted data sharing agreements with the Social Security Administration, Department of Employment Security, and a 2004 agreement with the Department of Public Aid which addressed interactions between the two agencies. An agreement was also provided between Aging, HFS, DHS and Revenue. The purpose of the agreement was to “*request, receive, and share information with HFS, IDOR, and DHS, for the limited purposes of (i) establishing and verifying the initial and continuing eligibility of older adults to participate in programs administered by IDoA; (ii) maximizing federal financial participation in State assistance expenditures; and (iii) investigating allegations of fraud or other abuse of publicly funded benefits. . . .*” While the Directors of Aging, Healthcare and Family Services, and Human Services signed the agreement, the Director of the Department of Revenue had not.

In its February 1 Report, Aging noted that several unsuccessful attempts have been made to get the Department of Revenue to sign the interagency agreement related to the CCP reform legislation. We requested additional evidence from Aging regarding its attempts to obtain a signed agreement with Revenue. Aging provided a series of emails between Aging and Revenue showing that although both agencies were working on the interagency agreement, as of January 31, one had not been signed. In a January 30, 2014 email to the Director of Revenue, the Aging Director stated that Aging was “at the ‘crisis’ point and need the ability to electronically apply state income information to the Benefit Access application. My department simply does not have the resources to manually verify income information any longer. . . . As we’ve discussed, Aging will put in writing and in practice, all the necessary data controls mandated by Revenue.”

The OAG followed up with Revenue as to the status of the interagency agreement. A Revenue official stated that Revenue takes data security very seriously and is undertaking a review of all interagency agreements and how agencies secure their data, including the Department on Aging. Revenue noted that it continues to be committed to and supports the Department on Aging’s acquisition of data needed to carry out its programs and will work with Aging to give Revenue the assurances it needs that taxpayer information will be appropriately safeguarded.

Since the interagency agreement has not been signed, we followed up with Aging to determine whether Aging staff were still manually verifying income information. Aging’s response was that at present, there is limited data-sharing between Aging and Revenue for processing purposes. On a weekly basis, Aging sends Revenue a list of applicants by their Social Security Numbers and Revenue provides Aging with information about the Adjusted Gross Income (AGI) listed on their income tax returns using individual “Y” or “N” indicators. If a ‘Y’ is reported, Aging requires the applicant to send in a copy of his or her tax return, which is then manually reviewed by staff to determine eligibility.

Aging officials went on to say that Aging received over 160,000 applications in calendar year 2013. This year, Aging is rolling out several new initiatives, including Managed Care, which will require the reassignment of staff, so it will no longer be possible to manually verify income information. They stated that Aging must have the ability to use income tax information in an electronic format to ensure that fraud, waste and abuse are prevented. Aging is requesting that Revenue’s and Aging’s respective IT staff work together to determine an acceptable process: 1) to identify an applicant and his or her adjusted gross income for the past two calendar years; and 2) to access the most current tax return of an applicant whose reported income and Adjusted Gross Income do not match.

Our review determined that Aging had not submitted data sharing agreements with two additional agencies identified in Public Act 98-0008 – the Office of Secretary of State and the U.S. Dept. of Veterans Affairs. We followed up with Aging as to why these agreements were not enacted. Aging officials stated that Aging does not believe the agreements are needed. According to Aging officials, an agreement with Veterans Affairs was not pursued because veterans’ benefits are accessed through the Department of Employment Security. Aging provided a shared data agreement request and signed IDES agreement. Aging officials stated they do not access or need information from the Secretary of State.

We asked Aging whether the data sharing under these agreements was occurring as envisioned by Public Act 98-0008 and to provide evidence to show that the data sharing is ongoing (with the SSA, DES, HFS, DHS) and how it is used by Aging. The verification of client information is critical to ensure that benefits are approved only for those who qualify for the program. This process also provides support, monitoring and quality assurance to the Community Care Program participants that are being transferred into managed care.

Aging stated they send files daily to Social Security for verification of name, date of birth, social security number, amount of social security benefits being paid if any, and date of disability determination, if applicable. The information is used to verify information received by HFS as well as to verify information for the Benefit Access Application for Aging.

Aging stated they have an agreement to receive a quarterly data file from DES which is used to verify income information reported on the Benefit Access Application.

Aging receives weekly data from HFS/DHS in regard to Managed Care Organizations and related information such as RIN, social security number, enrollment and termination dates, whether a person is enrolled in Medicaid and billing code information. The data received from HFS/DHS is used to verify the information for Community Care Units and Managed Care Organizations when they inquire about client information and to ensure there is continuity of care for the client between the two entities.

We noted that an agreement with the Department of Employment Security was dated 12-14-14 by the Aging Director. We followed up with the Aging officials who stated that it was a scrivener’s error, the date should have been 12-14-12. Aging stated it will work with DES to amend the date, noting the correct date of the signature.

Balance Incentive Payment (BIP) Program

Requirement: (20 ILCS 105/4.02(7)) *The Department shall increase the effectiveness of the existing Community Care Program by ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the State's home and community based services waiver and additional waiver opportunities, including applying for enrollment in the Balance Incentive Payment (BIP) Program by May 1, 2013, in order to maximize federal matching funds.*

Actions listed by Aging in February 1 Report: Aging reported that HFS submitted the BIP application to the federal Centers for Medicare and Medicaid Services (CMS) in March 2013. On June 12, 2013, the State of Illinois received official notification from federal CMS regarding the awarding of the BIP grant. The project period is July 1, 2013, through September 30, 2015. Aging noted that Illinois will receive an enhanced 2 percent match on non-institutional long-term services and supports, estimated at \$90.3 million during the project period.

OAG Review of Evidence Submitted: Aging provided HFS’ application to the federal CMS for the BIP grant, which was submitted on March 27, 2013 and approved on June 12, 2013. Aging also provided Illinois’ BIP funding proposals and a link to the federal CMS web-site showing that the Illinois BIP application was approved.

Service Authorization Guidelines for In-Home Service

Requirement: (20 ILCS 105/4.02(9)) *The Department shall increase the effectiveness of the existing Community Care Program by ensuring that services are authorized accurately and consistently for the Community Care Program (CCP). The Department shall implement a Service Authorization policy directive. The purpose shall be to ensure*

that eligibility and services are authorized accurately and consistently in the CCP program. The policy directive shall clarify service authorization guidelines to Care Coordination Units and Community Care Program providers no later than May 1, 2013.

Actions listed by Aging in February 1 Report: Aging reported that it issued the policy directive for Service Authorization Guidelines policy for Care Coordination Units (CCUs) statewide in April 2013. The overall intent of re-issuing guidelines was to strengthen consistent application of service task approvals across the State and to assure that services are approved according to an individual's need while promoting the participant's health, safety and welfare. Aging stated that the guidelines do not impact the access or eligibility to the CCP, or change the Determination of Need (DON) tool or the Service Cost Maximums. Statewide training was provided to Care Coordinators in April 2013, and the new guidelines took effect May 1, 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 completed three reviews of CCUs. Two CCUs were reviewed during December, and Aging stated its findings indicate that both were compliant with the service authorization guidelines. Three additional reviews were scheduled for January 2014.

OAG Review of Evidence Submitted: Aging submitted the policy directive for the revised Service Authorization Guidelines, as well as a copy of the Service Authorization Guidelines that were effective May 1, 2013. Aging also provided a PowerPoint presentation of the training provided on the Service Authorization Guidelines. We followed up with Aging to request the specific dates when training was held and who attended. Aging provided documentation that showed the training sessions were not held in April, as reported in the February 1, 2014 Report, but rather on May 2 and 3, 2013, and that 39 individuals participated in the training. The participants were from Care Coordination Units and Area Agencies on Aging.

In its February 1 Report, Aging noted that it conducted two reviews at CCUs in December 2013 and that both were compliant with the Service Authorization Guidelines. We reviewed copies of the two reviews provided by Aging – one on-site review and one desk review – and concluded that only the December desk review did not contain a Service Authorization Guidelines noncompliance finding. The December on-site review contained findings of non-compliance with Guidelines. We followed up with Aging regarding the inconsistency between their February 1 Report and our review. Aging confirmed that indeed the December on-site review did find instances of noncompliance with the Guidelines. For the four on-site reviews that have been completed in December and January, Aging responded that the percentage of files reviewed that were compliant with the Service Authorization Guidelines ranged from 67 to 82 percent.

At each of the four reviews where non-compliance was found, Aging stated that guidance was given to the CCU regarding utilization of the Service Authorization Guidelines. As part of each agency's corrective action, training is required to be provided to Care Coordinators regarding the Guidelines and how the CCU was not in compliance.

Agencies are required to submit to Aging documentation of corrective action when it is completed.

In its February 1 Report, Aging stated that three reviews were scheduled in January 2014. In response to our follow-up questions, Aging noted that the correct number of reviews scheduled and conducted in January were two.

Medicaid Waiver Enrollment and Claiming Improvements

Requirement: (20 ILCS 105/4.02(10)) *The Department shall increase the effectiveness of the existing Community Care Program by working in conjunction with Care Coordination Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or rules to insure more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible. The Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements.*

Actions listed by Aging in February 1 Report: Aging reported that it established a stakeholder group that includes DHS, DHS-OIG, CCUs, HFS, and AAAs (Area Agencies on Aging). The stakeholder group has met on October 31, November 14, and December 19, 2013. 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; 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; and 4) streamline the Home and Community Based Services work flow process for the Community Care Program. The stakeholder group continues to meet once a month and implement action steps for change.

OAG Review of Evidence Submitted: Aging submitted an “ABE” (Application for Benefits Eligibility) PowerPoint presentation. Aging also provided a Home and Community Based Services Work Flow for Aging’s CCP program, several listings of Aging/CCU liaisons, and agendas for the November 14 and December 19, 2013 stakeholder meetings.

We followed up with Aging, requesting additional evidence to support its actions, including documentation of the October 31, 2013 stakeholder meeting and what stakeholders participated in these meetings. In its response to our follow-up questions, Aging noted that the first meeting was actually held on November 1, not October 31. The participants at the stakeholder meetings included representatives from the Departments of

Human Services, Aging, and Healthcare and Family Services, as well as CCUs and Area Agencies on Aging. Aging also provided a list of seven recommendations being proposed by the stakeholder group, including the four that were referenced in its February 1 Report. Aging noted in its follow-up response that “None of the recommendations have been implemented to date.” We inquired as to whether any action has been taken on the seven recommendations. Aging officials responded that one of the recommendations was to continue to meet monthly. The group met February 27, 2014 and assignments were given to members of the group to accomplish. Currently, the timetable for completion has not been set but the group plans to start implementation of said recommendations as soon as possible.

Aging’s June 27, 2013 Report mentioned two additional activities to address the Medicaid Waiver Enrollment and Claiming Improvements requirement which were not addressed in the February 1, 2014 report. We followed up with Aging to determine the status of these activities. The first was that the June 27 report stated that Aging was working with DHS and CCUs to make improvements to the Medicaid claiming/enrollment procedures by granting CCUs access the DHS Public Aid Client Information System (PACIS) system. According to Aging officials, access to PACIS allows staff to inquire about benefits and wage information by social security number.

In response to our follow-up, Aging stated that IDOA has worked with DHS to assist in providing the CCUs access to PACIS. Aging provided a chart that describes where each CCU is at in the process of receiving PACIS. DHS plays a major role in granting PACIS access to the CCUs. Aging noted that the process for receiving access has been cumbersome and slow especially with the implementation of DHS’ ABE and IES system.

The second activity listed in the June 27 Report which was not on the February 1, 2014 report was the “Root Cause Analysis Project” (RCAP). The June 27 report noted the purpose of the project, initiated in February 2013, was to understand the barriers that prevent timely enrollment into Federal Medical Assistance Percentage (FMAP), as well as to implement solutions to better ensure enrollment of CCP clients who appear to be Medicaid eligible but currently are not. CCUs were surveyed to identify related causes. Aging provided the OAG with several documents related to the RCAP project, including actions taken by DHS and Aging to address problems identified by the Project.

Seven Minute Rounding Policy Clarification

Requirement: (20 ILCS 105/4.02(11)) *The Department shall increase the effectiveness of the existing Community Care Program by requiring home care service providers to comply with the rounding of hours worked provisions under the federal Fair Labor Standards Act (FLSA) and as set forth in 29 CFR 785.48(b) by May 1, 2013.*

Actions listed by Aging in February 1 Report: Aging reported 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 noted that it has conducted 44 Quality Improvement Reviews of in-home service provider agreements and that none of the reviews showed a lack of compliance with the 7-minute rounding policy.

OAG Review of Evidence Submitted: Aging submitted a policy titled “Entering Daily Units into the electronic Community Care Program Information System (eCCPIS) using 7 Minute Rounding Increments”. The policy had an effective date of May 1, 2013.

We asked Aging to provide additional evidence showing that it has been monitoring agencies’ compliance with the monitoring of hours and that no instances of non-compliance have been noted. Aging provided a copy of a completed Quality Improvement Review and identified the items on the checklist where non-compliance with the 7 minute rounding requirement would be noted. We also asked Aging for a listing of the 44 agencies where a Quality Improvement Review was conducted. Aging provided a listing of the agencies noting that the correct number of agencies with a completed Quality Improvement Review was 43, not 44 as stated in its February 1 Report.

Coordinated Enrollment (i.e., Managed Care)

Requirement: (20 ILCS 105/4.02(12)) *The Department shall increase the effectiveness of the existing Community Care Program by implementing any necessary policy changes or promulgating any rules, no later than January 1, 2014, to assist the Department of Healthcare and Family Services in moving as many participants as possible, consistent with federal regulations, into coordinated care plans if a care coordination plan that covers long term care is available in the recipient's area.*

Actions listed by Aging in Feb. 1, 2014 report: Aging reported that 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.

OAG Review of Evidence Submitted: Aging submitted several policy revisions which dealt with transferring CCP clients to managed care programs. For example, one policy titled “Transferring Current CCP Participants to Managed Care Organizations (MCOs)”, dated January 16, 2014, was created to notify CCUs of the procedure for transferring CCP participants to the State of Illinois’ Managed Care Organizations. Another policy was a July 23, 2013 policy informing CCUs of the procedure for determining eligibility for Home and Community Based waiver services for Managed Care Organization participants.

We followed up with Aging and requested additional documentation that was referred to in its February 1 Report. Aging subsequently provided emails showing bi-weekly

meetings with HFS. They also provided a copy of the “Managed Care Organizations Webinar for CCUs”, dated January 15, 2014 and dates of training.

Maintain Existing (FY13) CCP Rate in FY14

Requirement: (20 ILCS 105/4.02(13)) *The Department shall increase the effectiveness of the existing Community Care Program by maintaining fiscal year 2014 rates at the same level established on January 1, 2013.*

Actions listed by Aging in February 1 Report: All current CCP fee-for-service rates remain unchanged at the FY13 level.

OAG Review of Evidence Submitted: Aging submitted a listing of CCP billing rates for FY14. The listing showed that the FY14 rates were unchanged from FY13 levels.

Electronic Visit Verification

Requirement: (20 ILCS 105/4.02) *The Department shall implement an electronic service verification based on global positioning systems or other cost-effective technology for the Community Care Program no later than January 1, 2014.*

Actions listed by Aging in February 1 Report: Aging reported that 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. Aging reported that the EVV standards were distributed to the provider network on April 1, 2013 and 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.

As of January 31, 2014, Aging reported that 105 of the current 107 in-home service providers submitted compliance certification. All together, they provided 99.97 percent of the 40 million in-home service units that were delivered in FY13. Pursuant to data collected from the certification filings, providers are using telephony (44%), mobile technology (32%) and/or fixed visit verification devices (24%) to record the sign-in and sign-out time of all visits by home care aides who provide direct services within the residence of CCP participants.

OAG Review of Evidence Submitted: Aging submitted correspondence that was sent to Community Care Program participants that received in-home services as well as homecare aides informing them of the new EVV requirements as well as non-compliance notices sent to CCP providers. Aging provided a spreadsheet which listed 107 Community Care Providers and whether they were compliant as of January 7, 2014.

There were 107 providers listed, of which 6 were noted as not yet being compliant with the EVV requirement as of January 7, 2014. We followed up with Aging and obtained support showing that as of February 20, 2014, there were only two providers that were non-compliant.

Aging also submitted the Electronic Visit Verification Certification Guidelines, effective July 1, 2013, along with several other policy and procedure memos related to a CCP participant’s verification of services provided, setting standards for EVV systems, and guidelines to complete the certification process. Procurement related documents were also submitted, including an RFP issued by the Departments on Aging and Human Services for an electronic service/visit verification (EVV) and timekeeping system for home care services. Finally, Aging submitted drafts of rules establishing EVV requirements. The citation for the adopted EVV rulemaking project is 38 Ill. Reg. 5800 (March 7, 2014). The effective date of the rulemaking was February 21, 2014.

Reporting Requirements/Bi-Monthly Reporting

Requirement: (20 ILCS 105/4.02) *The Department shall provide a bi-monthly report on the progress of the Community Care Program reforms set forth in this amendatory Act of the 98th General Assembly to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.*

Actions listed by Aging in February 1 Report: Aging reported that it has filed reports on a bi-monthly basis.

OAG Review of Evidence Submitted: Aging submitted four bi-monthly reports that are addressed to the Governor and members of the General Assembly: July 1, 2013 (dated June 27, 2013); September 1, 2013 (dated August 29, 2013); November 1, 2013; and January 1, 2014. The reports list the various actions Aging is taking to implement the reforms required by Public Act 98-0008.

CCP Providers Submission of Bills or Invoices

Requirement: (20 ILCS 105/4.02) *In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.*

Actions listed by Aging in February 1 Report: Aging reported that this provision has been met, noting that as reported in prior bi-monthly reports, the Department's online

billing system for Vendor Requests for Payment was modified to contain certification language referring to a physical notarized statement.

OAG Review of Evidence Submitted: Aging submitted a Billing Certification Form that each eCCPIS (Community Care Program Information System) user is required to complete. The Form contains a certification which states that under penalty of perjury, the submitter has reviewed the billing information and that it is true, accurate, and complete. The submitter also agrees to cooperate with the Department to resolve verification and audit issues, as well as inform the Department promptly if errors are subsequently discovered. The Form then has a place for a notary to sign.

Aging also provided a screen shot of a billing page on its eCCPIS system. The billing page does not contain language referring to a notarized statement. When we followed up with Aging, they noted that a notarized form is not required to be submitted with each electronic billing. However, Aging noted that controls are in place which prevents someone who does not have a notarized statement on file from billing the Department for services. Aging stated that anywhere billing data is submitted through the eCCPIS system, there is one common statement that people agree to prior to submission.

Although this statement does not mention the Notarized Certification form, a user cannot see this statement or agree to it unless they have submitted a Billing Certification Form (containing the notarized statement) and are authorized to use the system in the first place.

Quarterly Reviews

Requirement: (20 ILCS 105/4.02) *The Department shall conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The quarterly review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. The Department shall collect and report longitudinal data on the performance of each care coordination unit.*

Actions listed by Aging in February 1 Report: Aging reported that the first quarterly review of Care Coordination Unit performance and adherence to service guidelines was completed, summarized and submitted in the November 2013 report. The next quarterly review will be addressed in the February 28, 2014 report.

OAG Review of Evidence Submitted: The February 1 report noted that the evidence submitted to support the actions taken included the November 1, 2013 Report to the General Assembly and supporting analysis. While Aging provided the November report sent to the Governor and the General Assembly which contained a “Quarterly Report” section discussing Aging’s review of CCU performance, the supporting analysis was not provided. We followed up with Aging and Aging subsequently provided a document titled “Service Authorization Guidelines DON Dump Analysis of Redeterminations and Initial Assessments by CCUs for the months of May, June, and July 2013 over the same

period of the previous year”. The document contained statistics supporting numbers presented in Aging’s November 1 Report.

The statute requires Aging to “collect and **report** longitudinal data **of each** care coordination unit.” [emphasis added]. The November 1 report contains summary information but does not provide a break down for each CCU. Aging stated that they played an active part in the negotiation of the legislation and that statute does not require the reporting on each CCU. Particularly regarding the issue of providing reports and data specific to each CCU, Aging believes that the legislative intent did not require them to disclose individual CCUs. In certain areas in the State there are single CCU entities representing the region.

The November 1 report also states that “Staff will complete on site CCU reviews **each month beginning in November . . .**” [emphasis added] However, Aging provided evidence in their February 1 report of only one on-site review conducted in November. A December review was provided, but it was a desk review. We followed up with Aging to determine whether on-site reviews were conducted in December and January, as alluded to in its February 1 Report. Aging provided documentation showing that three additional on-site reviews were conducted: one in December and two in January.

As noted earlier, this requirement was not listed in Aging’s June 27, 2013 report. We asked Aging for an explanation as to why this requirement was not on the June 27 report. Aging stated that the Department did not have baseline data available for the June report, since the Service Authorization Guideline policy went into effect on May 1, 2013. Aging noted that the first quarterly review of CCU performance was issued in their November 1, 2013 bi-monthly report.

Prior CCP Liability Payment Cap

Requirement: *30 ILCS 105/25(b-9) Medical payments not exceeding \$150,000,000 may be made by the Department on Aging from its appropriations relating to the Community Care Program for fiscal year 2014, without regard to the fact that the medical services being compensated for by such payment may have been rendered in a prior fiscal year, provided the payments are made on a fee-for-service basis consistent with requirements established for Medicaid reimbursement by the Department of Healthcare and Family Services, except as required by subsection (j) of this Section.*

Actions listed by Aging in February 1 Report: Aging reported that this provision has been met. The Department’s FY14 budget does not have prior year billing provisions in the appropriation. Aging stated it has communicated to providers the urgency of billing promptly, and that failure to submit FY14 bills prior to the end of the FY14 lapse period would require vendors to seek payment from the Court of Claims.

OAG Review of Evidence Submitted: Aging submitted a letter sent to providers regarding FY13 and FY14 billings. We followed up with Aging inquiring why this

provision was not included in the June 27, 2013 Report. Aging responded that this provision was not reported in the June 2013 Report since the Department’s FY14 budget did not have prior year billing provisions in the appropriation. However, Aging intended to report on each provision in the law for the February 2014 report to the Auditor General. Aging noted that it does not have a re-appropriated line in the FY14 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 Aging to pay prior years’ liability through FY12. The second supplemental appropriation of \$142,000,000 provided the Department sufficient funds to pay for services provided through June 30, 2013.

SCOPE OF REVIEW

The Office of the Auditor General conducted this review pursuant to the Illinois State Auditing Act (30 ILCS 5/2-27). This report does not constitute an audit as that term is defined in generally accepted government auditing standards.

Our review of the information provided by the Department on Aging in conjunction with its February 1, 2014 Report consisted of the following:

- Verified that the statutory provisions that Aging identified as requiring action in its June 27, 2013 Report were addressed in its February 1 Report; and
- Determined whether the evidence provided supported the actions Aging reported taking for each of the Community Care Program reform provisions to which it was referenced.

As directed by Section 2-27 of the Illinois State Auditing Act, our review focused on whether the Department had taken the action reported on its June 27, 2013 Report. Evidence of actions taken generally consisted of many types of documentation, including new or revised policies, proposed rules, meeting attendee information and agendas, training presentations, federal approval of payment initiative, etc. We followed up with Aging when we had questions concerning the evidence submitted, or if we concluded that the evidence submitted did not adequately address the actions the Department stated it took.

The scope of our review focused on reviewing the information submitted by the Department and not conducting direct audit tests of such information. We did not make a determination as to whether there were additional provisions in the CCP reform legislation that required further action by the Department or whether the actions taken by the Department fully addressed the intent of Public Act 98-0008.

The Department on Aging was provided a draft of this report for their review.

APPENDIX A

Public Act 98-0008

AN ACT concerning State government.

**Be it enacted by the People of the State of Illinois,
represented in the General Assembly:**

Section 5. The Illinois Act on the Aging is amended by changing Sections 4.01 and 4.02 as follows:

(20 ILCS 105/4.01) (from Ch. 23, par. 6104.01)

Sec. 4.01. Additional powers and duties of the Department. In addition to powers and duties otherwise provided by law, the Department shall have the following powers and duties:

. (1) To evaluate all programs, services, and facilities for the aged and for minority senior citizens within the State and determine the extent to which present public or private programs, services and facilities meet the needs of the aged.

(2) To coordinate and evaluate all programs, services, and facilities for the Aging and for minority senior citizens presently furnished by State agencies and make appropriate recommendations regarding such services, programs and facilities to the Governor and/or the General Assembly.

(2-a) To request, receive, and share information electronically through the use of data-sharing agreements for the purpose of (i) establishing and verifying the initial and continuing eligibility of older adults to participate in programs administered by the Department; (ii) maximizing federal financial participation in State assistance expenditures; and (iii) investigating allegations of fraud or other abuse of publicly funded benefits. Notwithstanding any other law to the contrary, but only for the limited purposes identified in the preceding sentence, this paragraph (2-a) expressly authorizes the exchanges of income, identification, and other pertinent eligibility information by and among the Department and the Social Security Administration, the Department of Employment Security, the Department of Healthcare and Family Services, the Department of Human Services, the Department of Revenue, the Secretary of State, the U.S. Department of Veterans Affairs, and any other governmental entity. The confidentiality of information otherwise shall be maintained as required by law. In addition, the Department on Aging shall verify employment information at the request of a community care provider for the purpose of ensuring program integrity under the Community Care Program.

(3) To function as the sole State agency to develop a comprehensive plan to meet the needs of the State's senior citizens and the State's minority senior citizens.

(4) To receive and disburse State and federal funds made available directly to the Department including those funds made available under the Older Americans Act and the Senior Community Service Employment Program for providing services for senior citizens and minority senior citizens or for purposes related thereto, and shall develop and administer any

State Plan for the Aging required by federal law.

(5) To solicit, accept, hold, and administer in behalf of the State any grants or legacies of money, securities, or property to the State of Illinois for services to senior citizens and minority senior citizens or purposes related thereto.

(6) To provide consultation and assistance to communities, area agencies on aging, and groups developing local services for senior citizens and minority senior citizens.

(7) To promote community education regarding the problems of senior citizens and minority senior citizens through institutes, publications, radio, television and the local press.

(8) To cooperate with agencies of the federal government in studies and conferences designed to examine the needs of senior citizens and minority senior citizens and to prepare programs and facilities to meet those needs.

(9) To establish and maintain information and referral sources throughout the State when not provided by other agencies.

(10) To provide the staff support that may reasonably be required by the Council.

(11) To make and enforce rules and regulations necessary and proper to the performance of its duties.

(12) To establish and fund programs or projects or experimental facilities that are specially designed as alternatives to institutional care.

(13) To develop a training program to train the counselors presently employed by the Department's aging network to provide Medicare beneficiaries with counseling and advocacy in Medicare, private health insurance, and related health care coverage plans. The Department shall report to the General Assembly on the implementation of the training program on or before December 1, 1986.

(14) To make a grant to an institution of higher learning to study the feasibility of establishing and implementing an affirmative action employment plan for the recruitment, hiring, training and retraining of persons 60 or more years old for jobs for which their employment would not be precluded by law.

(15) To present one award annually in each of the categories of community service, education, the performance and graphic arts, and the labor force to outstanding Illinois senior citizens and minority senior citizens in recognition of their individual contributions to either community service, education, the performance and graphic arts, or the labor force. The awards shall be presented to 4 senior citizens and minority senior citizens selected from a list of 44 nominees compiled annually by the Department. Nominations shall be solicited from senior citizens' service providers, area agencies on aging, senior citizens' centers, and senior citizens' organizations. The Department shall establish a central location within the State to be designated as the Senior Illinoisans Hall of Fame for the public display of all the annual awards, or replicas thereof.

(16) To establish multipurpose senior centers through area agencies on aging and to fund those new and existing multipurpose senior centers through area agencies on aging, the establishment and funding to begin in such areas of the State as the Department shall designate by rule and as specifically

appropriated funds become available.

(17) To develop the content and format of the acknowledgment regarding non-recourse reverse mortgage loans under Section 6.1 of the Illinois Banking Act; to provide independent consumer information on reverse mortgages and alternatives; and to refer consumers to independent counseling services with expertise in reverse mortgages.

(18) To develop a pamphlet in English and Spanish which may be used by physicians licensed to practice medicine in all of its branches pursuant to the Medical Practice Act of 1987, pharmacists licensed pursuant to the Pharmacy Practice Act, and Illinois residents 65 years of age or older for the purpose of assisting physicians, pharmacists, and patients in monitoring prescriptions provided by various physicians and to aid persons 65 years of age or older in complying with directions for proper use of pharmaceutical prescriptions. The pamphlet may provide space for recording information including but not limited to the following:

- (a) name and telephone number of the patient;
- (b) name and telephone number of the prescribing physician;
- (c) date of prescription;
- (d) name of drug prescribed;
- (e) directions for patient compliance; and
- (f) name and telephone number of dispensing pharmacy.

In developing the pamphlet, the Department shall consult with the Illinois State Medical Society, the Center for Minority Health Services, the Illinois Pharmacists Association and senior citizens organizations. The Department shall distribute the pamphlets to physicians, pharmacists and persons 65 years of age or older or various senior citizen organizations throughout the State.

(19) To conduct a study of the feasibility of implementing the Senior Companion Program throughout the State.

(20) The reimbursement rates paid through the community care program for chore housekeeping services and home care aides shall be the same.

(21) From funds appropriated to the Department from the Meals on Wheels Fund, a special fund in the State treasury that is hereby created, and in accordance with State and federal guidelines and the intrastate funding formula, to make grants to area agencies on aging, designated by the Department, for the sole purpose of delivering meals to homebound persons 60 years of age and older.

(22) To distribute, through its area agencies on aging, information alerting seniors on safety issues regarding emergency weather conditions, including extreme heat and cold, flooding, tornadoes, electrical storms, and other severe storm weather. The information shall include all necessary instructions for safety and all emergency telephone numbers of organizations that will provide additional information and assistance.

(23) To develop guidelines for the organization and implementation of Volunteer Services Credit Programs to be administered by Area Agencies on Aging or community based senior service organizations. The Department shall hold public hearings on the proposed guidelines for public comment, suggestion, and determination of public interest. The guidelines shall be based on the findings of other states and of community organizations in Illinois that are currently

operating volunteer services credit programs or demonstration volunteer services credit programs. The Department shall offer guidelines for all aspects of the programs including, but not limited to, the following:

- (a) types of services to be offered by volunteers;
- (b) types of services to be received upon the redemption of service credits;
- (c) issues of liability for the volunteers and the administering organizations;
- (d) methods of tracking service credits earned and service credits redeemed;
- (e) issues of time limits for redemption of service credits;
- (f) methods of recruitment of volunteers;
- (g) utilization of community volunteers, community service groups, and other resources for delivering services to be received by service credit program clients;
- (h) accountability and assurance that services will be available to individuals who have earned service credits; and
- (i) volunteer screening and qualifications.

The Department shall submit a written copy of the guidelines to the General Assembly by July 1, 1998.

(Source: P.A. 95-298, eff. 8-20-07; 95-689, eff. 10-29-07; 95-876, eff. 8-21-08; 96-918, eff. 6-9-10.)

(20 ILCS 105/4.02) (from Ch. 23, par. 6104.02)

Sec. 4.02. Community Care Program. The Department shall establish a program of services to prevent unnecessary institutionalization of persons age 60 and older in need of long term care or who are established as persons who suffer from Alzheimer's disease or a related disorder under the Alzheimer's Disease Assistance Act, thereby enabling them to remain in their own homes or in other living arrangements. Such preventive services, which may be coordinated with other programs for the aged and monitored by area agencies on aging in cooperation with the Department, may include, but are not limited to, any or all of the following:

- (a) (blank);
- (b) (blank);
- (c) home care aide services;
- (d) personal assistant services;
- (e) adult day services;
- (f) home-delivered meals;
- (g) education in self-care;
- (h) personal care services;
- (i) adult day health services;
- (j) habilitation services;
- (k) respite care;
- (k-5) community reintegration services;
- (k-6) flexible senior services;
- (k-7) medication management;
- (k-8) emergency home response;
- (l) other nonmedical social services that may enable the person to become self-supporting; or
- (m) clearinghouse for information provided by senior citizen home owners who want to rent rooms to or share living space with other senior citizens.

The Department shall establish eligibility standards for such services. In determining the amount and nature of services

for which a person may qualify, consideration shall not be given to the value of cash, property or other assets held in the name of the person's spouse pursuant to a written agreement dividing marital property into equal but separate shares or pursuant to a transfer of the person's interest in a home to his spouse, provided that the spouse's share of the marital property is not made available to the person seeking such services.

Beginning January 1, 2008, the Department shall require as a condition of eligibility that all new financially eligible applicants apply for and enroll in medical assistance under Article V of the Illinois Public Aid Code in accordance with rules promulgated by the Department.

The Department shall, in conjunction with the Department of Public Aid (now Department of Healthcare and Family Services), seek appropriate amendments under Sections 1915 and 1924 of the Social Security Act. The purpose of the amendments shall be to extend eligibility for home and community based services under Sections 1915 and 1924 of the Social Security Act to persons who transfer to or for the benefit of a spouse those amounts of income and resources allowed under Section 1924 of the Social Security Act. Subject to the approval of such amendments, the Department shall extend the provisions of Section 5-4 of the Illinois Public Aid Code to persons who, but for the provision of home or community-based services, would require the level of care provided in an institution, as is provided for in federal law. Those persons no longer found to be eligible for receiving noninstitutional services due to changes in the eligibility criteria shall be given 45 days notice prior to actual termination. Those persons receiving notice of termination may contact the Department and request the determination be appealed at any time during the 45 day notice period. The target population identified for the purposes of this Section are persons age 60 and older with an identified service need. Priority shall be given to those who are at imminent risk of institutionalization. The services shall be provided to eligible persons age 60 and older to the extent that the cost of the services together with the other personal maintenance expenses of the persons are reasonably related to the standards established for care in a group facility appropriate to the person's condition. These non-institutional services, pilot projects or experimental facilities may be provided as part of or in addition to those authorized by federal law or those funded and administered by the Department of Human Services. The Departments of Human Services, Healthcare and Family Services, Public Health, Veterans' Affairs, and Commerce and Economic Opportunity and other appropriate agencies of State, federal and local governments shall cooperate with the Department on Aging in the establishment and development of the non-institutional services. The Department shall require an annual audit from all personal assistant and home care aide vendors contracting with the Department under this Section. The annual audit shall assure that each audited vendor's procedures are in compliance with Department's financial reporting guidelines requiring an administrative and employee wage and benefits cost split as defined in administrative rules. The audit is a public record under the Freedom of Information Act. The Department shall execute, relative to the nursing home prescreening project, written inter-agency agreements with the Department of Human Services and the Department of Healthcare

and Family Services, to effect the following: (1) intake procedures and common eligibility criteria for those persons who are receiving non-institutional services; and (2) the establishment and development of non-institutional services in areas of the State where they are not currently available or are undeveloped. On and after July 1, 1996, all nursing home prescreenings for individuals 60 years of age or older shall be conducted by the Department.

As part of the Department on Aging's routine training of case managers and case manager supervisors, the Department may include information on family futures planning for persons who are age 60 or older and who are caregivers of their adult children with developmental disabilities. The content of the training shall be at the Department's discretion.

The Department is authorized to establish a system of recipient copayment for services provided under this Section, such copayment to be based upon the recipient's ability to pay but in no case to exceed the actual cost of the services provided. Additionally, any portion of a person's income which is equal to or less than the federal poverty standard shall not be considered by the Department in determining the copayment. The level of such copayment shall be adjusted whenever necessary to reflect any change in the officially designated federal poverty standard.

The Department, or the Department's authorized representative, may recover the amount of moneys expended for services provided to or in behalf of a person under this Section by a claim against the person's estate or against the estate of the person's surviving spouse, but no recovery may be had until after the death of the surviving spouse, if any, and then only at such time when there is no surviving child who is under age 21, blind, or permanently and totally disabled. This paragraph, however, shall not bar recovery, at the death of the person, of moneys for services provided to the person or in behalf of the person under this Section to which the person was not entitled; provided that such recovery shall not be enforced against any real estate while it is occupied as a homestead by the surviving spouse or other dependent, if no claims by other creditors have been filed against the estate, or, if such claims have been filed, they remain dormant for failure of prosecution or failure of the claimant to compel administration of the estate for the purpose of payment. This paragraph shall not bar recovery from the estate of a spouse, under Sections 1915 and 1924 of the Social Security Act and Section 5-4 of the Illinois Public Aid Code, who precedes a person receiving services under this Section in death. All moneys for services paid to or in behalf of the person under this Section shall be claimed for recovery from the deceased spouse's estate. "Homestead", as used in this paragraph, means the dwelling house and contiguous real estate occupied by a surviving spouse or relative, as defined by the rules and regulations of the Department of Healthcare and Family Services, regardless of the value of the property.

The Department shall increase the effectiveness of the existing Community Care Program by:

- (1) ensuring that in-home services included in the care plan are available on evenings and weekends;
- (2) ensuring that care plans contain the services that eligible participants need based on the number of days in a month, not limited to specific blocks of time, as

identified by the comprehensive assessment tool selected by the Department for use statewide, not to exceed the total monthly service cost maximum allowed for each service; the Department shall develop administrative rules to implement this item (2);

(3) ensuring that the participants have the right to choose the services contained in their care plan and to direct how those services are provided, based on administrative rules established by the Department;

(4) ensuring that the determination of need tool is accurate in determining the participants' level of need; to achieve this, the Department, in conjunction with the Older Adult Services Advisory Committee, shall institute a study of the relationship between the Determination of Need scores, level of need, service cost maximums, and the development and utilization of service plans no later than May 1, 2008; findings and recommendations shall be presented to the Governor and the General Assembly no later than January 1, 2009; recommendations shall include all needed changes to the service cost maximums schedule and additional covered services;

(5) ensuring that homemakers can provide personal care services that may or may not involve contact with clients, including but not limited to:

- (A) bathing;
- (B) grooming;
- (C) toileting;
- (D) nail care;
- (E) transferring;
- (F) respiratory services;
- (G) exercise; or
- (H) positioning;

(6) ensuring that homemaker program vendors are not restricted from hiring homemakers who are family members of clients or recommended by clients; the Department may not, by rule or policy, require homemakers who are family members of clients or recommended by clients to accept assignments in homes other than the client;

(7) ensuring that the State may access maximum federal matching funds by seeking approval for the Centers for Medicare and Medicaid Services for modifications to the State's home and community based services waiver and additional waiver opportunities, including applying for enrollment in the Balance Incentive Payment Program by May 1, 2013, in order to maximize federal matching funds; this shall include, but not be limited to, modification that reflects all changes in the Community Care Program services and all increases in the services cost maximum; and

(8) ensuring that the determination of need tool accurately reflects the service needs of individuals with Alzheimer's disease and related dementia disorders; -

(9) ensuring that services are authorized accurately and consistently for the Community Care Program (CCP); the Department shall implement a Service Authorization policy directive; the purpose shall be to ensure that eligibility and services are authorized accurately and consistently in the CCP program; the policy directive shall clarify service authorization guidelines to Care Coordination Units and Community Care Program providers no later than May 1, 2013;

(10) working in conjunction with Care Coordination

Units, the Department of Healthcare and Family Services, the Department of Human Services, Community Care Program providers, and other stakeholders to make improvements to the Medicaid claiming processes and the Medicaid enrollment procedures or requirements as needed, including, but not limited to, specific policy changes or rules to improve the up-front enrollment of participants in the Medicaid program and specific policy changes or rules to insure more prompt submission of bills to the federal government to secure maximum federal matching dollars as promptly as possible; the Department on Aging shall have at least 3 meetings with stakeholders by January 1, 2014 in order to address these improvements;

(11) requiring home care service providers to comply with the rounding of hours worked provisions under the federal Fair Labor Standards Act (FLSA) and as set forth in 29 CFR 785.48(b) by May 1, 2013;

(12) implementing any necessary policy changes or promulgating any rules, no later than January 1, 2014, to assist the Department of Healthcare and Family Services in moving as many participants as possible, consistent with federal regulations, into coordinated care plans if a care coordination plan that covers long term care is available in the recipient's area; and

(13) maintaining fiscal year 2014 rates at the same level established on January 1, 2013.

By January 1, 2009 or as soon after the end of the Cash and Counseling Demonstration Project as is practicable, the Department may, based on its evaluation of the demonstration project, promulgate rules concerning personal assistant services, to include, but need not be limited to, qualifications, employment screening, rights under fair labor standards, training, fiduciary agent, and supervision requirements. All applicants shall be subject to the provisions of the Health Care Worker Background Check Act.

The Department shall develop procedures to enhance availability of services on evenings, weekends, and on an emergency basis to meet the respite needs of caregivers. Procedures shall be developed to permit the utilization of services in successive blocks of 24 hours up to the monthly maximum established by the Department. Workers providing these services shall be appropriately trained.

Beginning on the effective date of this Amendatory Act of 1991, no person may perform chore/housekeeping and home care aide services under a program authorized by this Section unless that person has been issued a certificate of pre-service to do so by his or her employing agency. Information gathered to effect such certification shall include (i) the person's name, (ii) the date the person was hired by his or her current employer, and (iii) the training, including dates and levels. Persons engaged in the program authorized by this Section before the effective date of this amendatory Act of 1991 shall be issued a certificate of all pre- and in-service training from his or her employer upon submitting the necessary information. The employing agency shall be required to retain records of all staff pre- and in-service training, and shall provide such records to the Department upon request and upon termination of the employer's contract with the Department. In addition, the employing agency is responsible for the issuance of certifications of in-service training completed to their

employees.

The Department is required to develop a system to ensure that persons working as home care aides and personal assistants receive increases in their wages when the federal minimum wage is increased by requiring vendors to certify that they are meeting the federal minimum wage statute for home care aides and personal assistants. An employer that cannot ensure that the minimum wage increase is being given to home care aides and personal assistants shall be denied any increase in reimbursement costs.

The Community Care Program Advisory Committee is created in the Department on Aging. The Director shall appoint individuals to serve in the Committee, who shall serve at their own expense. Members of the Committee must abide by all applicable ethics laws. The Committee shall advise the Department on issues related to the Department's program of services to prevent unnecessary institutionalization. The Committee shall meet on a bi-monthly basis and shall serve to identify and advise the Department on present and potential issues affecting the service delivery network, the program's clients, and the Department and to recommend solution strategies. Persons appointed to the Committee shall be appointed on, but not limited to, their own and their agency's experience with the program, geographic representation, and willingness to serve. The Director shall appoint members to the Committee to represent provider, advocacy, policy research, and other constituencies committed to the delivery of high quality home and community-based services to older adults. Representatives shall be appointed to ensure representation from community care providers including, but not limited to, adult day service providers, homemaker providers, case coordination and case management units, emergency home response providers, statewide trade or labor unions that represent home care aides and direct care staff, area agencies on aging, adults over age 60, membership organizations representing older adults, and other organizational entities, providers of care, or individuals with demonstrated interest and expertise in the field of home and community care as determined by the Director.

Nominations may be presented from any agency or State association with interest in the program. The Director, or his or her designee, shall serve as the permanent co-chair of the advisory committee. One other co-chair shall be nominated and approved by the members of the committee on an annual basis. Committee members' terms of appointment shall be for 4 years with one-quarter of the appointees' terms expiring each year. A member shall continue to serve until his or her replacement is named. The Department shall fill vacancies that have a remaining term of over one year, and this replacement shall occur through the annual replacement of expiring terms. The Director shall designate Department staff to provide technical assistance and staff support to the committee. Department representation shall not constitute membership of the committee. All Committee papers, issues, recommendations, reports, and meeting memoranda are advisory only. The Director, or his or her designee, shall make a written report, as requested by the Committee, regarding issues before the Committee.

The Department on Aging and the Department of Human Services shall cooperate in the development and submission of an annual report on programs and services provided under this

Section. Such joint report shall be filed with the Governor and the General Assembly on or before September 30 each year.

The requirement for reporting to the General Assembly shall be satisfied by filing copies of the report with the Speaker, the Minority Leader and the Clerk of the House of Representatives and the President, the Minority Leader and the Secretary of the Senate and the Legislative Research Unit, as required by Section 3.1 of the General Assembly Organization Act and filing such additional copies with the State Government Report Distribution Center for the General Assembly as is required under paragraph (t) of Section 7 of the State Library Act.

Those persons previously found eligible for receiving non-institutional services whose services were discontinued under the Emergency Budget Act of Fiscal Year 1992, and who do not meet the eligibility standards in effect on or after July 1, 1992, shall remain ineligible on and after July 1, 1992. Those persons previously not required to cost-share and who were required to cost-share effective March 1, 1992, shall continue to meet cost-share requirements on and after July 1, 1992. Beginning July 1, 1992, all clients will be required to meet eligibility, cost-share, and other requirements and will have services discontinued or altered when they fail to meet these requirements.

For the purposes of this Section, "flexible senior services" refers to services that require one-time or periodic expenditures including, but not limited to, respite care, home modification, assistive technology, housing assistance, and transportation.

The Department shall implement an electronic service verification based on global positioning systems or other cost-effective technology for the Community Care Program no later than January 1, 2014.

The Department shall require, as a condition of eligibility, enrollment in the medical assistance program under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall delay Community Care Program services until an applicant is determined eligible for medical assistance under Article V of the Illinois Public Aid Code (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall implement co-payments for the Community Care Program at the federally allowable maximum level (i) beginning August 1, 2013, if the Auditor General has reported that the Department has failed to comply with the reporting requirements of Section 2-27 of the Illinois State Auditing Act; or (ii) beginning June 1, 2014, if the Auditor General has reported that the Department has not undertaken the

required actions listed in the report required by subsection (a) of Section 2-27 of the Illinois State Auditing Act.

The Department shall provide a bi-monthly report on the progress of the Community Care Program reforms set forth in this amendatory Act of the 98th General Assembly to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate.

The Department shall conduct a quarterly review of Care Coordination Unit performance and adherence to service guidelines. The quarterly review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. 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.

In regard to community care providers, failure to comply with Department on Aging policies shall be cause for disciplinary action, including, but not limited to, disqualification from serving Community Care Program clients. Each provider, upon submission of any bill or invoice to the Department for payment for services rendered, shall include a notarized statement, under penalty of perjury pursuant to Section 1-109 of the Code of Civil Procedure, that the provider has complied with all Department policies.

(Source: P.A. 96-918, eff. 6-9-10; 96-1129, eff. 7-20-10; 97-333, eff. 8-12-11.)

Section 9. The Illinois State Auditing Act is amended by adding Section 2-27 as follows:

(30 ILCS 5/2-27 new)

Sec. 2-27. Certification of Community Care Program reform implementation.

(a) No later than July 1, 2013, the Department on Aging shall file a report with the Auditor General, the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate listing any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State Policy changes and notifications required to implement this amendatory Act of the 98th General Assembly.

(b) No later than February 1, 2014, the Department on Aging shall provide evidence to the Auditor General that it has undertaken the required actions listed in the report required by subsection (a).

(c) No later than April 1, 2014, the Auditor General shall submit a report to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate as to whether the Department on Aging has undertaken the required actions listed in the report required by subsection (a).

Section 10. The State Finance Act is amended by changing Section 25 as follows:

(30 ILCS 105/25) (from Ch. 127, par. 161)

Sec. 25. Fiscal year limitations.

(a) All appropriations shall be available for expenditure for the fiscal year or for a lesser period if the Act making that appropriation so specifies. A deficiency or emergency appropriation shall be available for expenditure only through June 30 of the year when the Act making that appropriation is enacted unless that Act otherwise provides.

(b) Outstanding liabilities as of June 30, payable from appropriations which have otherwise expired, may be paid out of the expiring appropriations during the 2-month period ending at the close of business on August 31. Any service involving professional or artistic skills or any personal services by an employee whose compensation is subject to income tax withholding must be performed as of June 30 of the fiscal year in order to be considered an "outstanding liability as of June 30" that is thereby eligible for payment out of the expiring appropriation.

(b-1) However, payment of tuition reimbursement claims under Section 14-7.03 or 18-3 of the School Code may be made by the State Board of Education from its appropriations for those respective purposes for any fiscal year, even though the claims reimbursed by the payment may be claims attributable to a prior fiscal year, and payments may be made at the direction of the State Superintendent of Education from the fund from which the appropriation is made without regard to any fiscal year limitations, except as required by subsection (j) of this Section. Beginning on June 30, 2021, payment of tuition reimbursement claims under Section 14-7.03 or 18-3 of the School Code as of June 30, payable from appropriations that have otherwise expired, may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-2) All outstanding liabilities as of June 30, 2010, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2010, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2010, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2010.

(b-2.5) All outstanding liabilities as of June 30, 2011, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2011, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2011, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2011.

(b-2.6) All outstanding liabilities as of June 30, 2012, payable from appropriations that would otherwise expire at the conclusion of the lapse period for fiscal year 2012, and interest penalties payable on those liabilities under the State Prompt Payment Act, may be paid out of the expiring appropriations until December 31, 2012, without regard to the fiscal year in which the payment is made, as long as vouchers for the liabilities are received by the Comptroller no later than August 31, 2012.

(b-2.7) (b-2.6) For fiscal years 2012 and 2013, interest penalties payable under the State Prompt Payment Act associated with a voucher for which payment is issued after June 30 may be paid out of the next fiscal year's appropriation. The future year appropriation must be for the same purpose and from the same fund as the original payment. An interest penalty voucher submitted against a future year appropriation must be submitted within 60 days after the issuance of the associated voucher, and the Comptroller must issue the interest payment within 60 days after acceptance of the interest voucher.

(b-3) Medical payments may be made by the Department of Veterans' Affairs from its appropriations for those purposes for any fiscal year, without regard to the fact that the medical services being compensated for by such payment may have been rendered in a prior fiscal year, except as required by subsection (j) of this Section. Beginning on June 30, 2021, medical payments payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-4) Medical payments and child care payments may be made by the Department of Human Services (as successor to the Department of Public Aid) from appropriations for those purposes for any fiscal year, without regard to the fact that the medical or child care services being compensated for by such payment may have been rendered in a prior fiscal year; and payments may be made at the direction of the Department of Healthcare and Family Services (or successor agency) from the Health Insurance Reserve Fund without regard to any fiscal year limitations, except as required by subsection (j) of this Section. Beginning on June 30, 2021, medical and child care payments made by the Department of Human Services, and payments made at the discretion of the Department of Healthcare and Family Services (or successor agency) from the Health Insurance Reserve Fund and payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-5) Medical payments may be made by the Department of Human Services from its appropriations relating to substance abuse treatment services for any fiscal year, without regard to the fact that the medical services being compensated for by such payment may have been rendered in a prior fiscal year, provided the payments are made on a fee-for-service basis consistent with requirements established for Medicaid reimbursement by the Department of Healthcare and Family Services, except as required by subsection (j) of this Section. Beginning on June 30, 2021, medical payments made by the Department of Human Services relating to substance abuse treatment services payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-6) Additionally, payments may be made by the Department of Human Services from its appropriations, or any other State agency from its appropriations with the approval of the Department of Human Services, from the Immigration Reform and Control Fund for purposes authorized pursuant to the Immigration Reform and Control Act of 1986, without regard to any fiscal year limitations, except as required by subsection

(j) of this Section. Beginning on June 30, 2021, payments made by the Department of Human Services from the Immigration Reform and Control Fund for purposes authorized pursuant to the Immigration Reform and Control Act of 1986 payable from appropriations that have otherwise expired may be paid out of the expiring appropriation during the 4-month period ending at the close of business on October 31.

(b-7) Payments may be made in accordance with a plan authorized by paragraph (11) or (12) of Section 405-105 of the Department of Central Management Services Law from appropriations for those payments without regard to fiscal year limitations.

(b-9) Medical payments not exceeding \$150,000,000 may be made by the Department on Aging from its appropriations relating to the Community Care Program for fiscal year 2014, without regard to the fact that the medical services being compensated for by such payment may have been rendered in a prior fiscal year, provided the payments are made on a fee-for-service basis consistent with requirements established for Medicaid reimbursement by the Department of Healthcare and Family Services, except as required by subsection (j) of this Section.

(c) Further, payments may be made by the Department of Public Health and the Department of Human Services (acting as successor to the Department of Public Health under the Department of Human Services Act) from their respective appropriations for grants for medical care to or on behalf of premature and high-mortality risk infants and their mothers and for grants for supplemental food supplies provided under the United States Department of Agriculture Women, Infants and Children Nutrition Program, for any fiscal year without regard to the fact that the services being compensated for by such payment may have been rendered in a prior fiscal year, except as required by subsection (j) of this Section. Beginning on June 30, 2021, payments made by the Department of Public Health and the Department of Human Services from their respective appropriations for grants for medical care to or on behalf of premature and high-mortality risk infants and their mothers and for grants for supplemental food supplies provided under the United States Department of Agriculture Women, Infants and Children Nutrition Program payable from appropriations that have otherwise expired may be paid out of the expiring appropriations during the 4-month period ending at the close of business on October 31.

(d) The Department of Public Health and the Department of Human Services (acting as successor to the Department of Public Health under the Department of Human Services Act) shall each annually submit to the State Comptroller, Senate President, Senate Minority Leader, Speaker of the House, House Minority Leader, and the respective Chairmen and Minority Spokesmen of the Appropriations Committees of the Senate and the House, on or before December 31, a report of fiscal year funds used to pay for services provided in any prior fiscal year. This report shall document by program or service category those expenditures from the most recently completed fiscal year used to pay for services provided in prior fiscal years.

(e) The Department of Healthcare and Family Services, the Department of Human Services (acting as successor to the Department of Public Aid), and the Department of Human Services making fee-for-service payments relating to substance abuse

treatment services provided during a previous fiscal year shall each annually submit to the State Comptroller, Senate President, Senate Minority Leader, Speaker of the House, House Minority Leader, the respective Chairmen and Minority Spokesmen of the Appropriations Committees of the Senate and the House, on or before November 30, a report that shall document by program or service category those expenditures from the most recently completed fiscal year used to pay for (i) services provided in prior fiscal years and (ii) services for which claims were received in prior fiscal years.

(f) The Department of Human Services (as successor to the Department of Public Aid) shall annually submit to the State Comptroller, Senate President, Senate Minority Leader, Speaker of the House, House Minority Leader, and the respective Chairmen and Minority Spokesmen of the Appropriations Committees of the Senate and the House, on or before December 31, a report of fiscal year funds used to pay for services (other than medical care) provided in any prior fiscal year. This report shall document by program or service category those expenditures from the most recently completed fiscal year used to pay for services provided in prior fiscal years.

(g) In addition, each annual report required to be submitted by the Department of Healthcare and Family Services under subsection (e) shall include the following information with respect to the State's Medicaid program:

(1) Explanations of the exact causes of the variance between the previous year's estimated and actual liabilities.

(2) Factors affecting the Department of Healthcare and Family Services' liabilities, including but not limited to numbers of aid recipients, levels of medical service utilization by aid recipients, and inflation in the cost of medical services.

(3) The results of the Department's efforts to combat fraud and abuse.

(h) As provided in Section 4 of the General Assembly Compensation Act, any utility bill for service provided to a General Assembly member's district office for a period including portions of 2 consecutive fiscal years may be paid from funds appropriated for such expenditure in either fiscal year.

(i) An agency which administers a fund classified by the Comptroller as an internal service fund may issue rules for:

(1) billing user agencies in advance for payments or authorized inter-fund transfers based on estimated charges for goods or services;

(2) issuing credits, refunding through inter-fund transfers, or reducing future inter-fund transfers during the subsequent fiscal year for all user agency payments or authorized inter-fund transfers received during the prior fiscal year which were in excess of the final amounts owed by the user agency for that period; and

(3) issuing catch-up billings to user agencies during the subsequent fiscal year for amounts remaining due when payments or authorized inter-fund transfers received from the user agency during the prior fiscal year were less than the total amount owed for that period.

User agencies are authorized to reimburse internal service funds for catch-up billings by vouchers drawn against their respective appropriations for the fiscal year in which the

catch-up billing was issued or by increasing an authorized inter-fund transfer during the current fiscal year. For the purposes of this Act, "inter-fund transfers" means transfers without the use of the voucher-warrant process, as authorized by Section 9.01 of the State Comptroller Act.

(i-1) Beginning on July 1, 2021, all outstanding liabilities, not payable during the 4-month lapse period as described in subsections (b-1), (b-3), (b-4), (b-5), (b-6), and (c) of this Section, that are made from appropriations for that purpose for any fiscal year, without regard to the fact that the services being compensated for by those payments may have been rendered in a prior fiscal year, are limited to only those claims that have been incurred but for which a proper bill or invoice as defined by the State Prompt Payment Act has not been received by September 30th following the end of the fiscal year in which the service was rendered.

(j) Notwithstanding any other provision of this Act, the aggregate amount of payments to be made without regard for fiscal year limitations as contained in subsections (b-1), (b-3), (b-4), (b-5), (b-6), and (c) of this Section, and determined by using Generally Accepted Accounting Principles, shall not exceed the following amounts:

- (1) \$6,000,000,000 for outstanding liabilities related to fiscal year 2012;
- (2) \$5,300,000,000 for outstanding liabilities related to fiscal year 2013;
- (3) \$4,600,000,000 for outstanding liabilities related to fiscal year 2014;
- (4) \$4,000,000,000 for outstanding liabilities related to fiscal year 2015;
- (5) \$3,300,000,000 for outstanding liabilities related to fiscal year 2016;
- (6) \$2,600,000,000 for outstanding liabilities related to fiscal year 2017;
- (7) \$2,000,000,000 for outstanding liabilities related to fiscal year 2018;
- (8) \$1,300,000,000 for outstanding liabilities related to fiscal year 2019;
- (9) \$600,000,000 for outstanding liabilities related to fiscal year 2020; and
- (10) \$0 for outstanding liabilities related to fiscal year 2021 and fiscal years thereafter.

(k) Department of Healthcare and Family Services Medical Assistance Payments.

(1) Definition of Medical Assistance.

For purposes of this subsection, the term "Medical Assistance" shall include, but not necessarily be limited to, medical programs and services authorized under Titles XIX and XXI of the Social Security Act, the Illinois Public Aid Code, the Children's Health Insurance Program Act, the Covering ALL KIDS Health Insurance Act, the Long Term Acute Care Hospital Quality Improvement Transfer Program Act, and medical care to or on behalf of persons suffering from chronic renal disease, persons suffering from hemophilia, and victims of sexual assault.

(2) Limitations on Medical Assistance payments that may be paid from future fiscal year appropriations.

(A) The maximum amounts of annual unpaid Medical Assistance bills received and recorded by the

Department of Healthcare and Family Services on or before June 30th of a particular fiscal year attributable in aggregate to the General Revenue Fund, Healthcare Provider Relief Fund, Tobacco Settlement Recovery Fund, Long-Term Care Provider Fund, and the Drug Rebate Fund that may be paid in total by the Department from future fiscal year Medical Assistance appropriations to those funds are: \$700,000,000 for fiscal year 2013 and \$100,000,000 for fiscal year 2014 and each fiscal year thereafter.

(B) Bills for Medical Assistance services rendered in a particular fiscal year, but received and recorded by the Department of Healthcare and Family Services after June 30th of that fiscal year, may be paid from either appropriations for that fiscal year or future fiscal year appropriations for Medical Assistance. Such payments shall not be subject to the requirements of subparagraph (A).

(C) Medical Assistance bills received by the Department of Healthcare and Family Services in a particular fiscal year, but subject to payment amount adjustments in a future fiscal year may be paid from a future fiscal year's appropriation for Medical Assistance. Such payments shall not be subject to the requirements of subparagraph (A).

(D) Medical Assistance payments made by the Department of Healthcare and Family Services from funds other than those specifically referenced in subparagraph (A) may be made from appropriations for those purposes for any fiscal year without regard to the fact that the Medical Assistance services being compensated for by such payment may have been rendered in a prior fiscal year. Such payments shall not be subject to the requirements of subparagraph (A).

(3) Extended lapse period for Department of Healthcare and Family Services Medical Assistance payments.

Notwithstanding any other State law to the contrary, outstanding Department of Healthcare and Family Services Medical Assistance liabilities, as of June 30th, payable from appropriations which have otherwise expired, may be paid out of the expiring appropriations during the 6-month period ending at the close of business on December 31st.

(1) The changes to this Section made by Public Act 97-691 ~~this amendatory Act of the 97th General Assembly~~ shall be effective for payment of Medical Assistance bills incurred in fiscal year 2013 and future fiscal years. The changes to this Section made by Public Act 97-691 ~~this amendatory Act of the 97th General Assembly~~ shall not be applied to Medical Assistance bills incurred in fiscal year 2012 or prior fiscal years.

(m) ~~tk~~ The Comptroller must issue payments against outstanding liabilities that were received prior to the lapse period deadlines set forth in this Section as soon thereafter as practical, but no payment may be issued after the 4 months following the lapse period deadline without the signed authorization of the Comptroller and the Governor.

(Source: P.A. 96-928, eff. 6-15-10; 96-958, eff. 7-1-10; 96-1501, eff. 1-25-11; 97-75, eff. 6-30-11; 97-333, eff. 8-12-11; 97-691, eff. 7-1-12; 97-732, eff. 6-30-12; 97-932, eff. 8-10-12; revised 8-23-12.)

Section 15. The Illinois Public Aid Code is amended by changing Section 12-13.1 as follows:

(305 ILCS 5/12-13.1)

Sec. 12-13.1. Inspector General.

(a) The Governor shall appoint, and the Senate shall confirm, an Inspector General who shall function within the Illinois Department of Public Aid (now Healthcare and Family Services) and report to the Governor. The term of the Inspector General shall expire on the third Monday of January, 1997 and every 4 years thereafter.

(b) In order to prevent, detect, and eliminate fraud, waste, abuse, mismanagement, and misconduct, the Inspector General shall oversee the Department of Healthcare and Family Services' and the Department on Aging's integrity functions, which include, but are not limited to, the following:

(1) Investigation of misconduct by employees, vendors, contractors and medical providers, except for allegations of violations of the State Officials and Employees Ethics Act which shall be referred to the Office of the Governor's Executive Inspector General for investigation.

(2) Prepayment and post-payment audits of medical providers related to ensuring that appropriate payments are made for services rendered and to the prevention and recovery of overpayments.

(3) Monitoring of quality assurance programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(4) Quality control measurements of the programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(5) Investigations of fraud or intentional program violations committed by clients of the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(6) Actions initiated against contractors, vendors, or medical providers for any of the following reasons:

(A) Violations of the medical assistance program and the Community Care Program administered by the Department on Aging.

(B) Sanctions against providers brought in conjunction with the Department of Public Health or the Department of Human Services (as successor to the Department of Mental Health and Developmental Disabilities).

(C) Recoveries of assessments against hospitals and long-term care facilities.

(D) Sanctions mandated by the United States Department of Health and Human Services against medical providers.

(E) Violations of contracts related to any programs administered by the Department of Healthcare and Family Services and the Community Care Program administered by the Department on Aging.

(7) Representation of the Department of Healthcare and Family Services at hearings with the Illinois Department of Financial and Professional Regulation in actions taken

against professional licenses held by persons who are in violation of orders for child support payments.

(b-5) At the request of the Secretary of Human Services, the Inspector General shall, in relation to any function performed by the Department of Human Services as successor to the Department of Public Aid, exercise one or more of the powers provided under this Section as if those powers related to the Department of Human Services; in such matters, the Inspector General shall report his or her findings to the Secretary of Human Services.

(c) Notwithstanding, and in addition to, any other provision of law, the Inspector General shall have access to all information, personnel and facilities of the Department of Healthcare and Family Services and the Department of Human Services (as successor to the Department of Public Aid), their employees, vendors, contractors and medical providers and any federal, State or local governmental agency that are necessary to perform the duties of the Office as directly related to public assistance programs administered by those departments. No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the programs administered by the Department of Healthcare and Family Services. State and local governmental agencies are authorized and directed to provide the requested information, assistance or cooperation.

For purposes of enhanced program integrity functions and oversight, and to the extent consistent with applicable information and privacy, security, and disclosure laws, State agencies and departments shall provide the Office of Inspector General access to confidential and other information and data, and the Inspector General is authorized to enter into agreements with appropriate federal agencies and departments to secure similar data. This includes, but is not limited to, information pertaining to: licensure; certification; earnings; immigration status; citizenship; wage reporting; unearned and earned income; pension income; employment; supplemental security income; social security numbers; National Provider Identifier (NPI) numbers; the National Practitioner Data Bank (NPDB); program and agency exclusions; taxpayer identification numbers; tax delinquency; corporate information; and death records.

The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies and departments shall share data necessary for medical assistance program integrity functions and oversight. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, under which such agencies shall share data necessary for recipient and vendor screening, review, and investigation, including but not limited to vendor payment and recipient eligibility verification. The Inspector General shall develop, in cooperation with other State and federal agencies and departments, and in compliance with applicable federal laws and regulations, appropriate and effective methods to share such data. The Inspector General shall enter into agreements with State agencies and departments, and is authorized to enter into agreements with federal agencies and departments, including, but not limited to: the Secretary of State; the Department of

Revenue; the Department of Public Health; the Department of Human Services; and the Department of Financial and Professional Regulation.

The Inspector General shall have the authority to deny payment, prevent overpayments, and recover overpayments.

The Inspector General shall have the authority to deny or suspend payment to, and deny, terminate, or suspend the eligibility of, any vendor who fails to grant the Inspector General timely access to full and complete records, including records of recipients under the medical assistance program for the most recent 6 years, in accordance with Section 140.28 of Title 89 of the Illinois Administrative Code, and other information for the purpose of audits, investigations, or other program integrity functions, after reasonable written request by the Inspector General.

(d) The Inspector General shall serve as the Department of Healthcare and Family Services' primary liaison with law enforcement, investigatory and prosecutorial agencies, including but not limited to the following:

(1) The Department of State Police.

(2) The Federal Bureau of Investigation and other federal law enforcement agencies.

(3) The various Inspectors General of federal agencies overseeing the programs administered by the Department of Healthcare and Family Services.

(4) The various Inspectors General of any other State agencies with responsibilities for portions of programs primarily administered by the Department of Healthcare and Family Services.

(5) The Offices of the several United States Attorneys in Illinois.

(6) The several State's Attorneys.

(7) The offices of the Centers for Medicare and Medicaid Services that administer the Medicare and Medicaid integrity programs.

The Inspector General shall meet on a regular basis with these entities to share information regarding possible misconduct by any persons or entities involved with the public aid programs administered by the Department of Healthcare and Family Services.

(e) All investigations conducted by the Inspector General shall be conducted in a manner that ensures the preservation of evidence for use in criminal prosecutions. If the Inspector General determines that a possible criminal act relating to fraud in the provision or administration of the medical assistance program has been committed, the Inspector General shall immediately notify the Medicaid Fraud Control Unit. If the Inspector General determines that a possible criminal act has been committed within the jurisdiction of the Office, the Inspector General may request the special expertise of the Department of State Police. The Inspector General may present for prosecution the findings of any criminal investigation to the Office of the Attorney General, the Offices of the several United States Attorneys in Illinois or the several State's Attorneys.

(f) To carry out his or her duties as described in this Section, the Inspector General and his or her designees shall have the power to compel by subpoena the attendance and testimony of witnesses and the production of books, electronic records and papers as directly related to public assistance

programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid). No medical provider shall be compelled, however, to provide individual medical records of patients who are not clients of the Medical Assistance Program.

(g) The Inspector General shall report all convictions, terminations, and suspensions taken against vendors, contractors and medical providers to the Department of Healthcare and Family Services and to any agency responsible for licensing or regulating those persons or entities.

(h) The Inspector General shall make annual reports, findings, and recommendations regarding the Office's investigations into reports of fraud, waste, abuse, mismanagement, or misconduct relating to any programs administered by the Department of Healthcare and Family Services or the Department of Human Services (as successor to the Department of Public Aid) to the General Assembly and the Governor. These reports shall include, but not be limited to, the following information:

(1) Aggregate provider billing and payment information, including the number of providers at various Medicaid earning levels.

(2) The number of audits of the medical assistance program and the dollar savings resulting from those audits.

(3) The number of prescriptions rejected annually under the Department of Healthcare and Family Services' Refill Too Soon program and the dollar savings resulting from that program.

(4) Provider sanctions, in the aggregate, including terminations and suspensions.

(5) A detailed summary of the investigations undertaken in the previous fiscal year. These summaries shall comply with all laws and rules regarding maintaining confidentiality in the public aid programs.

(i) Nothing in this Section shall limit investigations by the Department of Healthcare and Family Services or the Department of Human Services that may otherwise be required by law or that may be necessary in their capacity as the central administrative authorities responsible for administration of their agency's programs in this State.

(j) The Inspector General may issue shields or other distinctive identification to his or her employees not exercising the powers of a peace officer if the Inspector General determines that a shield or distinctive identification is needed by an employee to carry out his or her responsibilities.

(Source: P.A. 96-555, eff. 8-18-09; 96-1316, eff. 1-1-11; 97-689, eff. 6-14-12.)

(320 ILCS 50/15 rep.)

Section 20. The Senior Pharmaceutical Assistance Act is amended by repealing Section 15.

Section 99. Effective date. This Act takes effect upon becoming law.

APPENDIX B

Aging's June 27, 2013 Report

June 27, 2013

TO: The Governor of the State of Illinois
The Auditor General of the State of Illinois
The Honorable Members of the Illinois General Assembly

The Illinois Department on Aging (IDoA) is happy to offer the bi-monthly report scheduled within HB 2275 (Public Act 98-0008). This report describes in detail the progress to-date by amended ILCS statute, 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.

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

- ✓ All agreements are in place with the exception of the U.S Department on Veterans Affairs and the Illinois Department of Revenue. It is expected that as of September 1, 2013, all agreements will be utilized.

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

- ✓ The Illinois Department of Healthcare and Family Services (HFS) submitted the BIP application to the federal Centers for Medicare and Medicaid Services (CMS) in March 2013. On June 12, 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. The Director of IDoA serves on an interagency committee that is preparing the BIP work plan which is due to CMS in September 2013.

20 ILCS 105/4.02(9) (service authorization guidelines for in-home service)

- ✓ IDoA implemented a Service Authorization policy for Case Coordination Units (CCUs) statewide on April 1, 2013. The Department also followed up with trainings to the CCUs in the Month of April and May.

Respect for yesterday. Support for today. Hope for tomorrow.

The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in programs or activities 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).

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

- ✓ IDoA is working in conjunction with Department of Human Services (DHS) and Care Coordination Units (CCUs) to make improvements to the Medicaid claiming process/enrollment procedures by granting CCUs access to the DHS PACIS system; establishing liaisons in each Family and Community Resource Center (FCRC); streamlining application submission; cross training of agency staff; and developing a plan for centralization of services and reestablishing a stakeholders group to improve processes.

In cooperation with a bipartisan group of General Assembly members, state agencies, and stakeholders from the Aging Network, IDoA initiated a Root Cause Analysis Project (RCAP) in February 2013 to understand barriers that prevent timely enrollment into Federal Medical Assistance Percentage (FMAP), as well as to implement solutions to better ensure enrollment of CCP clients who appear to be Medicaid eligible but currently are not. A survey was done of select CCUs to determine related causes which is being followed up now with all CCUs to perform a review of their individual clients to pursue FMAP (re)application and enrollment where eligible. DHS and IDoA have met and have outlined various steps to address the issues identified from the RCAP.

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

- ✓ 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.

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

- ✓ IDoA has worked with HFS to develop policies for the implementation of the managed care Integrated Care Program (ICP) for suburban Cook County (outside the City of Chicago) in February 2013. In addition, IDoA is working on implementation for the expansion of ICP which will take place throughout the state in FY14.

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

- ✓ IDoA has no plans to increase the FY14 Community Care Program rates from FY13 levels.

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

- ✓ IDoA has developed standards for EVV systems and sent the policy to in-home service providers requiring compliance by 7/1/13. EVV standards have been posted to the Electronic Community Care Program Information System (eCCPIS), as well as the IDoA website. We have also reviewed and drafted an amendment to administrative rules (Section 240.1530). This policy was shared with CCP providers at the Community Care Program Advisory Council meeting on 6/25/13. IDoA also shared a list of EVV vendors that responded to the Request for Proposal (RFP) and announced that DHS and IDoA providers may use the vendor of their choice as long as they meet policy standards.

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

- ✓ This report will satisfy the intended requirement of HB 2275.

20 ILCS 105/4.02(new) (CCP providers non-compliance)

- ✓ Our on-line billing system for Vendor Requests for Payment (VRFP) has been modified to contain certification language referring to a physical notarized statement from each provider (Notarized Certification Form). Each person who submits VRFP information must sign the form and the form must be notarized and on-file at IDoA. All eCCPIS users who submit VRFP payments must have a State of Illinois-issued public-key infrastructure (PKI) entrusted ID which ensures that the identity of the user is credentialed and approved by the organization they represent.

30 ILCS 5/2-27(new) (certification of CCP reforms)

- ✓ This report will satisfy the intended requirement of HB 2275.

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

Sincerely,



John K. Holton, PhD
Director
Illinois Department on Aging

cc: Mary Killough, Deputy Director
Mikal Sutton, Legislative Liaison

APPENDIX C

Aging's February 1, 2014 Report



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

February 1, 2014

The Honorable William Holland
Auditor General for the State of Illinois
Iles Park Plaza
740 East Ash St.
Springfield, IL 62703-3154

Dear Auditor General Holland:

The Illinois Department on Aging (IDoA) is pleased to offer the February 1, 2014, report to the Auditor General, as required under HB 2275 (Public Act 98-0008):

(30 ILCS 5/2-27 new)

Sec. 2-27. Certification of Community Care Program reform implementation.

(a) No later than July 1, 2013, the Department on Aging shall file a report with the Auditor General, the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate listing any necessary amendment to the Illinois Title XIX State plan, any federal waiver request, any State administrative rule, or any State Policy changes and notifications required to implement this amendatory Act of the 98th General Assembly.

(b) No later than February 1, 2014, the Department on Aging shall provide evidence to the Auditor General that it has undertaken the required actions listed in the report required by subsection (a).

(c) No later than April 1, 2014, the Auditor General shall submit a report to the Governor, the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate as to whether the Department on Aging has undertaken the required actions listed in the report required by subsection (a).

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 and includes references

to the evidence as attachments, for compliance of each provision. This report also summarizes 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.

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

1. Most interagency data sharing agreements have been signed to enhance the verification and eligibility determination processes for services that are administered by the Department with the exception of the two noted below. The Department is currently working to establish the secure transfer of information processes among the agencies.
 - Regarding the IDOR IGA, repeated attempts have been made requesting the Director of the Department of Revenue to sign the IGA between IDoA, HFS and DHS with unsuccessful results to-date.
 - The Social Security Administration is in agreement with the content of the renewed IGA and are in the process of signing the data-sharing agreement with IDoA.

Evidence: Copies of Data Sharing Agreements.

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

2. The first quarterly review of Care Coordination Unit performance and adherence to service guidelines was completed, summarized and submitted in the November report. The next quarterly review will be addressed in the February 28, 2014, report.

Evidence: November 1, 2013, Report to the General Assembly and supporting analysis.

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

3. 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 18, 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.

Evidence: Balancing Incentive Payment Program Application submitted to Centers for Medicare and Medicaid Services (CMS). Our approved IL BIP Work Plan is published

on the Medicaid site: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Balancing/Balancing-Incentive-Program.html>

20 ILCS 105/4.02(9) (service authorization guidelines for in-home service)

4. IDoA implemented a Service Authorization Guidelines policy for Care Coordination Units (CCUs) statewide on April 1, 2013. The overall intent of re-issuing guidelines is to strengthen consistent application of service task approvals across the state 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 the 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, and the new guidelines took effect May 1, 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 completed three reviews of CCUs. Two CCUs were reviewed during December, and our findings indicate that both were compliant with the service authorization guidelines. Three additional reviews have been scheduled for January 2014.

Evidence: A) Service Authorization Guidelines Policy issued to Care Coordination Units issued on April 1, 2013; B) Power Point Training document on Service Authorization Guidelines; C) Reviews of CCUs documenting their compliance with Service Authorization Guidelines.

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

5. The Department has established a stakeholder group that includes DHS, DHS-OIG, CCUs, HFS, and AAAs (Area Agencies on Aging). The stakeholder group has met three times. The dates were October 31, 2013, November 14, 2013, and December 19, 2013. 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; and 4) streamline the Home and Community Base Services work flow process for the Community Care Program. The stakeholder group continues to meet once a month and implement action steps for change.

Evidence: Agendas, recommendations from the stakeholder group, and working documents including a flow chart of the Medicaid application process, training materials, and lists of Family Community Resource Center (FCRC) liaisons which were shared with CCUs.

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

6. 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.

Evidence: Since the policy instruction memorandum was issued on April 1, 2013, the Department has conducted 44 Quality Improvement Reviews of in-home service provider agreements. None of the reviews showed lack of compliance with the 7-minute rounding policy. The Department conducts routine Aging Network meetings for providers where this policy was also discussed, while technical assistance was also provided to agencies that sought clarification on implementing the provision.

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

7. 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.

Evidence: Policies for the Integrated Care Program, PowerPoint Training, list of MCO training dates and topics covered.

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

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

Evidence: eCCPIS system and FY 2014 Budget Book.

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

9. 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.

To date, 105 or 97% of the current 107 INH legal entities submitted compliance certification. All together, they provided 99.97% of the 40 million INH service units that were delivered in FY13. Pursuant to data collected from the certification filings, providers are using telephony (44%), mobile technology (32%) and/or fixed visit verification devices (24%) to record the sign-in and sign-out time of all visits by home care aides who provide direct services within the residence of CCP participants.

The Department requires 100% compliance with the EVV mandate by providers. The implementation process also involved the issuance of several notices and reminders on being compliant, while new client referrals were suspended on January 1, 2014 for eight (8) providers that were not compliant. As of January 30, 2014, there were three (3) remaining provider agencies that are yet to be compliant. They are very small or new to CCP. Failure to implement EVV by February 1, 2014, will result in further contract action up to and including contract termination.

Evidence – see rules; policies; client and participant notices of EVV; EVV compliance tracking; compliance notification letters; and contract action letters.

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

10. Reports have been filed on a bi-monthly basis.

Evidence – Reports filed with the General Assembly on 7/1/13, 9/1/13, 11/1/13, 1/1/14.

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

11. This provision has been met. As reported in the August 30, 2013, and October 31, 2013, reports, the Department's online billing system for Vendor Requests for Payment was modified to contain certification language referring to a physical notarized statement.

Evidence – Screen shots from our secure online system (eCCPIS) requiring Providers to verify, upon submission of an invoice, that the billing is true, accurate and complete, and notarized Billing Certification Forms for all eCCPIS users are on file.

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

12. This provision has been met. The Department's FY14 budget does not have prior year billing provisions in the appropriation. Aging has communicated to providers the urgency of billing promptly, and that failure to submit FY14 bills prior to the end of the FY14 lapse period would require vendors to seek payment from the Court of Claims.

Evidence: FY 2014 Budget Book, communication to providers about the urgency of billing properly.

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 that reads "John K. Holton".

John K. Holton, PhD
Director
Illinois Department on Aging

cc: Mary Killough, Deputy Director
Deb Shipley, Chief of Staff-Operations
Attachments: 100 files submitted via flash drive