State of Illinois
Illinois Department on Aging

Illinois Department on Aging

ILLINOIS LONG TERM CARE COUNCIL

Public Forum
December 12, 2012

ILLINOIS DEPARTMENT ON AGING
ILLINOIS LONG TERM CARE COUNCIL MEMBERS

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Illinois Department on Aging

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Wayne Smallwood
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David Sutor
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Dave Vinkler
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Bill Bell
Illinois Department of Public Health

Gwen Diehl
Illinois Department of Veterans Affairs

Sergeant Todd Trautvetter
Illinois State Police

Illinois Long Term Care Council

February 28, 2013

On December 12, 2012, the Illinois Long Term Care Council held a Public Forum regarding Managed Care at the Illinois Department on Aging's Governor's Conference.

It was the intent of the Council not to come away from the forum with final answers and solutions, but to begin the open dialogue regarding how this frail and vulnerable population will fit into the Managed Care world. To have advocates, state agencies, services providers and managed care organizations all together, discussing their concerns and clarifying points, was a step in the right direction.

We have included in this packet a listing of all witnesses along with submitted testimonies and a roughly-edited transcript copy of the public forum. Please note that the copy of this transcript is provided in a rough-draft format. Communication Access Realtime Translation (CART) was provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings. You will find within these testimonies support for the goals of moving towards the Managed Care approach: improved healthcare, more control over costs and cost shifting, and improved communications among Healthcare systems. But you will also see concerns stressed by many witnesses regarding such things as consumer protections, quality assurances, monitoring and oversight, network adequacy and access to care.

The mission of the Illinois Long Term Care Council is to bring together individuals representing different perspectives on the issues related to long term care in this state. The Council was created pursuant to Section 4.04a of the IL Act on Aging and is appointed by the Director of the Department on Aging. The Council is also to make recommendations on a wide range of issues relating to the quality of care of residents of long term care facilities. At future council meetings, each selected Managed Care organization will be attending to answer direct questions regarding how service will be delivered to those receiving long term care services. From these conversations, the Council intends to make recommendations to the IL Department on Aging regarding the new Managed Care approach.

If you have any questions, we encourage you to contact either Co-Chair Director Holton at the IL Department on Aging at (217) 785-2870 or Tami Wacker at (309) 829-2065 ext. 209.

Sincerely,

Co-Chair
John K. Holton, Ph.D., Director
Illinois Department on Aging

Co-Chair
Tami L. Wacker, Regional Ombudsman
East Central IL Area Agency on Aging

Illinois Long Term Care Council Public Forum

Wednesday, December 12, 2013
2:30 p.m. – 4:30 p.m.
At the Illinois Department on Aging Governor's Conference on Aging
Chicago, Illinois

Panelists:

Director John K. Holton, Illinois Department on Aging
Tami Wacker
Sally Petrone
Phyllis Mitzen
Stephen Iden
Representative Mary Flowers
Senator Heather Steans

Witnesses:

Family/Advocates
Laura Prohov - CJE Senior Life
Kristen Pavle - HMPRG
Michael O'Donnell - I4A
David Vinkler - AARP
Myrtle Klauer -IL Council on Long Term Care

State Agencies
Director Julie Hamos – Illinois Department of Healthcare and Family Services
Beverly Laubert -Ohio State Long Term Care Ombudsman
Melanie McNeil - Georgia State Long Term Care Ombudsman

Managed Care Organizations
Michael Cotton - Meridian Health Plan
John Jansa - Molina Illinois
Sheri Husa - Illini Health Care
Dr. William Gerardi - Advent Health

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Illinois Department on Aging
Illinois Long-Term Care Council Public Forum
Sheraton Chicago Hotel & Towers
301 E. North Water Street
Chicago, Illinois
Wednesday, December 12, 2012
2:30 p.m. - 4:30 p.m.

Services provided by:
LMH Certified Reporting
3013 Harris Drive
Joliet, Illinois 60431
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>> TAMI WACKER: It is 2:30 right now. We are ready to begin. But we're waiting for a few people.

Okay, everyone. Thank you so much so much for joining us. Thank you for joining us here today for the Illinois Long-Term Care Council public forum. I'm going to give you a few ground rules for today. If you could shut off or silence your cell phone so it's not interrupting to anyone here. We're also going to be doing a lot of transitioning. We're going to be bringing the witnesses up in panels, so if you give up a little bit of time for the transition period, and we'll try to make sure this is a seamless type of operation.

Okay?

We'll go ahead and -- and my name is Tami Wacker. I'm the regional ombudsman and operations manager with the East central area on aging and I'm cochair of the public -- of the Illinois long-term care council.

>> AUDIENCE MEMBER: Would you use the mic?

>> TAMI WACKER: Okay.

>> There's chairs up here.

>> There's some up here.

>> TAMI WACKER: Could everyone hear me now?

>> AUDIENCE MEMBER: Yes.

>> TAMI WACKER: Would you please just turn your cell phones off or silence them. And then we'll go ahead and begin. Again I'm Tami Wacker from the Illinois Long-Term Care Council.

>> JOHN HOLTON: Good afternoon, everyone. I'm John Holton, director of the Department on Aging. Welcome to this important discussion and forum sponsored by hosted by, developed by, conceived by the Illinois Long-Term Care Council. The Illinois Long-Term Care Council is an advisory body to the Department on Aging. Its focus particularly is on older adults who reside in facilities, nursing facilities and other facilities, and the purpose -- the concept behind today's forum was to make sure that we don't lose sight of thousands of older adults who have, either by choice or less than choice, find themselves residing in a long-term care facility, and the emphasis, budgetarily and often conceptually within the department is on home services, which we know is much less expensive to provide care for someone in their own home and in their own community. It's much more expensive to have services provided in a nursing home. Regardless of that reality, we don't want to lose sight that the value of a person who resides in a nursing home is just as important as a person who resides in their own home or in the home of a loved one, relative, guardian. And to that, we wanted to review what is coming in our state via managed care, and what that will mean for folks who reside in long-term care facilities.

So we have organized a series of panels to come and offer to this distinguished group at the dais who will introduce themselves, but will also ask questions of our panelists to clarify comments or statements that are made, to make sure that this department moves forward in a way that is fair and the way that achieves parity of services, and a way that allows us to realize our mission, which is to provide and administer services in a dignified manner for older adults.

So with that, let's bring up our first panel, which consists of family advocates.

>> Lurletha Ward, Leslie Best, Michael O'Connell, Kristin Pavle. If you'll come up to the panel and take a seat. O'Donnell, I'm sorry. O'Donnell.

>> TAMI WACKER: And the panel also -- Dave Binkler and Myrtle (inaudible).

We have a statement that's submitted by Mary Ann (inaudible) of the Catholic archdiocese of Chicago.

>> JOHN HOLTON: I think Laura Provol from CJE senior life is also on this panel.

Before you give us your testimony, why don't we have the panelists on the dais introduce themselves.

>> STEPHEN IDEN: My name is Steve Iden. I work for Land of Lincoln legal services and I'm a senior advocate.

>> HEATHER STEANS: I'm Senator Heather Steans. I represent the northernmost lakefront district in the City of Chicago. I got into nursing home issues, because we have many there, many of those taking care of people with mental health challenges and I became an advocate to try to make sure we had people into home community based care settings and I was also the person who helped negotiate the Medicare reform law. So I am very much interested in hearing from folks on this. It's new to Illinois. We have a lot to learn and I'm thrilled to be part of the panel up here and listening to what everyone has to say.

>> PHYLLIS MITZEN: My name is -- is this on?

My name is Phyllis Mitzen and I am with health and medicine policy research group, the center for long-term care reform. I also serve on the long-term care council and also on the council on aging, so we are very, very interested in hearing what people have to say about this transformation in the state from the system that we've known for so many years to a system of managed care, which offers, as was said earlier, some hope and promise.

>> SALLY PETRONE: Good afternoon. My name is Sally Petrone, I'm state long-term care ombudsman for the State of Illinois and I welcome you and thank you very much for attending today's public forum.

And I am with the Illinois Department on Aging and I am also part of the long-term care council.

>> PHYLLIS MITZEN: And by the way, I will be the timekeeper for today. I've got my two minute and one minute warning.

(Laughter.)

>> TAMI WACKER: All right. Do we want to get started?

>> Thank you. Can everybody hear me?

>> AUDIENCE MEMBER: No.

>> No? Okay. Good afternoon. My name is Laura Provol, I'm the vice president of services at CJE senior life. We have been committed to providing subsidized community based and residential services for 40 years. We have enjoyed a very long partnership with the Illinois Department on Aging through our community care program, managed community care program, and also CCRS for more than a couple of decades. Our agency mission statement and the broad array of services speaks to our commitment to help older adults age in place and remain in the community as long as possible and then to provide needed options when this is no longer the case.

CJE currently operates a 240 bed skilled nursing facility, which accepts both Medicare and Medicaid clients. We have implemented targeted initiatives at our skilled nursing facility, and as a result, have reduced rehospitalization rates to 19 percent. National average is 26 percent. Just by point of reference.

I'd like to make three points about the performance of provider

involvement in the planning and implementation of the state's new managed care initiatives as it pertains to this long term clientele.

First of all, we certainly recognize that the system for providing older adult services through the state is changing. And we are willing to be on board with the new initiatives. We welcome the opportunity to participate in the process as the state transitions to managed care and frankly we applaud the opportunities to link the services that serve our older adult population in Illinois. It is a fragmented system right now.

There is significant emphasis on providing supportive services post hospitalization, but we would also note that the important role of providing services to older adults prior to hospitalization so that we can help them maintain their health regimen and avoid unnecessary hospitalizations. We long have been known as an innovator in the field of aging and are one of 50 organizations selected nationally by federal CMS in collaboration with area hospitals, focusing on reducing rehospitalization rates for community residing older adults as well as older adults in nursing homes.

In our ongoing role as advocates for frail older adults we feel strong think that providers such as us give an opportunity to provide input into the process in rolling out the new managed care initiatives. We're not in a position to manage the geographic reach or capacity of some of the larger providers in Illinois but like many of our peer agencies which collectively care for thousands of older adults we bring experience to the table. We are now transitioning from a system in which we provided this care inclusive of the managed care function to a system that will redefine and reduce our role to simply be vendors. The state shouldn't ignore the important contributions agencies such as CJE have made in shaping older adults services in Illinois by simply handing the reins over to insurance companies charged with managing the managed care initiatives. After 40 years of providing services, we have learned much about caring for this population. We can identify best practices, client care systems and accountability measures. The process of implementing managed care should include input from CJE and other season the older adult service providers, so that what we have learned from decades of experience in partnership with the state can be incorporated into the new system.

Thank you for the opportunity to speak, and we look forward to continuing our work with the State of Illinois on behalf of older adults.

>> Can you hear me?

In the back, yes?

>> AUDIENCE MEMBER: Yes.

>> Good afternoon. My name is Kristin Pavle, and I'm the

associate director of health and medicine policy research group in the center of long-term care reform. We are also a health and medicine. Thank you for the opportunity to provide testimony today.

HMPRG is a 30 year old policy and advocacy think thank that promotes social justices, we have worked since 2001 to develop a strong long-term care system in Illinois, that supports the needs and desires of older adults and persons with disabilities and their caregivers. Our work includes analysis of managed care in the state's transition to a Medicaid managed care system. While HMPRG supports this transition, we are concerned about its potential impact on seniors and persons with disabilities for the following reasons.

First, Illinois has a low penetration rate of capitated managed care that serves people with disabilities. The only program is the integrated care program and it has been in existence for two years.

Our second concern is the state Medicaid agency, HSS, has not had experience with implementation of managed care that includes long term services and supports.

Finally, the state is attempting over the next six months to (inaudible) long term services and supports and targets seniors and persons with disabilities. The second phase of the integrated program, the innovation project, and the Medicare and Medicaid alignment initiative. We are concerned that this transition is happening too quickly.

Today I want to share with you the research and recommendations that HMPRG has developed in collaboration with SEAU, healthcare in Illinois and Indiana that addresses these concerns. Our recommendations focus on how Illinois can ensure consumer protections and quality assurances in its new managed care system, specifically focusing on seniors and persons with disabilities and people who require long term services and supports.

There are seven main areas that our research and recommendations cover. The first is member education, which is integral to the success of the managed care system and focuses on the providers to the transition to the managed care system, what changes to expect and how to get involved.

The second is monitoring and oversight, which describes the role that HSS must provide to MTEs. This is the single most important activity to ensure accountability and success of Illinois' managed care system.

One important recommendation in this area is that HFS works closely with the departments on aging and human services, which have years of experience in LTSS monitoring and oversight.

The third area is consumer input. HFS must ensure through its contracts with MCEs that consumers have a voice and advisory capacity in the involvement and implementation and through appeals and grievance processes. The role of an independent ombudsman is

important in this area.

The fourth area is network adequacy and access to care. For individuals who require LTSS, provider networks and access to care must extend beyond traditional managed care requirements. A priority recommendation is that HFS ensures eligibility. For individuals who require LTSS receiving these services in a timely manner, can make the difference between staying at home and in an emergency room visit. The fifth area is continuity of care. As Medicaid beneficiaries transition. This transition is important for seniors and persons with disabilities who require LTSS, because this population has many different providers who provide care frequently. Without ensuring that the providers are in new manage the care networks or care is transitioned to a new set of providers, seniors and persons with disabilities are vulnerable to poor health outcomes.

The sixth area is LTSS provider standards. We recommend that the state develop universal standards for personal assistants and other LTSS providers. Nationally there are guides to developing these standards. It's ultimately the state's best interests to ensure LTSS providers are operating at a baseline standard of quality to ensure positive health outcomes.

The seventh and final area is evaluation and quality measurement for consumer outcomes. LTSS are provided frequently over a long period of time and are often intimate in nature. For example, think about someone helping you use the toilet or to get dressed. Adds such evaluation and quality measurement is particularly important and must include the personal relationship between caregiver and care receiver.

The overview of us that I presented today is the beginning of ongoing work and potentially the beginning of legislation in Illinois of how we manage LTSS in our state. I look forward to working with many of you in the room, to ensure consumer protections and quality assurances in Illinois' managed LTSS programs and I thank the long-term care council for your time today.

>> Good afternoon. My name is Mike owe dodge. I'm chairperson of the Illinois association of area agencies on aging's legislative committee and I'll be presenting testimony on behalf of the 13 area agencies on aging in our state.

The Department on Aging and the area agencies should play a critical role in facilitating the statewide implementation of long term services and supports for individuals enrolled in managed care through moat the integrated care program and the Medicare Medicaid alignment initiative. The Department on Aging can ensure a transparent implementation process for the delivery of cost effective services and director Holton we thank you for your leadership in helping that happen. Areas on aging have a statutory mandate to provide long term services and supports in every

planning and service area in our state. To enable older adults to live in their homes with health, independence and dignity for as long as possible and if they go into a long-term care facility that their rights are upheld. Area agencies on aging have over 38 years of experience administering grants and contracts with over 250 community based provider agencies, including elder abuse provider agencies and regional compare ombudsman programs. Area agencies and their provider networks serve over 500,000 older adults and 43,000 caregivers annually. Triple As in Illinois are managing ageing and disability resource networks in collaboration with the Department on Aging and Centers for Independent Living. Our ADRC network is a national model that has been included in the Affordable Care Act as a single or coordinated point of entry for long term services and supports for older adults and persons with disabilities. Triple As and their ADRC networks can carry out multiple functions to implement managed care in collaboration with traditional community partners, including contracted care coordination units. To provide assessments, eligibility determination, care planning, care coordination, and care transitions from hospital to rehab facility and back home again.

Area agencies on aging and ADRC networks provide a variety of services beyond those authorized under our Medicaid waiver community care program. To enable managed care organizations to respond holistically to the needs of older adults and persons with disabilities enrolled in managed care. These services can include information and assistance and benefit screening, the enhanced services program which provides a database of statewide services for older adults and persons with disabilities. The senior health assistance program which has helped so many older adults find affordable prescription drugs, outreach, partnerships with community organizations with cultural competencies that hold inclusiveness issue that we talked about earlier today. Transportation to access to non-emergency outpatient healthcare services, which is critical. Nutrition assessments and education. Home delivered meals and well-being checks. And evidence based programs such as the chronic disease self-management program to empower the consumer to take charge of their own health and of course adult protective services, and education and respite services for caregivers.

We feel we have the experience and the skills to assure quality and accountability. We administer federal and state dollars currently through grant assistance with the community organizations and we have staff who regularly monitor grants, administration and service delivery for hundreds of community agencies.

The aging network brings added value to managed care by ensuring that community based long term services and supports are linked seamlessly to individuals enrolled in the Medicare Medicaid alignment initiative and lastly Triple A's and their ADRC networks

have earned the trust of older adults and their families. They can engage families and their networks to provide quality customer service to their members, including information assistance, problem solving, complaint investigation and advocacy.

Thank you for this opportunity to testify.

>> Thank you to the panel for having us. And share our thoughts on managed care and moving forward with long-term care under the managed care system. I tailored my comments to the questions posed in the session. The first was how managed care will affect the client.

>> JOHN HOLTON: Who are you?

>> Sorry. I'm David Vinkler with AARP.

(Laughter.)

So the first question was how managed care will affect long-term care clients and in the spirit of some of the things that Phyllis brought up, I want to highlight some of the things that we hope to see. First, managed care will provide Illinois an opportunity to really redesign in a holistic way how we look at managed care. This is especially important since Illinois leads other states in the number of low care need residents in nursing homes, as was found in the scan foundation report that came out just a couple of years ago, so what that means is Illinois has a system that is paying way more than we need to pay for long-term care services.

And as we fought and fought for better quality, we really ought to see that quality in nursing homes and that has to come with those payments.

The other thing, and I'm kind of channelling the former director, Charles Johnson here who frequently criticized how we invested in the community care program, the packages of services can be expanded beyond what we have right now. Now, having said all that, we need to make sure that we're not doing this just under the auspices of budget cuts. We know the state budget is contracting. We know that a good number of these initiatives come under the auspices of cuts, and reducing and spending in Medicaid. So that will work against us in achieving some of these goals, so if we say the program is a mile wide and an inch deep we want to expand the service package in the community. We need to make sure we invest in it. And what that's going to take is really consumer voices being involved in this process.

So -- and I'll get more into that a little later, but the second question was the long-term care council, and what its role can be in the future. I think the long-term care council and the ombudsman have a unique perspective. I think a lot of our advisory committees are really focused around provider organizations, talking about how their role is going to be affected by managed care. The long-term care council is an organization that offers advice from ombudsman. Ombudsman that are frequently volunteers, and their entire role is quality in the provider driven system. So

they offer a unique perspective. Often they're relatively small groups so they can be overlooked but their expertise in this will really help us design a system that really puts quality first. And quality needs to be as much of a driver in this system as the cost savings.

So the last question is what statutory changes are needed, and we have a lot of statutes right now. What I will say that's changed in my job as a lobbyist for AARP is we spend a lot more time under this system, or under what we've seen in the smart act, and what we've seen in Medicaid reform, in administrative advocacy, and working not just in the legislature, but on advisory committees. Going to the departments, going to JCAR, and these are very, very complicated times, and it really makes it very hard for consumers to get involved, but -- and I probably should be facing the other way. I would call for all of the advocates that are here today to make sure that they're participating in all these venues. I think HFS has made it relatively easy to advise on what we'd like to see in each one of the managed care roll outs, so make sure you're going on the website, getting involved, going to advisory committees, asking how to get involved. I think what you have in the panel here today is a lot of people know where you should be, where you should be investing your time and how you can make this system reflect the voices of advocates and consumers.

So thank you.

>> Hello. My name is Myrtle Clower and I'm the director of resident services of the Illinois council on long-term care. I too am a member of the long-term care council. I sit on (inaudible) and I am on the board of the Illinois pioneer coalition. I've worked for 40 years in long-term care. I am here this afternoon on behalf of the healthcare council of Illinois.

The healthcare council of Illinois embraces what the state wants to do regarding the implementation of managed care. However, I want to remind you that the residents in today's long-term care facilities have medically complex needs. Other states that the have tried managed care have abandoned it as there is not enough cost savings due to these medically complex needs.

It is for this reason that most states do not include long-term care in the managed care mix. While the healthcare council of Illinois supports the effort of the state to manage healthcare costs, we urge you to remember that any transition to managed care must preserve the long-term care infrastructure so that needed services are available to all people in Illinois. It is also our hope that you will allow the industry associations to share our expertise, and help you as we step forward into the managed care world.

Thank you.

>> TAMI WACKER: If the witnesses will stay put for a few minutes. If the panel has questions. We have three minutes to ask

you questions. Any questions?

>> HEATHER STEANS: Well, I would love to ask just one. I know you were -- I'm wondering what the consistency or inconsistency between a couple of the panelists in terms of where we need to as a state be investing resources at this moment in terms of focusing -- I think Myrtle you were mentioning the infrastructure for the long-term care infrastructure must be preserved. I also heard speaking of trying to invest in the community and infrastructure as well. Does anybody have any insights or thoughts they'd like to share on that?

>> If you look at statistics, a lot of our facilities are now going into the subacute care and our goal is to return people to the community and most of our patients stay less than 90 days. They go back out into the community. And that's our goal. So we keep only the frailest of the frail.

David mentioned that across the board, Illinois has low care people. Illinois makes no provisions for the mentally ill. That's why they are in long-term care. And so if Illinois would focus their money on a program and housing for the mentally ill, it would take them out of nursing homes, to convert those, because those are your low care residents.

>> HEATHER STEANS: Thank you.

>> May I add one point? As spokesperson for a community based services, the integration of healthcare and in home services is absolutely imperative, as we try to help older adults manage medications, and this is one of the chief reasons why they reenter the hospital, and so I think the promise of managed care is it will be able to have qualified healthcare professionals working arm in arm with community based care coordinators in home care to provide the skilled aspect of medication management that we currently lack.

>> HEATHER STEANS: Is that a service currently in the CCP program?

>> No.

>> No.

>> It's really needed.

>> I would also add that because care is a costly continuum, I think managed care is a good opportunity to do evaluation (inaudible) whether it's home based care, low needs or skilled care high needs, (inaudible) spending money, where are the gaps, how can the state come fill in where those gaps are in quality.

>> I think just to add one last thing and take up your three minutes, we want to focus on the front door, and I think managed care is a good way to do that. Why are people going into this as many as opposed to that system, and I think that's really where we should emphasize our focus. If people are going into the wrong venue for care, that's a problem. If they're saying there, that's a problem. I think the managed care organizations will really look at that, from a cost perspective. It's going to be up to us in the

design of the program to look at the quality perspective and make sure the managed care makes that a priority.

>> STEPHEN IDEN: I have a question. Miss Pavle. You had stated before that you thought the process was going too fast. What kind of time frame were you thinking about in your analysis?

>> KRISTIN PAVLE: You know, I haven't put much thought into an actual time period, but I think in my experience what I've seen is a lot of action and not enough time for stakeholders to actually sit around the table and say what is the time line that we think we can agree on that seems reasonable and agree on benchmarks as we move along. I think to implement three new programs that include capitated managed care with seniors and persons with disabilities for the first time ever in Illinois history within six months is just a huge undertaking and while we support the ideas behind it, I don't know if I could put an exact time on it, but I do think it would be something that would be nice to stagger a little bit. And to have a conversation between current providers, current consumers, what do you think is reasonable, how are we going to do this together.

>> Our conversation thus far is mostly around managed care without a real sense of what the rate is going to be. So it's easy to talk about what managed care could be when we don't know what the scope of the rate will allow.

>> TAMI WACKER: Thank you all.

>> JOHN HOLTON: Folks in the back there, there are seats up front for each and every one of you. And now would be a good time to come up while the next panel comes forward.

>> The next panel is state agencies. Julie Hamos, Beverly Laubert, Melanie McNeil, Sandra Alexander.

>> TAMI WACKER: And while our next panel is coming up I want to you know the process for this. So the submitted and oral testimony, we will have a transcript of these. These will be posted on the website on the Illinois Department of Aging under the long-term care section. It will be mailed to all of our legislators and if you are interested in receiving a copy of the packet, you can see me afterwards and make sure you have the information on that, okay? Thank you very much.

Yes?

>> AUDIENCE MEMBER: I just have a quick question. Is there any time for the audience to ask any questions or not?

>> TAMI WACKER: At the very end of the session, we can see if there's any questions. We don't know if they'll be able to be addressed to the panelists, but we'll make sure the council gets them answered and gets them out to the public.

>> JULIE HAMOS: Good afternoon. Julie Hamos. I'm the director of the Department of Health care and family services.

So first I want to say that we have in the front here some of the real leaders of healthcare reform. Senator Heather Steans who

I don't have enough chance to say publicly what an amazing job she's doing in the state legislature. Taking a huge amount of time in understanding the issues, dignity and really not glossing over the complicated set of issues and we need good support but also oversight in our we'll really rolling out some of these major very significant changes.

And John Holton, who is my partner in crime in some ways. (Laughter.)

I consider him to be a visionary leader who again asks probing questions, challenges, should, he should do that, but at the end of the day I think we see each other as partners and we're moving along arm in arm in trying to make sure that this is a really good program and system that we're rolling out.

So let me -- I listened to some of the previous panel, and most of it actually, and I know those people. I know their organizations. I have a huge amount of respect. I have been working in the trenches with them for a long time. Most everybody sitting at this table, if not everybody, so I think we're all on the same page. I just want to say that we all are -- we have the same value systems. We all understand the challenges, we know the players.

Having said this, this is a change. This is a change and I would say a very much needed change in our service delivery system. So as everybody here knows, senator Steans was again at the table when we created the state law that said that 50 percent of our clients will be in care coordination within the next two years. That is not the impetus that's driving this effort. It's a backdrop, and it's important, and in some ways (inaudible) to our sales, but actually this would be -- wind to our sails but this would be needed at this point in time. It is the national movement, it is an era of innovation that in some ways the Affordable Care Act I think launched and how we can improve the service delivery system and we are on that exact same wavelength. We would be doing this even if we didn't have that state law. We are doing it a little bit differently than other states. You heard that at this table and there was some caution expressed because it is true that almost every other Medicaid program in the country, certainly in all the major states, is -- has made a movement toward managed care in some cases 10, 15 years ago. And yes, they did start with children and families, and those are the babies to start with. We're starting at the other end with the most complex cases, the people who have the most complicated health conditions, in many cases behavioral health conditions, but really, these are the people who need care coordination the most. So I would say to you that, yes, we're starting in a different way than other states, but if these are the -- I would say that this population really needs some assistance in navigating what I consider to be, and now that I'm in it, even more so, a very much fragmented, siloed system.

How many minutes?
>> Five minutes.
>> JULIE HAMOS: How many do I have left?
>> Two.
>> JULIE HAMOS: I didn't see it. That's okay.
>> JOHN HOLTON: She can have more.
>> Oh, terrific.
>> JULIE HAMOS: I have two more?
>> JOHN HOLTON: Seven more.
>> JULIE HAMOS: Terrific.
I was going to try to cram them into two.
(Laughter.)
So let me just say this. I consider this to be a very much a fragmented system, and in part -- part of the reason, I want us to do some self-analysis here, is because we have spent an endless amount of time talking about the medical model, and the social model. And that dichotomy I think in some ways has created some fragmentation, and I think in anything, our care coordination programs that we are rolling out will bridge those two. I think we all get it. You get it. I think the managed care companies need to understand that the social model is equally important to people with these sets of needs. And they see the providers of those services, what we've typically called the waiver providers, to be an essential part of being in the mix of what our clients need. Our clients need. So in part we're going to break down those silos and it's challenges because in some ways the provider community has created those silos. Again a little bit of self-criticism and self-analysis is when we have -- and our state agencies have done the same. So we have a senior who has diabetes and mental health issues and who also needs meals on wheels, he needs four different agencies, five different programs, across town. We need to integrate that. We really believe that an integrated delivery system across those realms, social and medical, will create better health outcomes. We truly believe that. Now we need to measure that. And we need to hold the companies accountable with that. We agree with the people in the previous panel that said that's an important role. I think of our agency as changing roles. We heard this from other states, as being an agency that will be managing the managed care companies and entities. We went to the legislature the very first year, even before our major rollout this last spring in the budget was so tight and it was so challenging as you all know, the real terrible wrenching problem we went through, I call it the wrenching process. We also said that we need to boost our managed care bureau to make sure that we're doing that kind of oversight. So we are doubling the staff and we're creating -- we already have a national consultant working with us to really help think through what we need to do to make sure that this happens effectively. And that we are providing the right

amount of oversight.

Now, we also believe and I think everybody here does too, that we need to have performance standards. Now, we are looking at the performance standards across the board for all of our state agencies and how they collect that data now and what they are collecting and what we need to be collecting again across the board.

And by the way, today we're talking about some of the rollout, the integrated care program vendors, there's two of them, as you know, the future, which I think there will be eight managed care companies that we said we could bring on board as soon as the feds allow it, but we also have some other models in Illinois. As you know we have care coordination entities, provider organized networks, and we have so far one managed care community network, again a provider organized entity, across the board they're going to be working with these complex populations, seniors and persons with disabilities. We think that the what we're calling now the health and quality of life standards should be applied across the board. All of them should be asked to report and keep -- and track the same set of measures. We are now as state agencies looking at what those look like, what they are. Again crossing the realms, health, medical model and social model. I think we do need stakeholder input into developing those and finalizing those. We're at the very early stages of looking across the board into all the agencies, but I would welcome the opportunity to work with the stakeholder group in reviewing those and getting feedback and input and consensus around what those should be, and once we decide, let's decide those are the standards, and let's apply them across the board and hold everybody accountable to the same set of standards. So I really believe in stakeholder input in many of those things.

So let me stop with that and say that we understand that change is difficult. We are going to be asking the provider community to change the way they do business, but I really believe that our vision is that when we have providers working -- providers and managed care companies and care coordinators working together, in a very much multidisciplinary kind of fashion, across agencies, across disabilities, across services, and that when we really provide care coordination for the people who need help in navigating this complicated system, it -- we will have better results and better health outcomes.

Thank you.

>> Thank you. I'm Beverly Laubert. I'm the state long-term care ombudsman from the state of Ohio. Given the scarlet and gray that I'm wearing.

I am really happy to be here and I appreciate this opportunity. I have written testimony. I won't read through all of it. I'll focus on a few areas. But I'll start with a quote from Greg Moody,

who is the director of Ohio's governor's office of health transformation, when he said, we are at a real moment here. And I can see Illinois is now at that moment too.

Just today, governor John Kasich issued a release to announce that Ohio now has a signed memorandum of understanding with CMS for integrated care delivery system, our dual eligibles project. We will be providing.

>> JULIE HAMOS: (Inaudible).

(Laughter.)

>> We were trying really hard, we were third and second with the model that we have.

We are -- we're a little competitive.

(Laughter.)

So my remarks here today are really to talk about how I believe that the role of the ombudsman and consumer advocacy is really a natural fit with this new system.

We will be in Ohio beginning enrollment in ICDS, integrated care delivery system in September of 2013. And I believe the original vision paper was issued in early 2011. So it has taken some time, and there's been an excellent stakeholder engagement process, and in my remarks you'll see an excerpt from the stakeholder engagement report.

I think that it's important to note that as everyone else has said, the system is fragmented, it's often difficult to have Medicare and Medicaid systems talking together to really focus on the individual.

I have also in my written remarks some experience with money follows the person, which is kind of where I'm -- I learned some of the experiences that I think will serve us well going forward into working with managed care.

I think that it's important for the facility-based provider community to adapt to welcome care management without relinquishing their responsibilities to provide quality care. One of the things we learned with money follows the person was once we had transition coordinators who were charged with helping a person find housing, helping them get signed up for benefits that they lost when they went into the nursing home and so on, that the social service staff of the nursing home said, oh, you're here. You're doing that. I don't need to. So I think it's important to make sure everybody is fulfilling the roles that they are required to fulfill to make sure that the consumers are getting what they need.

Ombudsmen can provide a wealth of information about the quality of services that are available, provide data about complaints. I met with one of our managed care companies already. I met with one of our managed care companies earlier this week, and talked about the kind of information that we can share and when they contract with providers, that they should call an ombudsman and say we're thinking about contracting with ABC nursing home. What can you

tell us about them, to make sure that they're really contracting with quality providers.

Several years ago, some national organizations got together and put together some things that states and ombudsman programs should consider when expanding their -- not expanding their role, but expanding the area in which we advocate. And so my -- again my written remarks kind of walk through those considerations. One is making sure that ombudsman are at the table in these discussions. We know a lot about the systems that residents of nursing homes especially, in most ombudsman programs and in Ohio we also provide advocacy for home care consumers, so make sure that an ombudsman is there and provide information about the real experience of residents of facilities.

It's important to -- for an ombudsman to expand their knowledge and skills in these areas. I know at least in Ohio we don't license home care, so in nursing homes, we have a pretty big regulatory back pocket. If we are not able to get cooperation in trying to resolve a problem, we know who the regulators are. We work with them well, and so when you're expanding into other services, it's important to learn those systems for consumers receiving care in home and so on.

Important access to legal counsel. We will help someone who is in a Medicare advantage plan with navigating, if they maybe a resident of a nurse home, gets denied or terminated from therapy and they want to appeal that. We've learned that it takes real distinct training and expertise to assist someone with those appeals. So I think it's ready important for an ombudsman as you're going forward and consumer advocates to make sure that you have a good connection with legal services and people who can help you with those kinds of complicated appeals, and cultivating those referral relationships.

Sources of funding. If the ombudsman program gets involved and we are in Ohio, I'm going to be involved in ICDS. That Medicaid, administrative funds are really an under utilized source for ombudsman and we have federal agencies talking among themselves and the national association of state ombudsman programs weighing in frequently on the unique role of the ombudsman that were key in the effective and efficient operation of the Medicaid program. We are independent overseers of quality and consumer rights, so I believe that that's an important consideration.

And I just finished -- can I just finish a couple of sentences? Something else I would strongly urge you to do is not compartmentalize funding and services the. The federal government pays for ombudsman to pay for services in facility based environments and in Ohio we have other revenue sources for our home care work, and it's important that we not say this pot of money has to be used for this home care, because it then just becomes too complicated to administer.

Consider conflicts of interest and make sure that you have solid -- a solid core of advocates before you move forward.

Thank you.

>> I'm Melanie McNeil. I'm the state long-term care ombudsman for Georgia, so go dogs.

(Laughter.)

I had to put that in.

And I also -- just a quick story, because you a few folks have for nor gotten to introduce themselves. We were at a church and we did a prayer and I launched into our presentation and about five minutes in a guy in the front, an elderly guy said who is she. So we all do that.

I just wanted to share a few things about our Georgia experience, because I think we're kind of in the same position that Illinois is in that we have managed care in Georgia, but we started with the traditional Medicaid population, so children and moms. But now we're talking about managed care for long-term care. So as our Medicaid agency was talking about that, and rolling this forward and had a very aggressive time line, we're going to have a report last January, we were going to have an RFP out by the spring, we're going to have a contract by the summer, all the advocates, including ombudsman, providers, other individuals, said, wait a minute. You know, you're moving way too fast, which is what we have people here who are concerned about the speed. So the advocates really got together and went to the department to say, this is a big change that you're making. We'd like you to convene some work groups, really talk to the stakeholders, the providers had a work group, advocates had a work group. The core data group -- I should say advocates for age line disabled, that new group coming in, the advocates for people with mental health and the department convened those groups and we sat down with them to say as you're looking at this, you have a certain amend of data and a -- amount of data and a certain plan going forward but you're looking at things generally rather than specifically and it's important to really be sure what you're doing isn't just taking a broad brush and making a change for change sake. So I say to the advocates to make sure you raise your voice and say please include us.

We also asked that as the department thinks about implementing managed care for age line and disabled that they do it in kind of a rollout way with increments. So start with those folks who aren't managed first, because as we know, for this population that we're going to be including now, age line and disabled, some folks are in waivered programs, so they have some care management already. Do they really need to be managed right off the bat? Maybe not. But there are some folks, those individuals who are on waivers that have developmental disabilities, or behavioral health issues, they don't really have care management. So why don't you start with

those folks first and it seems like that's likely what they will do. Foster children were also carved out in Georgia, so start with them. Do something to help them first. And evaluate as you go along what's working and what isn't, and add these other groups. So the representative from the area agencies on aging was describing for you there's already some care coordination and some management for at least some folks. Well it seems to me, and this is what we have been urging our department in Georgia, is don't manage them right off. Get to those people who really need the management first. And evaluate and then move forward from there.

So we are in the process of making some formal recommendations to the department as well. First of all, we want to be sure that our department is not overlaying care management for people who are already managed. So that's our first suggestion, and to be clear, who is managed and who isn't, so one of the advocates that is involved with us works with individuals with hemophilia, for example. We don't get paid for care management, but we do care manage these folks. So let's kind of set out at first who isn't care managed and let's attack that, and then let's add these other folks as we need to. So just making sure that we're very thoughtful about how we do the managed care. Also recognizing that people who are to be managed are very diverse, and so, you know for us in Georgia, ADD is the most expensive group, but if you look at ADD, not everybody is really expensive. Some of the people on ADD is really expensive but not everybody. So as you're looking in Illinois at managing folks, you might do the same thing, you might take a look and see who is the most expensive and let's look at those folks, drill down through your data and figure that out. It was interesting, one of our advocates is the parent of a man with physical disabilities, and he said, you know, the folks with physical disabilities on that waiver are the most expensive, but if you look at it, it's really just a handful of folks. Not everybody who is profoundly disabled goes to the hospital all the time. My son is profoundly disabled but he has been to the hospital only once in 30 years. So I suggest you look closely at what the data provides.

Make sure there's a process for appeals and grievances for folks. But most importantly, I think since I'm an ombudsman, is making sure that there's ombudsman services available. Legal services, so the elderly legal assistance program or your protection advocacy agency are the folks that need to be available for those formal appeals, but ombudsman are folks that residents know. People might tell an ombudsman what they won't tell anybody else, and an ombudsman are often very creative at problem solving so it may be that you don't have to get to the appeal or you don't have to get to a grievance. An ombudsman can help that person navigate what the situation is and resolve that pretty inexpensively.

And the last thing is accountability, so just making sure that as you use a care management organization that they really are providing some accountability to you about what they're doing and if there are some issues related to performance, then that you have some abilities to make some adjustments to whatever is going on. Just one other quick thing. In Georgia a few years back, we had a new M MIS system. And you know, you write the contract thinking everything's going to go great. Well, it didn't. And they had some ability to require some accountability, but not as much as they should have, so this time around when it comes to managed care, the department has learned we want to go with a positive way of doing it, but we do also need to be able to have that ability, when things don't go the way you wanted it to, okay, let's regroup or do some other things. So I would just urge you to be sure that you have some abilities that way too.

So thank you for the opportunity.

>> TAMI WACKER: Any questions? Representative Flowers, would you like to introduce yourself?

>> MARY FLOWERS: Good afternoon. I'm state representative Mary Flowers. And I am the chairman of the healthcare committee, and it's really my pleasure to be here. I have a conflict of interest 'cause one day I do look forward to being old.

(Laughter.)

Older. And I think we have to go forward and prepare a place, and -- for our most vulnerable population, and I really appreciate your testimony, Miss Georgia. I'm sorry, I didn't get your name, about being accountable. And going slow with what it is that we're doing and not paint with a broad brush, because all of -- we're not cookie cutters. We're all not alike, and all of our age, line and disabled do not cost the state a lot of money and I think the way we have gone about it, we have put a burden on this vulnerable community and we're not even prepared to deal with it. So thank you very much.

>> I just want to comment. Everybody's going to call her Miss Georgia.

(Laughter.)

The state ombudsman network is a very tight program.

(Laughter.)

>> HEATHER STEANS: So you're Miss Ohio?

(Laughter.)

>> And I'm Miss Illinois.

>> MARY FLOWERS: And Miss Illinois.

>> TAMI WACKER: Are there any questions from the panel?

>> MARY FLOWERS: Well, I would like to know, Miss Illinois, how is our program coming along as far as -- because I wrote a letter asking you to give me an update on the population, as well as how is it -- the cuts that we've made for the age, blind and disabled, because oftentimes we don't know the problems that we cause because

these seniors can no longer afford their two co-pays now, because we only limit them to four prescription drugs, and some of them need six. So they have to go into their pockets to pay for that, and so we're costing them more moneys. And the biggest problem, that group of people were not prepared for things we have done to them, trying to balance the budget, and it appears to me that we've cost ourselves more money as opposed to trying to save moneys off this vulnerable community. So can you tell me what is the status?

>> JULIE HAMOS: So I wish I could.

It is true that we implemented all those cuts very fast. Illinois cares RX is an example of that, which we've cut out pretty much overnight. We were under the budget pressure to get to the cost savings estimates that we put forth.

And it is true that co-pays are an issue, but I think a lot of providers are not collecting it. And so it's an indirect rate cut when providers don't collect it because we still take it off their plan.

>> MARY FLOWERS: I would say that, because in my community, they're collecting it.

>> JULIE HAMOS: But I do want to just make a correction that I think is important, that the force script is not a hard limit at all. It does require prior approval for drugs, more than four scripts. We're still at eight right now. So we are reviewing people who are taking more than eight different drugs, eight scripts, and there is a prior approval process for that.

>> MARY FLOWERS: I hate to interrupt you (inaudible).

>> JULIE HAMOS: Certainly the pharmacists and doctors are saying that there's a limit because they are the ones who are able to override it. We should never have called it a limit. It's a prior approval process is what it is. And we're still at eight. So we're not even close to the four. We'll see if we get there.

But it is the case in the Medicaid world that providers sometimes take a long time getting their bills to us. It used to be a year. They had a year getting their bills to us. Now we have reduced that to six months. We are now today in early dice and we don't have a lot of -- in early December, and we don't have a lot of bills so I don't know how it's going.

>> MARY FLOWERS: I guess I wasn't -- this is not a putdown to the providers. I'm really more interested in the type of and the quality of services that our constituents are supposed to be getting. Just to give you an example, I was at Access Living and a young lady who is hearing-impaired, all she needed was a new battery. The old battery was causing a piercing sound in her ear. She just needed a new battery. She never did get that new battery, but she did get an operation. An unnecessary operation. So when you talk about managed care, and -- it was stated earlier that we really need to look into the population and get the vulnerable population first, because some people who were in the system

already, they were getting the necessary care that they needed, and what we have done has created a bigger problem, so this young lady who needed just a new battery ended up with an ear operation, which cost the state a lot more money, and she still can't hear because she still hasn't gotten a new battery.

>> JULIE HAMOS: And I would love to know if she is one of our -- we don't have many people in managed care right now. So we have a small population. I would love to know if she's one of those because the one thing that managed care companies has a financial incentive is to get her the battery instead of paying for the operation. That's one place where the incentives are working the right way. But I bet she's not in managed care because she had nobody to go to, it's a fragmented system and maybe she didn't know where to go and who to ask. That's the problem I believe in what's going on right now. But I would love to know her case to really follow up on that. I think that managed care companies will do a better job in that situation.

>> MARY FLOWERS: Well, I just want to say in closing, that I think we did ourselves a disservice. I think we did our constituents a disservice because we rolled the program out too broadly, to fast, without having any checks and balances and knowing what the safety net is going to be for when the people fall in between the cracks. So it is my hope that when we go back in January, that we can rollback some of these problems that we created.

Thank you.

>> TAMI WACKER: Thank you guys so much for giving your testimony. It was wonderful to hear everything very much.

Why don't we go ahead and transition to the next panel. That is our managed care organization providers.

>> Managed care. Michael Cotton, John Jansa, Rick Frederickson. Managed care organizations.

>> TAMI WACKER: Go ahead, please.

>> I am Michael Cotton. I'm from Meridian health plan of Illinois. I'm the president. And we have been operating Medicaid managed care for over 15 years now, serving seniors and persons with disabilities during that time. Now in three different state markets. If anybody who has had any really interaction with Meridian knows that quality of care and improving quality of care is really an obsession for us. We're a family owned organization. My family and my father started the organization. He was a doctor by trade and was an academic medicine all his life before starting a health plan, and when he started the health plan, his entire mantra was how can we add value to the system, and truly if we're not adding value then we don't feel we should be a part of it.

That being said, as a managed care organization, we believe we can accompany the consumer across the entire care continuum and thus reducing fragmentation of care that's prevalent among this

fragile population and we do appreciate the fragile nature of this population. We offer an incredibly robust care program. It's at the core of our delivery model and each consumer has an individual customized care program. I think that's important to understand. We do not reduce these people to a population. There's not one size fits all. They all have different social factors, different medical factors, different family supports, and we recognize that and within our care coordination program, there's entire teams that we build around these people. We have behavioral health, pharmacy, we have just regular care coordinator that may be just day-to-day handling transportation, arrange the appointments, those kind of things, as well as clinical services, assessing when there's a need or event that changes their health status, reassessing for risks in those kinds of things.

Based on our experience, our goal is not simply to decrease utilization for nursing other long term support services. It's really what we've done throughout our tenure is find the people that need more care and apply it. And that's really what our goal is, is assessing who is receiving the care, is it being received in the best possible way and our are there people that maybe don't need to be in long-term care that can be supported in the community, and are there people in the community that should be supported in long-term care, and that's truly we realize that in a fragmented system, there's plenty of people that fall through the cracks for various reasons, and resulting in catastrophic scenarios.

Our person centered integrated care model features services distinctly developed to meet each consumer's need, and in this way we ensure that participants, independence and voice are prioritized within their customized plan of care and by collaborating with the existing community entities and leveraging their capabilities, not bringing in our own and supplanting but leveraging existing community entities, such as the care coordination units, LTSS providers, we believe we're aligning ourselves with practitioners who share our philosophies and promoting participant independence and we believe this improves communication and collaboration among all the different medical care, long-term care and LTSS support services and we're committed, absolutely committed to making this a seamless transition when this transition comes. We are one of the plans that's selected for the greater Chicago area for MMI and in defense of HFS, it's been made very clear that if as a plan we are not prepared for the LTSS services, we will not be a plan that's moving forward in the program. So it is the onus is on us to ensure that we are prepared, we're meeting with all the providers in the community, we know that, who the integral partners are and that we're able to seamlessly transition these member's care.

Additionally, we would not only welcome but recommend collaboration with the LTC council, meeting regularly with Meridian

health plan, as well as the ombudsman, together we can jointly identify the metrics, develop quality performance measures as well as outcomes and out of that, the LTC council and Meridian can collaborate and coordinate training initiatives for our subcontractors as well as delivering services for quality baselines to be established and reported.

Additionally we believe in furthering the health literacy of possible participants and their caregivers and resources for both LTC facilities and community based supports and we think through various educational outreach models, jointly developed by the LTC, by the ombudsman, by Meridian, as well as the different community agencies we believe we can strive to make sure that all the participants are informed and actively involved in their care. And again thank you for having us in front of this council.

>> Good afternoon. My name is John Jansa. I am the director of community engagement for Molina Illinois. Thank you for the opportunity to present testimony today and I would like to first say we're certainly excited to be given the opportunity to serve dual eligible members in Central Illinois as part of the M MAI initiative.

We see care coordination in Illinois as an extremely positive development. We see this as a positive development in how Illinois provides long term services, long-term care services and supports in Illinois. The mission of Molina healthcare is to provide individuals with the right care at the right time in the right setting. And to provide that care effectively, we firmly believe the consumer must be a full participant in the process. That was our mission when Dr. C. David Molina started Molina healthcare as a clinic, serving underserved populations in Southern California in 1980 and it remains our mission today. We must ensure that the services that are provided to those that are enrolled with us are appropriate and they are what the consumer wants. If that means services in a long-term care facility, then we need to ensure that our staff work in tandem with the staff of those facilities to ensure that any problems encountered are addressed and resolved. No person wants to go through the revolving door of hospital admission to nursing home placement, back to hospital, back to nursing home placement. That is something we want to avoid at all costs.

We see managed care reinforcing innovations that are already under way in the area of enhanced hospital discharges and we look forward to partnering with organizations that are part of those processes moving forward, establishing strong care coordination prior to hospital discharge, will again ensure that people receive a higher quality of care in the community and that translates into a higher quality of life.

We know we cannot succeed in Illinois without full participation of all the groups that have a role in ensuring quality healthcare

delivery in Illinois. And that means hearing from advocates in all forms, if there are issues that need to be addressed.

We know that the process of managing care implementation is going to bring challenges. We won't be able to address those challenges if we're not aware of the problems that are in the community. And so we urge to hear from members of all forums and all types of community settings to let us know about the issues as they come forward.

Our founder and our current leadership has stressed not just in our operations here in Illinois, but in other states, they've always made the point of saying we're not perfect. We don't have all the answers right at the start. We're excited about the opportunity to be in Illinois. But we're also excited to learn how we can make the process work better for everyone.

All our current health plans have received NCQA accreditation and part of the reason for that is our ability to listen and to respond to the people that we serve. I want to thank you council for the opportunity to provide this today. Thank you very much.

>> Well, obviously I'm not Rick Frederickson.

Hello, everybody. I'm Sherry Husa. I am the CEO of the Illini care health plan, we are a division of the Sentene corporation. Just a little history of my company. It was founded in Milwaukee, Wisconsin in 1984. We were actually founded by a woman who was orphaned as a child. She grew up in the Medicaid system, and she encountered difficulties obtaining care for herself and her children, and as she became older and she became more successful in her life, she founded the company because it was her personal mission to help make access to quality healthcare services an easier process for the most vulnerable in the population, and that's how we came to be and we're still in Milwaukee today. In fact we're in 18 states. We cover over 2.35 million lives and we employ more than 6400 people nationwide.

Here in Illinois, we cover almost 18,000 consumers and we employ over a hundred individuals.

Our experiences in other states, such as Texas, Arizona, and Florida, have contributed to the development of the unique model of care coordination we use here in Illinois today. We believe that healthcare is best delivered and coordinated locally and our model uses an integrated approach that is delivered by local people who know the providers, who know the systems and who know some of those geographic constraints. I'll describe our integrated care team more in a bit.

Part of our approach is we put the consumer in the center of all we do and we understand the importance of care and choice. In understanding the care and quality of life perspective. In our model we see our care coordinators as true advocates for both the consumer and caregiver. Our multidisciplinary care teams are based on the holistic view of the consumer, and these teams are staffed

by professionals who are nurses, behavioral health clinicians and social workers, who consider all of a consumer's needs, including the medical, behavioral, and social needs along with the desires to live independently in the community.

Our teams work collaboratively with our consumers to understand their needs and goals, and create a plan to help them achieve those goals while again preserving choice and voice and preserving outcomes along the way.

Since we've been operational in Illinois, since May of 2010, we have issued hundreds of free cell phones to consumers, who have needed access to reliable telephonic service. We have hosted numerous health fairs in the community to educate consumers on healthy living, eating and other behaviors. We've issued thousands of debit cards under our (inaudible) account program to help reward consumers for healthy behaviors. We've helped consumers to receive dental care services. We have found housing and in many cases, we have helped keep the lights on because we've interfaced with utility companies threatening to shut off utilities to our consumers residences.

And we've offered additional benefits to the consumers we serve, other and above traditional Medicare, such as disposable contact lenses and practice visits with certain healthcare providers in order to lessen the anxiety of visiting a dentist or an OB-GYN. We are very excited about the opportunity to become a more integral partner with the State of Illinois and its agencies. (Inaudible) advocacy and community organizations who work with our consumers today, most importantly with the consumers we serve. Thank you for allowing me to provide testimony today.

>> Good afternoon. My name is Dr. William Gerardi. I am the chief medical officer for advent health Illinois.

Thank you for letting me support my organization.

We along with my colleagues have served the ICP program since May of 2011. Our company's emphasis is on coordinating high quality, integrated and efficient care for our members who need it most. We have a multidisciplinary team of case managers, pharmacists, social workers, and medical directors, including psychiatrists. This team addresses the biocycle -- we actually use a bio cycle social framework to address the very complex needs of this population.

We serve as you all know, the suburban Cook County, as well as the five collar counties, Cook, DuPage, Kane, Kankakee, Lake and Will, but I think it's also important that Aetna Medicaid has over 15 years of experience around the country, and in fact our organization was one of the first to address long term services and support in our Arizona market.

And as we prepare to launch our long term services support program under service package two of the integrated care program, in February 1, 2013, I think it's important to note that our

emphasis is going to be on continuity of care for members at that very important time of transition. Under service package two, the Aetna team will be working with members residing in the community. To self-direct their care as they access services under the following waivers: Aging, HIV, traumatic brain injury, disabilities, and those who are residing in supportive living facilities. We will also support members living in long-term care if a sits and I want to reach back to -- facilities. And I want to reach back to one of the comments that one of the earlier panelists referenced in terms of the importance of the integration of home care and healthcare. I think it's a point that can't be overstressed. Right now under our current model those two pieces are fragmented but we view fragmentation of home care and healthcare as sort of moving along the a continuum and being able to work with our members in their homes, to keep those two pieces aligned, will allow them to be at the right place at the right time depending on their continue.

We have a very broad network of providers and that includes professional, institutional, and ancillary. And we are in the process of actively contracting with the waiver service providers in our service area an and at this point in time in preparation for the February launch, we are close to 90 percent contracted with those providers who are currently serving our membership.

We are contracting with any willing provider who is currently a state Medicaid provider and we're encouraging others to get that Medicaid certification so they can continue to serve members.

We are -- we have conducted monthly webinars for the long-term care provider community since before our program launched, and has continued in preparation for the launch of service package two. We have been conducting a series of (inaudible) and learn sessions it over 200 waiver service providers over the past three months in preparation for this launch and that's not a one and done situation. This is really meant to be the start of a long term continuous process, because what we are asking these waiver providers to do is different from what they're currently doing today.

Our case managers will be visiting members residing in long-term care facilities, at least every 180 days, after the lawn of the program. These -- launch of the program. These are members who we probably have not addressed already and are currently in case management. For members in the community, and this is a very important point, our primary goal at the start of the program is to ensure continuity of care with their current service providers.

The transition period will last at least 180 days. The first weeks of our program will be to make sure that authorizations are entered into the system so that those waiver services that they're currently receiving will continue uninterrupted.

Case managers will begin home assessments in the second month of

the program, and all members who receive these home and community based services will be visited in their home at least every 90 days, sometimes more if needed. And I'll go back to that earlier point I made where these case managers are also going to be responsible for the medical component of the members' needs.

We have met regularly with the department -- with health and family services, and the Department of Aging, in preparation for service package two launch and we will continue to do that after that launch. We believe that getting the state input is extremely important.

And probably as important as anything, is that we have a very active member advisory council. And that council meets quarterly, and included on that are advocates, a representative from the area agency on aging, home and community advocates, as well as members and their families.

As we have done in the ICP, we look forward to collaborating with those advocates and members and their families and we look forward to delivering a high quality product when the service package 2 launches in February.

Thank you for your time.

>> HEATHER STEANS: Well, so thank you all very much for being here, and certainly I'm feeling hopeful about the way you guys each speak about the consumer being at the center of the kind of care and really trying to do the coordination of care. That's certainly the hope that we have in moving towards that model, so it's very heartening for you to speak to that first and foremost. That's very encouraging and welcome news.

I want to ask you just three quick questions. On how you see the implementation here going.

We heard from the panel prior to this, particularly from the consumer panel, and I think the state agencies too, that setting out performance standards that are really put in place along with consumer input would be helpful thing to have and should be applied across all types. I want to just understand if you think that's also helpful and something you would expect to be part of the way that the business is done here in these -- in managed care situation.

Two, we heard concern about going too fast, time frame. Wondering whether you share that concern, what your thoughts are about that.

And three, I know one of the issues we had as a pilot up front is getting providers on board and wanting to know whether that shifted at all yet, whether you're having an easier time getting providers to join your network so we don't have issues with people not getting care from providers when we get into managed care, when that starts getting kicked in.

>> I'll start with the third one first.

(Laughter.)

Network. I joined the organization in January of this year. So I missed a bit of the difficulty during the launch of service package one, but I would say that even in the 11 months that been with the -- I've been with the program, we have seen a significant sea change in the responsiveness of the physicians and hospitals and ancillary providers in our network. I believe that they see that the managed care program is real. That we are trying to do the right thing by our members, and we have had a great deal of success in signing up the hospitals and physician groups.

With respect to whether or not it's -- and I've already referenced our success with getting the waiver service providers on board for the launch of service package two.

With respect to the question of whether it's too fast, I think -- I believe it's our position that it's not. With respect to service package 2, which is the waiver services, these are members that we already know. We have been visiting these members in the home. We visited them in nursing homes where they're residing. We understand their needs and I firmly believe that by the launch of service package 2, we will be better -- the integration of the medical component with the waiver component, will really get to those members' needs and will keep them from unnecessary hospitals of hospitalizations, unnecessary readmissions, unnecessary times in long-term care facilities. So in terms of the too fast, our organization is ready to launch in February. And we're expecting to do so.

And the last point with respect to consumer input, we welcome that. I believe that we have taken a very collaborative approach with our provider community, with our advocacy community and with our LLIC partner and as well as the state and an example of that is we have jointly developed a performance improvement plan with respect to readmissions with the ICP program and I look forward to working with developing something as it relates to service package 2 but also as you get ready to launch the M MAI initiative later in the year.

>> TAMI WACKER: With respect to the consumer input, director Holton and I -- we have a quarterly long-term care council meeting and we've been discussing possibly adding managed care to every single agenda.

>> Absolutely.

>> TAMI WACKER: So possibly on a rotation basis, someone from your companies could come, addressing concerns that the entire council could have and it's always open to public comments as well, so if there's any community members.

Also if there's something that the ombudsman program, the advocates are feeling there's a concern, that would be a really nice time for that to be addressed. Dose that sound agreeable?

>> We would love that.

>> MARY FLOWERS: So which one of you guys are a managed care

company?

>> They all are.

>> MARY FLOWERS: You're all managed care companies. Okay. So all of you all have been signed up for the state already? You have a state contract?

>> We are currently serving the ICP program (inaudible).

>> MARY FLOWERS: Okay. You have your contract has been signed.

>> We do.

>> MARY FLOWERS: And you guys?

>> We currently are not. It's voluntary.

>> MARY FLOWERS: So you haven't signed on yet?

>> Not for (inaudible) we currently serve Medicaid beneficiaries (inaudible) not for the ICP.

>> MARY FLOWERS: So is there -- what is the delay?

>> What is the delay? I don't think there's a delay. It's part of the implementation program that HFS has laid out. So we've been here for four years. The ICP program just started two years ago. It was only -- they only went (inaudible) for that program. Now they're expanding the other opportunities for ICP in different regions as well as the M MAI program.

>> MARY FLOWERS: So what do you do exactly with Medicaid?

>> We're currently servicing what's traditionally known as the moms and babies program. We service 20 babies in Illinois.

>> MARY FLOWERS: What areas? What are the counties?

>> Cook County, the Quad Cities as well as some counties in southern and Central Illinois.

>> MARY FLOWERS: So you had mentioned in your remarks about reducing the fragmentation. How do you foresee reducing the fragmentation of the access to care?

>> Well, so we've had a long history of creating access to care for our members. So we're actually measured in our state contracts for access to care, and we have routinely hit the 90th percentile.

>> MARY FLOWERS: How?

>> By creating the largest network. That's why we're able to be in 20 counties now. It's the largest regions that we cover under any of the managed care plans, because we have -- we're a very provider oriented organization. We have (inaudible). We allow them to practice medicine and we reduce the amount of authorization work that they're required to do. That's kind of traditional in nature. We allow somewhat of an open access to our network for our members. It's just kind of the philosophy that we've had.

>> MARY FLOWERS: Where would a person go to complain?

>> They can complain through our grievance coordinator within our plan and then they also have the option to go to the HFS or the Department of Insurance.

>> MARY FLOWERS: Is there an outside person that they could complain to?

>> That would be the HFS or DOI. There's not a third party administrator that I know of.

>> MARY FLOWERS: And you, Mr. Jansa, you talked about the right time in the right setting.

>> JOHN JANSA: Correct.

>> MARY FLOWERS: So tell we me about the right time and the right setting about the people you serve.

>> JOHN JANSA: First to follow up on the question you asked earlier, what is our role currently with the state. Our organization is in negotiations with HFS. We do not currently have a contract. We are new to Illinois. And so we will be hopefully soon signing an agreement to serve people on Medicare and Medicaid in Central Illinois.

In terms of -- I'm sorry. Could you repeat the question again?

>> MARY FLOWERS: Well, let me just go back to why is it you don't think that there is an urgency for you to have been signed up already, considering there's a lot of people out there who are in need of the services?

>> JOHN JANSA: Well, when we entered into the -- when we entered into the -- or made the decision to enter into Illinois, we followed through on the time frame that was laid out by HFS, and we were committed to that time frame, and so we understood HFS put that time frame in place for a reason and so we were willing to follow through on that. Now that time frame for M MAI has shifted, implementation will be next fall. And so we're willing to pursue that implementation plan as well. But we understand that there are people that require care coordination in the State of Illinois, and could benefit from it. I can tell you from my experience working on the home community based service side that there are a lot of very capable state agencies and community based organizations that have filled that role of care coordination. And so I would say that in my comments and the way we see our role going forward is we're not here to replace those organizations or those agencies. We're here to supplement the work that they do. And in -- by doing that, we feel like we can just be another player in the process providing long-term care services.

>> TAMI WACKER: I think currently right now, beside Illini care, all the other agencies have been notified that their RFPs have been approved so right now there is a time line in process. It's not that there's been a delay for anyone because of any problems identified or anything. And in fact I think what we've heard so far today is that we're kind of -- we're glad that there's a little bit more of a taking a deep breath and making sure that the process is going correctly and taking its time, not rushing through everything. So I think in our sense that's a good thing. It's not an indicator of any ill will or anything bad going on.

>> MARY FLOWERS: I know from some telephone calls that there were some problems and HFS was told that they were not going to

pursue or rush to sign on these managed care companies.

>> TAMI WACKER: Okay.

>> MARY FLOWERS: I just wanted some clarity on that.

>> TAMI WACKER: Sure. I think we've got -- the time has kind of wrapped up. I want to thank everyone from the managed care organizations for attending. And again for accepting our invitation to attend the long-term care council.

I just kind of want to wrap up just a little bit. I want to thank everyone here for attending. Really one of the main purposes for us to come together with the long-term care council and to have the forum on managed care was because we wanted to make sure that everyone understood that these were human beings. And when I say these are human beings, I'm talking about everyone that's involved with this. Not only the families and advocates and the patients that are involved with managed care, but the state agencies that are assigning the contracts and that are dealing with the concerns, as well as the managed care organizations and that everyone is human, and that as long as we're all working together and we're working towards the common goal, that's what's going to be able to serve our very vulnerable and frail population.

So I know that there was some questions that some of the members of the public had, and so please after this is convened, if you can come up and see me, we'll make sure we get those, and any contact information, and then that way the entire pact along with the attempt to -- packet along with the attempt to answer questions will be mailed out to you, and also again it will be posted out to the website on the Illinois Department of Aging and if you go to the Illinois long-term care's council's site on there, that's where it will be. We have our next meeting on January 15 of 2013 at the Illinois department of aging and that's housed at the department of natural resources in Springfield and also we have a public comments time, so you're more than welcome to attend that as well, and at that point we will be giving our report and we'll be coming together with the full council to determine what will be included in the packet, and again once it's complete, then it will be mailed out to each one of the legislators with the long-term care council's recommendation.

Thank you so much for being patient with everyone, and for attending, and it was a success. Thank you.

(Applause.)

(End of session.)

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cje SeniorLife

Illinois Long Term Care Council Public Forum on Managed Care

Date: Wednesday, December 12, 2013

Good Afternoon. My name is Laura Prohov. I am the Vice President of Community Services at CJE SeniorLife. CJE has been committed to providing subsidized community based and residential services for 40 years. We have enjoyed a very long partnership with the Illinois Department on Aging through the Community Care Program and the Managed Community Care Program for more than two decades. Our agency mission statement and the broad array of services we provide speaks to our long standing commitment to help older adults age in place and remain in the community as long as possible and then to provide needed options when this is no longer the case. CJE currently operates a 240 bed skilled nursing facility which accepts both Medicare and Medicaid clients. We have implemented targeted initiatives at our skilled nursing facility and as a result have successfully reduced re-hospitalization rates to 19%. The national average is currently 26%. I would like to make three points about the importance of provider involvement in the planning and implementation of the state's new managed care initiatives as it pertains to this clientele:

1. We certainly recognize that the system for providing older adult services through the state is changing and we are willing to be on board with the new initiatives. We welcome the opportunity to participate in the process as the State transitions to managed care. Frankly, we applaud the efforts to link the healthcare and social service networks that serve our older adult population in Illinois. There is significant emphasis on providing supportive services post hospitalization. We would also note the important role of these services in enabling older adults to maintain a medical/health regimen to avoid unnecessary hospitalizations in the first place. CJE has long been known as an innovator in older adult services. We are one of 47 organizations nationally selected by Federal CMS to implement a transitional care program in collaboration with area hospitals aimed at reducing re-hospitalization rates for frail older adults with the goal of reducing Medicare costs.

2. In our ongoing role as advocates for frail older adults, we feel strongly that providers such as CJE be given the opportunity to provide input into the process of developing and rolling out the new managed care initiatives. We are not in a position to match the geographic reach or capacity of some of the larger providers in Illinois but like many of our peer agencies which collectively care for thousands of older adults, we bring experience and expertise to the table.

3. We are now transitioning from a system in which we provided this care inclusive of the care management function to a system that will redefine and reduce our role to simply being vendors. The State should not ignore the important contributions agencies such as CJE have made in shaping older adult services in Illinois by simply handing the reins to the insurance companies charged with developing the new managed care initiatives. After 40 years of providing services to Illinois' frail older adults we have learned much about caring for this population. We can identify best practices, client care standards and accountability measures. The process should include input from CJE and other seasoned older adult services providers so that what we have learned from decades of experience in partnership with the State can be incorporated into the new system.

Thank you for this opportunity to speak. CJE SeniorLife looks forward to continuing to work with the State of Illinois on meeting the needs of our older adult population.

Good afternoon, my name is Kristen Pavle and I am the Associate Director of the Center for Long Term Care Reform at Health & Medicine Policy Research Group, or HMPRG. Thank you for the opportunity to provide testimony today.

HMPRG, is a 30-year policy and advocacy think-tank that promotes social justice and challenges inequities in health and health care. HMPRG has worked since 2001 to develop a strong long-term care system in Illinois that supports the needs and desires of older adults and persons with disabilities and their caregivers. Our work includes analysis of managed care and the State's transition to a Medicaid managed care system.

While HMPRG supports this transition, we are concerned about its potential impact on seniors and persons with disabilities, for the following reasons: first Illinois has a low penetration rate of **capitated** managed care that serves seniors and persons with disabilities. The only such program is the Integrated Care Program, and it has only been operational for about 2 years.

Our second concern is that the State Medicaid agency (the Department of Healthcare and Family Services, or HFS) has not had any experience with the implementation of a managed care program that includes long-term supports and services.

Finally, the State is attempting over the next 6 months to implement 3 new capitated managed care initiatives that include long-term supports and services for seniors and persons with disabilities: the second phase of the Integrated Care Program, the Innovations Project and the Medicare-Medicaid Alignment Initiative. We are concerned that this transition is happening too quickly.

Today, I want to share with you the research and recommendations that HMPRG has developed in collaboration with SEIU Healthcare Illinois and Indiana that addresses these concerns. Our recommendations focus on how Illinois can **ensure consumer protections and quality assurances** in its new managed care system, specifically focusing on seniors and persons with disabilities who require long-term services and supports, or LTSS.

There are seven main areas that our research and recommendations cover. The first is **member education**, which is integral to the success of Illinois' managed care system and focuses on the State's education of consumers and providers about their vision for the new managed care system, what changes to expect, and how to get involved.

The second area is **monitoring and oversight**, which describes the role that HFS must play in the monitoring and oversight of managed care entities or MCEs. This is the single most important activity to ensure accountability and success of Illinois' managed care system. One important recommendation in this area is that HFS work closely with the Department on Aging and the Department of Human Services which have years of experience in LTSS monitoring and oversight.

The third area is **consumer input and rights**. HFS must ensure through its contracts with MCEs that consumers have a voice in an advisory capacity, in the development and implementation of their care plans and through grievance and appeals processes. The role of an **independent Ombudsman** is important in the area of consumer input and rights.

The fourth area is **network adequacy and access to Care**; for individuals who require LTSS, provider networks and access to care must extend beyond traditional managed care requirements. A priority recommendation is that HFS ensures timely LTSS eligibility determination. For individuals who require LTSS, receiving these services in a timely manner can mean the difference between staying at home—whether this is in an assisted, supportive or nursing facility—and an emergency department visit.

The fifth area is the **continuity of care** as Medicaid beneficiaries transition from fee-for-service to managed care. This transition is particularly important for seniors and persons with disabilities who require LTSS because this population often has many different providers who are providing care frequently. Without ensuring that the same providers are in the new managed care networks, or that care is carefully planned and transitioned to a new set of providers, seniors and persons with disabilities are vulnerable to poor health outcomes.

The sixth area is **LTSS provider standards**. We recommend that the State develop universal standards for personal assistants and LTSS providers. Nationally, there are guides to developing these standards. It is ultimately in the State's best interest to ensure that LTSS providers are operating at a baseline standard of quality in order to ensure positive health outcomes.

The seventh and final area is **evaluation and quality measurement** for consumer outcomes. LTSS are provided frequently, over a long period of time and are often intimate in nature; for example think about someone helping you to use the toilet, or get dressed. As such, evaluation and quality measurement of LTSS is particularly important and must include the personal relationships between care-giver and care-receiver.

The overview of HMPRG and SEIU's research that I've presented today is the beginning of ongoing work, and potentially the beginning of legislation in Illinois to govern how we provide managed LTSS in our state. I look forward to working with many of you in the room to ensure consumer protections and quality assurance in Illinois' managed LTSS programs, and I thank the Long-Term Care Council for your time today.

"Consumer Protections and Quality Assurances In Managed Long-Term Supports and Services Programs"

December, 2012

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Contact: Kristen Pavle (kpavle@hmprg.org) or Sharon Post (Sharon.Post@seiuhcil.org)

Executive Summary

1. Introduction
   - Illinois lacks experience with managed care. The Illinois Department of Healthcare and Family Services (HFS) has included long-term services and supports (LTSS) in their managed care system initiatives. States and managed care entities (MCEs) are relatively inexperienced with managed LTSS (MLTSS). Given this inexperience in Illinois and nationally, HFS must put mechanisms in place to ensure consumer protections and quality assurances in any MLTSS program. **We recommend that HFS hire an FTE, with Medicaid LTSS experience, to ensure that the recommendations identified in this document are further research and implemented.**
   - Rebalancing LTSS is an important part of Illinois health reform and the State's managed care system.

2. Member Education: Transition to and Ongoing Implementation of a Managed Care System
   - Transparency and Medicaid beneficiary education are integral to the successful of Illinois' managed care system and are currently lacking.
   - Recommendations include: collaboration with sister agencies, applying lessons learned from the Integrated Care Program (ICP) and development of a consumer friendly website.

3. Monitoring & Oversight
   - HFS monitoring and oversight for MCEs is the single most important activity to ensure accountability and success of Illinois' managed care system.
   - Recommendations focus on 5 core-areas of oversight for MLTSS programs: (1) contract monitoring and performance improvement, (2) provider network adequacy and access to services, (3) quality assurance and improvement, (4) member education and consumer rights, and (5) rate setting.
   - Recommendations for oversight structure include working closely with the Department on Aging and the Department of Human Services/Division of Rehabilitative Services which have years of experience in the monitoring and oversight of LTSS quality.

4. Consumer Input and Rights
   - The State's proposal for the Medicare-Medicaid Alignment Initiative calls for both an enrollee advisory committee and a stakeholder advisory committee. We support these two committees, and recommend that HFS collaborate with MCEs, consumers and other stakeholders before finalizing the role of these committees.
   - We recommend that (1) consumers have meaningful input into developing their care plans; (2) the care plan development and assessment of needs be on-going, consumer directed, and culturally appropriate; and (3) that MCEs be required to collaborate with existing community case managers to coordinate services in the consumers' existing care plan.
   - We recommend that consumers have easy access to clear and user-friendly grievance and appeals processes. This includes the role of an independent ombudsman for MLTSS consumers, and ongoing training on Olmstead and disability rights for appropriate personnel.

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5. Network Adequacy/Access to Care
   - MLTSS requires that specific attention paid to network adequacy and access to care, beyond the traditional managed care requirements.
   - Illinois' determination of eligibility process should remain with the Care Coordination Units and Division of Rehab Services; the State must ensure timely determination of eligibility. We recommend additional funding for this activity and for the State to review the current system that may need reform.
   - We support Illinois MMAI proposal to offer supplemental services. This is especially important in the context of rebalancing; MCEs should have the flexibility to offer services beyond the traditional Medicaid Waiver programs.
   - In an effort to promote rebalancing efforts, termination of community services or a sharp decrease in authorized community services should be approved by HFS prior to implementation by MCE.
   - Community Health Workers (CHWs) should play a formal role in Illinois' managed care system. CHWs offer culturally competent support and have an existing trusting relationship with consumers.
   - The State must ensure that all MCE's adhere to and are in compliance with the Americans with Disabilities Act and must provide an appropriate level of oversight and monitoring toward that end.

6. Continuity of Care
   - Illinois should use 'smart-assignment' for auto-enrollment of Medicaid beneficiaries into managed care programs. Given the complex conditions of seniors and persons with disabilities and this populations' need for LTSS, it's important to ensure placement of consumers into the MCEs which can meet their individual needs.
   - Individuals with complex and LTSS needs are particularly vulnerable and the MMAI proposed 90-day transition period is not long enough. The treatment plan and drug approval should extend for one year to accommodate the needs of this targeted population.
   - Additional recommendations to ensure that the transition to a managed care system protects individuals with LTSS needs include: (1)prior to approval to terminate or reduce an LTSS care plan the consumer will continue to receive services; (2)continuity of care period applies to all MCE contracted providers; (3) MCEs will provide an initial assessment based on existing data to identify high-needs consumers who require contact immediately; (4) an enrollment broker should be used for all managed care enrollment; (5) during transition period, out-of-network providers will be paid in-network rates.

7. Provider Standards
   - The State should work with MCEs to: (1) build quality LTSS provider networks: helping to identify problems with providers that include infrastructure gaps; (2) craft performance evaluation and improvement plans to address quality issues.
   - The State should develop universal standards for Personal Assistants and LTSS providers through stakeholder collaboration.

8. Evaluation/Quality Measurement
   - Illinois should develop LTSS-specific outcome measures that include: (1) personal relationships given the intimacy of LTSS care. LTSS measures should be included in any evaluation or incentive plan (including pay for performance); (2) disability and senior specific data, and ADA compliance.

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1. Introduction

In order to realistically take into account the research and recommendations provided in this document and to develop effective partnerships with stakeholders, HFS should identify an FTE who is responsible for ensuring LTSS consumer protections and quality assurances in Illinois' Managed Care System.

Another resource that has been underutilized and available to provide recommendations is the legislatively mandated Older Adult Services Advisory Committee (OASAC)[1]. We are also available to consult with the State; having done extensive research on consumer protections and LTSS programs and policies, we can be valuable as the State designs its approach to managed care.

The State of Illinois has embarked on several managed care projects to better coordinate health care and services for Medicaid enrollees. Each of these programs focuses on seniors and people with disabilities (SPD). The new programs include:

1. The Integrated Care Program (ICP)
2. The Innovations Project
3. The Medicare-Medicaid Alignment Initiatives (MMAI)

Illinois' Experience with Managed Care

Illinois has a relatively low penetration of capitated managed care, less than 10% of Illinois' Medicaid beneficiaries[2], and the current move to enroll at least half of all Medicaid beneficiaries into capitated managed care by 2015, many who require long-term services and supports (LTSS), is unprecedented[3]. Illinois' lack of experience with managed care and aggressive goals for the transition of many Medicaid beneficiaries into managed care over a relatively short period of time is concerning.

Illinois has chosen to include the integration of LTSS in their managed care initiatives. While we support the integration of LTSS, primary, behavioral, and acute care, we also acknowledge that across the country very few Medicaid beneficiaries with LTSS needs have been served through managed care. In a report released in 2011 by the Kaiser Family Foundation, only 11 states operated capitated managed LTSS programs, serving just 173,600 of Medicaid beneficiaries across the country[4]. To put Illinois' ambitious goals into perspective, the State has proposed to enroll 172,000 Medicaid beneficiaries into the MMAI managed care program that will include LTSS. This is just one of three major Medicaid managed care initiatives for Illinois that includes LTSS.

The lack of experience across the country with implementing managed LTSS (MLTSS) is a challenge not only for the State, but also for the managed care organizations that will be accepting risk for LTSS. As a result, Illinois must work closely with the entities they choose to contract with to provide MLTSS **and** key stakeholders in both the development and implementation phases of any managed care initiative[5].

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[1] OASAC already provides recommendations to the Directors of the Departments on Aging, HFS, Public Health. http://www.state.il.us/aging/1athome/oasa/oasa_ac.htm

[2] Kaiser Family Foundation. (2010). Illinois: Medicaid Managed Care. Available online: http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=56&rgn=15

[3] Illinois public act 96-1501 requires 50% of Medicaid beneficiaries to be covered in capitated, risk-based managed care by January 2015. Available online: http://www.ilga.gov/legislation/publicacts/96/096-1501.htm

[4] Kaiser Family Foundation. (2011). "Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider." Available online: http://www.kff.org/medicaid/upload/8243.pdf; Saucier, P. (2009). "States, Dual SNPs and Medicaid Managed LTC: High Complexity Limits Widespread Implementation." Association for Community Affiliated Plans. Available online: http://communityplans.net/Portals/0/Events/2009%20CEO%20Summit/Saucier%20LTC%20Costs.ppt

[5] Lind A., Gore S., Barnette, L., and Somers S., Profiles of State Innovation: Roadmap for Managing

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Rebalancing in Favor of Community-Based Care

A key goal of better coordinating care for SPDs is rebalancing LTSS—shifting more resources from institutional care to home and community-based services (HCBS). A key component of rebalancing is ensuring the availability of quality community-based LTSS for seniors and people with disabilities which enables these individuals to stay in or return to the community. The central goal of rebalancing LTSS depends on Illinois' new managed care system's ability to support the consumer by prioritizing consumer choice, self-direction, and independence.

Community-based care is often the least restrictive setting, or most integrated setting, in which an individual may receive LTSS. By law, individuals who require LTSS and desire to and are able to live in the community, are entitled to community-living. Illinois recently settled 3 lawsuits as a result of the State's inability to ensure access to community-based LTSS; these are known as Olmstead lawsuits in reference to the historic United State Supreme Court ruling. [6]

The State is currently implementing 3 separate consent decrees associated with these Olmstead lawsuits (i.e. Ligas, Williams and Colbert lawsuits[7]). Managed care is a vehicle for the State to use in providing increased access and support in the community for individuals who require LTSS. In fact, Illinois' Colbert implementation plan is built around the new managed care system.[8]

The Intent of This Document

This document summarizes the specific consumer protections and quality assurances that we believe are necessary in all Medicaid MLTSS programs, including MMAI, the Innovations Project and the ICP. HFS' decision to require mandatory Medicaid enrollment in the MMAI amplifies the need to have stronger consumer protections so that consumers who do not have a choice to leave a program will still have some control and protections in Illinois' managed care system. The guiding principle of this document is that MLTSS requires a comprehensive, intentional, and enforceable system of consumer protections and quality assurances.

Illinois must play a strong role in ensuring consumer protections and quality assurances through which the State must exercise oversight and monitoring as managed care entities (MCE), providers, and consumers help build and navigate a transformed Medicaid system together. We see the State's Memorandum of Understanding with federal CMS for the MMAI and the existing contracts with MCEs in the ICP as starting points. Future contracts between the State and MCEs, and where applicable between MCEs and providers, should include language reflective of the recommendations in this document.

We recognize that HFS has already incorporated some of our recommendations into its managed care policies through RFPs, formal proposals, and contracts with MCEs; we have highlighted HFS' existing proposals, policies and procedures throughout the document though we acknowledge that details are likely missing. In order to be sure that the consumer protections we recommend are universally applied to all MCEs and providers in all programs, we also plan to develop legislation to govern how Illinois implements MLTSS.

Long-Term Supports and Services (Center for HealthCare Strategies, November 2010). Available online: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf

[6] Pavle, K. (2012). "Medicaid Home Care Cuts: Analysis of Unintended and Unnecessary Consequences." Health & Medicine Policy Research Group. Page 5: http://hmprg.org/wp-content/uploads/2012/05/IHHC_Report_Final.pdf

[7] Center for Personal Assistant Services. (2012). Illinois Olmstead and Olmstead Related Cases, 2012. Available online: http://www.pascenter.org/olmstead/olmstead_cases.php?state=illinois

[8] Pathways to Community Living; Money Follows the Person. (2012). Colbert v. Quinn. Available online: http://mfp.illinois.gov/colbert.html

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We view this document as a way to raise consumer protection issues, elevate the discussion as a priority in Illinois' continued development and implementation of a managed care system. This document is also a starting point for future partnerships between and among HFS and the stakeholder community.

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2. Medicaid Beneficiary Input and Education: Transition to and Ongoing Implementation of a Managed Care System

It is essential that HFS provide leadership in the transition to and the ongoing implementation of a Medicaid managed care system. We recognize HFS' efforts in provider education, but educating Medicaid beneficiaries is also imperative. The education needed is not about any specific health plan, rather it needs to be about the overall transition to and ongoing implementation of a managed care system. This will help Medicaid beneficiaries in navigating the new managed care environment in Illinois.

Transparency is essential during the transition to mandatory Medicaid managed care for individuals receiving LTSS, and through implementation. In New York State's experience, the transition to mandatory Medicaid managed care has caused great confusion for individuals who depend on personal care LTSS when they were expected to choose a new method of receiving services (i.e. a managed care organization)[9].

In order to ensure a smooth transition to and ongoing implementation of managed care in Illinois we recommend the following:

1. HFS should work closely with its sister agencies (i.e. DOA, DRS, DPH, DOI), consumers, advocates, unions, providers community organizations and other stakeholders to begin the process of educating current Medicaid beneficiaries about the changes that will affect them in the near future, their available choices and rights under the new program, and the process for enrollment and access to services under managed care. The managed care system will be ever-changing, so educational channels established prior to implementation will be of great use over the course of the managed care initiatives.
    - HFS should utilize existing advocacy groups in the development of educational materials and educational strategies. HFS should collaborate with the Make Medicare Work coalition (MMW)[10], Area Agencies on Aging, Care Coordination Units[11] and Centers for Independent Living[12] in order to utilize existing communication channels and to partner with entities with expertise in the dissemination of health reform information. These partners are also trusted community-based organizations who are familiar with LTSS.
        - In order to ensure that accurate information is being disseminated to Medicaid beneficiaries and stakeholders, HFS must be involved in the approval of educational materials.

2. We highly recommend that HFS implement recommendations regarding enrollee education and communication from the independent evaluation of the ICP. The advisory committee to the evaluation team has addressed the following key issues during ICP implementation that the State should learn from for future programs:
    a. Lack of clarity about the changes taking place, the choice of MCEs, and the availability of services in the new program. Difficulty obtaining and understanding information about ICP was a particular problem for consumers residing in institutions.
    b. The adequacy of transition periods for those consumers whose current provider does not join an MCE network

[9] Ad Hoc Coalition of Consumer Advocacy Organizations in New York State. Letter to the Centers for Medicare and Medicaid Services. August 28, 2012. Available online: wnylc.com/health/file/339/
[10] Make Medicare Work Coalition. http://www.makemedicarework.org/
[11] Illinois' Area Agencies on Aging and Care Coordination Units: http://www.state.il.us/aging/1athome/case-mgmt.htm
[12] Illinois Network of Centers for Independent Living: http://www.incil.org/

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c. Post-implementation communication between MCEs and stakeholders, especially community-based organizations that already perform care management services related to the MCEs care management responsibilities.

3. HFS should create a section of their website with direct and understandable information on new Medicaid care coordination programs that is specifically for consumers. Information should be available before enrollment begins so consumers can learn about, and prepare for plans for the new programs before they begin.

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3. Monitoring & Oversight for MCOs

Contracting oversight and monitoring is an essential component for effective implementation of MLTSS[13]. Studies of existing MLTSS programs have identified the importance of monitoring and oversight: "When states delegate functions to MCOs, they cannot cede responsibility for management and guidance, especially for the very vulnerable populations that require LTSS."[14]

"[illegible] it necessary to be very prescriptive, particularly during the early program stage, to ensure that contractors are providing **a state-specific model rather than an off-the-shelf product**. To that end, they have taken a "manage or be managed" approach and have developed very specific contracts that set clear standards and expectations for plan performance."[15]

Illinois' lack of a concrete plan or approach to monitoring and oversight for MLTSS is problematic. However, Illinois is not alone: nationally for the MMAI demonstration, the Kaiser Family Foundation found that all of the 26 states who submitted a proposal contained insufficient details on: quality measures, oversight and monitoring[16]. Yet, the importance of state oversight and monitoring cannot be overstated; a successful managed care program requires that the MCO adheres to contracts. Without attention paid to quality measures, oversight, and monitoring, Illinois' contracts with managed care organizations are "empty promises"[17].

In this section we offer recommendations on how to develop an approach to monitoring MTLSS based on a recent research study by AARP and Mathematica, two respected authorities on health policy and practice[18]. Our recommendations are also in alignment with the Report's four guidance principles:

- State oversight is essential "to ensuring the delivery of high quality, person- and family-centered, cost-effective care for older adults and people with disabilities."
- Oversight of Medicaid managed care for older adults and people with disabilities requires specific capacities that differ from the capacities required to provide oversight for managed care plans covering primary and acute care services for younger individuals and individuals without disabilities.
- All states have room for improvement and to build upon their capacity for MLTSS oversight.
- States must develop monitoring and oversight capacity **before** beneficiaries are enrolled into new managed care programs.

We recommend that HFS provide comprehensive oversight of MCOs involved in MLTSS in five core areas based off of the AARP report. While we were able to cite specific recommendations from this report, we also acknowledge the importance of developing an Illinois-specific approach to managed care oversight and monitoring.

Therefore, we strongly recommend that HFS develop working groups around the five core areas for monitoring and oversight identified in the AARP report: Contract monitoring/improvement, Provider network adequacy and access to

[13] Lind, A. et al. (2010). http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
[14] Summer, L. (2011) Examining Medicaid Managed Long-Term Service and Support Programs: Key Issues to Consider (Washington, DC: Kaiser Commission on Medicaid and the Uninsured). http://www.kff.org/medicaid/upload/8243.pdf
[15] Bold emphasis added. Lind, A. et al. (2010). Page 24: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
[16] Musumeci, M. (2012). "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS". Kaiser Family Foundation. Available online: http://www.kff.org/medicaid/upload/8369.pdf
[17] Lipson D.J., Libersky, J., Machta, R., Flowers, L., and Fox-Grage, W. (2012). "Keeping Watching: Building State Capacity to Oversee Medicaid Managed Long-Term Services and Supports." AARP, Mathematica. Available online: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf
[18] Lipson, et al. (2012).

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services, Quality assurance and improvement, Member education and consumer rights, and Rate setting. Further recommendations for these workgroups include:

1. These working groups should play a role in the development and ongoing implementation of an oversight and monitoring system for Illinois' new managed care system. They will be advisory to HFS and are expected to provide recommendations based on the managed care system, not on specific MCOs.

2. Seats should be reserved for seniors, people with disabilities and their home care workers on committees as deemed appropriate.

3. HFS can either facilitate these groups with existing staff, or HFS can contract with stakeholders to provide this function.
   - Illinois' consumer and advocacy community has a lot of expertise that can be drawn on to lessen the burden on HFS, and to ensure a smooth transition and implementation of mandatory managed care.

The workgroups and HFS should consider the following recommendations, as taken from the AARP report on MLTSS oversight and monitoring[19]:

1. Contract Monitoring and Performance Improvement
   - **At a minimum HFS should adopt the following standards:**
     i. Readiness reviews with new MCO contractors; regular onsite reviews for continuing contractors.
     ii. Strong partnership with MCOs, measured by frequent communication about contract issues.
     iii. MCOs should be rewarded through shared savings or Pay for Performance arrangements for exceeding HCBS targets relative to institutional utilization.
     iv. State or external quality review organization (EQRO) provides technical assistance to MCOs with performance issues.
     v. Requirement of MCO to submit corrective action plans to address contract compliance problems; State must follow-up to ensure implementation of plans.
     vi. Suspended enrollment or financial penalties for MCOs that repeatedly fail to meet contract performance standards.

   - **HFS should consider adopting the following standards that go beyond a minimal requirement:**
     i. Automated workflow tools to ensure MCO report submissions and reviews are appropriately acted upon.
     ii. Audit of MCO internal management processes to verify contract requirements are met.
     iii. Regular revisions of contract to include new or higher performance targets.
     iv. Offering MCOs incentives to meet or exceed quality standards. (We acknowledge that the State has already adopted this standard for the ICP and MMAI).

2. Provider Network Adequacy and Access to Services
   - **At a minimum HFS should adopt the following standards:**
     i. State regularly reviews MCO lists of providers and service areas.
     ii. State uses external agency or organization to validate network adequacy and access.
     iii. Reviews summary utilization data from MCOs and LTSS.
     iv. Reviews provider networks against population-specific geographic access standards for plans that cover acute, primary, and specialty services; individuals who have LTSS needs often require

[19] Lipson, et al. (2012).http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

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a diverse provider network because of complex and numerous conditions making network adequacy for all service types important.

v. Offers help to MCOs that have significant gaps in service by identifying potential providers.
vi. Reviews adequacy of MCO provider reimbursement rates to determine if they contribute to access limitations or provider network inadequacies.

- **HFS should consider adopting the following standards that go beyond a minimal requirement:**
  i. State or EQRO verifies provider network lists (in member handbooks or on websites) by contacting provider offices to verify that they accept new patients
  ii. State uses "mystery shoppers" to verify that provider offices are open and accepting new enrollees
  iii. Covers telehealth services in the benefit package to ensure access in underserved areas.[20]

- **"Caution Flags" that advocates and the State legislature will look for to hold HFS accountable:**
  i. Inability to collect accurate encounter data. Encounter data allows the State to provide oversight on MCE utilization goals and patterns for specific populations. Encounter data is also useful to confirm network adequacy and access to services.
  ii. Lack of standardized data collection and reporting interfering with useful comparisons of plans' network adequacy.

3. Quality Assurance and Improvements
   - **At a minimum HFS should adopt the following standards:**
     i. Reviews enrollee assessment/functional screen data
     ii. Reviews care management activities as part of broader quality review process
     iii. Works with MCOs to identify performance improvement project annually
     iv. Contacts members directly for feedback on services or incorporates consumer feedback into quality review framework
     v. Monitors complaints, grievances, and appeals as part of quality review
     vi. Performs onsite compliance audits of member records
     vii. Produces quality reports and makes them available to the public

   - **HFS should consider adopting the following standards that go beyond the minimal requirement:**
     i. Adopting an electronic visit verification system to monitor home care services in real time.[21]
        1. We strongly urge diverse stakeholder input to implement this new initiative. Anecdotally we have heard that other states have found this to be challenging for providers/workers.
     ii. Creates a dashboard of quality indicators to get a comprehensive picture of each MCO's performance
     iii. Analyzes encounter data to construct their own quality measures

   - **"Caution Flags" that advocates and the State legislature will look for to hold HFS accountable:**

[20] In a 2003 report to Congress, the Office of Disability, Aging and Long Term Care Policy recommended enhanced use of technology in long-term care service provision for the purposes of recordkeeping, patient care and patient Monitoring. Office of Disability, Aging and Long-Term Care Policy (DALTCP). (2003). The future supply of long-term care workers in relation to the aging baby boom generation: Report to Congress. Washington, DC: Author. Retrieved 38846 from http://aspe.hhs.gov/daltcp/reports/ltcwork.htm

[21] Illinois Public Act 097-0689 (Senate Bill 2840, or the "SMART Act") requires Medicaid home health and Illinois' Home Services Program and Community Care Program (Medicaid home and community-based waiver programs) to implement "electronic service verification".

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i. Quality reports are not readily available to the public
ii. Develops quality oversight plan after program implementation

4. Member Education and Consumer Rights
   - **At a minimum HFS should adopt the following standards:**
     i. Reviews and approves MCOs' marketing and member education materials to ensure that all are clear and accessible
     ii. Education on LTSS benefits integrated with information about acute, primary, and specialty care benefits (when applicable)
     iii. Regularly reviews MCO reports on member grievances and appeals, investigates delays in MCO appeal processes; discusses patterns with MCO managers
     iv. State-sponsored hotline available for member complaints and grievances

   - **HFS should consider adopting the following standards that go beyond the minimal requirement:**
     i. MCOs provide one set of consistent Medicaid/Medicare Advantage- SNP member materials
     ii. Dedicated ombudsman responsible for investigating managed LTSS member problems
     iii. State monitors critical incidents daily

5. Rate Setting

HFS should play a role in ensuring that MCO monthly capitation rates are adjusted for members' health and functional status. Rates need to be adequate in order to reduce the risk of MCOs denying services for their members. Adequate rates also ensure that MCOs are able to pay their providers appropriately. Without appropriate pay, providers may not participate in an MCOs network, in turn, this restricts members' provider options. Additionally, MCOs enrolling members with more complex conditions that require more care are at risk of insolvency if the rates set are not appropriate. In this situation, MCOs will look to enroll healthier members. [22]

For all of these reasons, finding the appropriate rate is essential to the success of a managed care system. However, as MLTSS is a new and growing area within managed care, few actuarial firms have the experience in setting appropriate capitated rates that include LTSS. Illinois and "their actuarial partners may be on a learning curve together."[23]

Taking this into account, HFS and the MCOs should have ongoing collaboration in regards to the capitated rates. States with experience with MLTSS have found that this ongoing collaboration with national MCOs is critical in order to ensure "that the state's program goals and financial incentives are aligned in the rate-setting process"[24]

The Center for Health Care Strategies produced a report in 2008, "Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States"; HFS should utilized this reports' recommendations and findings on how to set and update MLTSS rates[25]. This report highlights best practices from Arizona, California, Florida, Massachusetts, Minnesota, New York, Texas, Washington, and Wisconsin.

[22] Lipson, et al. (2012). Page 32-34: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf
[23] Lind, A. et al. (2010). Page 20: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
[24] Lind, A. et al. (2010). Page 20: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
[25] Kronick, R. & Llanos, K. (2008). "Rate Setting for Medicaid Managed Long-Term Supports and Services: Best Practices and Recommendations for States." Princeton, NJ: Center for Health Care Strategies.

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Setting Rates with Incentives for Home and Community-Based Services (HCBS)
HFS should work with MCOs to negotiate financial incentives that support rebalancing, i.e. providing more care in the home- and community- based setting. All 8 of the states who had existing MLTSS programs in the AARP study had a goal for their MLTSS programs to support rebalancing and worked to ensure there were financial incentives to support this goal[26]. The Center for Health Care Strategies' "Roadmap for Managing Long-Term Supports and Services" also recommends the development of financial incentives to align with state specific goals.[27]

The State should meet with SEIU Healthcare Illinois and Indiana to discuss how MCE's will contract for Personal Assistant (PA) services. The current structure is that the State and the person receiving PA services is the co-employer of the PA. The State should issue clear guidance on how this relationship will be maintained based on stakeholder input.

The State should also engage stakeholders to determine how to ensure that health insurance fees paid to home care agencies are maintained in a managed care system. Currently, the State provides home care agencies that provide health insurance for their workers a specific rate per hour worked that must go towards health insurance. The State should issue clear guidance on how this health insurance pass-through will be maintained based on stakeholder input.

Stop-Loss Insurance, Reinsurance and Risk Corridors
HFS should use rate setting techniques that ensure the financial solvency of the MCEs and to also protect the State from financial risk. Stop-loss insurance, reinsurance and risk corridors are common rate setting techniques used in managed care contracts. These techniques spread financial risk for high-cost individuals, often individuals with special health care needs including those who require LTSS. These techniques can also be used as financial incentives to meet specific quality or service delivery targets that are decided and agreed upon by the State, CMS and MCE.[28] On a case-by-case basis, HFS should negotiate with MCEs to include these rate setting techniques, as appropriate.

Risk corridors are a risk sharing mechanism in which the State and contracted MCE share in both profits and losses beyond a predetermined threshold amount: after the MCE crosses this threshold (or after this initial 'corridor'), the State contributes a portion for any additionally incurred losses, and receives a portion of any additional profits. **Risk corridors are "sometimes used in the early stages of a managed care program with populations for whom there is no managed care experience as a protection for both the State and the plan against unanticipated losses or gains."**[29] There are limits to the amount the State will pay after the initial corridor and this is governed by what the State would have paid under its fee-for-service system or another agreed upon amount specified in a contract between the State and MCE.

A stop-loss limit is an agreed upon limit of potential financial losses an MCE may incur under its contract with the State; the amount may be in aggregate costs or per member costs for a specific time period. The State would pay

[26] Lipson, et al. (2012). P. 32: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf
[27] Lind, A. et al. (2010). Page 25: http://www.chcs.org/usr_doc/MLTS_Roadmap_112210.pdf
[28] Centers for Medicare and Medicaid Services. (2009). "Providing Long Term Services and Supports in a Managed Care Delivery System: Enrollment Authorities and Rate Setting Techniques: Strategies States May Employ to Offer Managed HCBS, CMS Review Processes and Quality Requirements." Available online, see page 17: http://170.107.180.99/WMS/help/LTSS_ManagedCareDeliverySystems.pdf
[29] Centers for Medicare and Medicaid Services. (2009). Available online, see page 17: http://170.107.180.99/WMS/help/LTSS_ManagedCareDeliverySystems.pdf

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for costs incurred beyond the limit through fee-for-service access to care. Under this technique, capitation rates need to be adjusted in order to account for potential losses projected through the additional fee-for-service cost incurred.
Lastly, reinsurance is similar to stop-loss, but purchased from a private company as opposed to being part of the contract between the State and MCE. Thus there would be no impact on the rate setting process because the state would incur no additional costs regardless of the MCE's financial losses.

Oversight Structure
We also recommend that Illinois approach MLTSS oversight with a "separate model" organizational approach where separate entities are responsible for overall managed care system oversight and the MLTSS oversight. We do not think that HFS currently has the capacity to provide sufficient oversight for MLTSS due to their lack of previous experience with Medicaid LTSS.

While HFS transitions to a more mature Medicaid managed care system, we recommend that the Department on Aging (DOA), the Department of Human Services/Division of Rehabilitation Services (DRS), the Department of Public Health (DPH) and the Department of Insurance (DOI) play a leadership role in MLTSS oversight.

HFS has contracted with DOA and DRS for over 30 years to implement and provide oversight over the State's Medicaid waiver LTSS programs. HFS should continue to contract with DOA and DRS to provide MLTSS oversight in addition to their current role providing Medicaid LTSS waiver oversight. Given DPH's current role in providing oversight for health and medical services (including with institutional LTSS) and DOI's expertise in ensuring consumer protections in the market-place insurance industry, we strongly recommend that HFS consider the roles DPH and DOI should play in this process as well.

In the future, we recommend that HFS transition to a fully-integrated MLTSS oversight organizational model. In this model, HFS would provide oversight for all Medicaid managed care services, including LTSS.
The fully-integrated oversight model is ideal as this will give HFS a comprehensive view of the entire managed care service package. Further, adopting a fully-integrated oversight model will streamline staffing, allow for easier communication, and ultimately increase efficiency. It is worth restating that we do not believe that HFS is now ready to implement a fully-integrated model due to their current lack of expertise in LTSS.[30]

[30] Lipson, et al. (2012). Pp. 11-14: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

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4. Consumer Input and Rights

Consumers and advocates' input and rights are essential to the success of Illinois' transition to managed care. The stakeholder meetings and development of advisory groups for each of the health plans in the ICP and MMAI is insufficient to ensure consumer input and rights.

Regular HFS stakeholder meetings have been more useful for conveying information from HFS to stakeholders, but less useful for actually integrating stakeholder input into program design and implementation.

This section describes a systematic approach to creating transparent and accessible channels for ensuring consumer input and consumer rights throughout the process of developing, implementing, and improving care coordination. Such a system requires three basic categories of consumer input:

A. Consumers should have meaningful input as members of a health plan regarding the MCEs' performance through a member advisory board.
B. Consumers should have meaningful input in care plans, treatment decisions, and provider choice
C. Consumers should have recourse to a grievance and appeals process with which they are comfortable and that is responsive to their concerns

In order for the rights of consumers to influence the programs that directly affect their lives and well-being, consumers need to be aware of changes to Medicaid programs. Therefore, our first recommendation is reiterate our recommendation from Section 2: to improve outreach and education of potential enrollees before a program begins, and to develop consistent education protocols that can support consumers' ability to give meaningful input for the duration of each program.

A. Consumer Input to MCE through Consumer Advisory Committee

Illinois' MMAI proposal specified that MCEs are required to host quarterly consumer advisory board meetings, this is not a sufficient structure for consumers to provide input to MCEs.

Instead, we recommend requiring MCEs to adhere to a more stringent structure of consumer input. We recommend that the State utilize the following structure for obtaining meaningful consumer input for all MLTSS programs: the Enrollee Advisory Committee and Consumer Stakeholder Committee language in Illinois' Managed Care Community Network application and contract language for the ICP contracts, as described below.

Managed Care Community Network application language:

"Enrollee Advisory Committee and Community Stakeholder Committee – There shall be an Enrollee Advisory Committee and Community Stakeholder Committee that will provide feedback to the QAP [Quality Assurance Plan] Committee on the Plan's performance from Enrollee and community perspectives. These committees shall recommend program enhancements based on Enrollee and community needs; review Provider and Enrollee satisfaction survey results; evaluate performance levels and telephone response timelines; evaluate access and provider feedback on issues requested by the QAP Committee; identify key program issues, such as disparities, that may impact community groups; and offer guidance on reviewing Enrollee materials and effective approaches for reaching enrollees. The Enrollee Advisory Committee will be comprised of randomly selected Enrollees, family members and other caregivers. The Community Stakeholder Committee will be comprised of local representation from key community stakeholders such as churches, advocacy groups, and other community-based organizations. Contractor [i.e. MCE] will educate Enrollees and

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community stakeholders about these committees through materials such as handbooks, newsletters, websites and communication events.[31]"

ICP contract language with Aetna and IlliniCare (attachment XI):
"Contractor shall use a multifaceted approach to locate and engage Enrollees and shall capitalize on every Enrollee contact to obtain and update Enrollee contact information and engage the Enrollees in their own care. Input will be solicited from Contractor's Enrollee Advisory Committee and Community Stakeholder Committee to help develop strategies to increase motivation of Enrollees in participating in their own care." 5.18.7 ICP contracts

Additionally, in order to ensure that these committees produce a meaningful channel for consumer voices, HFS should adopt the following additional recommendations:

1. Because coordinating services for people with disabilities is a new challenge for Illinois and for most MCEs, both must prepare to engage with consumers with disabilities by implementing staff training programs that incorporate disability civil rights and disability cultural competence, as recommended by the Disability Rights Education and Defense Fund[32]

2. In addition to the QAP, the State should explicitly require MCEs to include the following topics for review and advice by their consumer advisory committees:
   - Access to appropriate durable medical equipment
   - Long term services and supports
   - Transportation services
   - Americans with Disabilities Act compliance
   - Provider networks
   - Consumer satisfaction measurement and improvement
   - Pharmacy networks and prescription drug access

3. The consumer advisory committees must be permitted to review all written policies on the topics identified above and advise MCEs on the development and implementation of those policies

4. MCEs must make all consumer complaints available to the consumer advisory committee, along with the outcomes of those complaints and any plans for corrective action that are required

B. Care Plans

Care plans and care management will largely define the consumer experience of coordinated LTSS. It is vital that consumers are active participants in care teams, engaged partners with care managers, and invested co-authors of care plans.

We recommend the following to assure consumer direction of care plans and care management:

1. Consumers who are eligible to receive LTSS and their HCBS providers will participate in care plan development.

[31] Managed Care Community Network application. (2012). P. 33
http://www2.illinois.gov/hfs/sitecollectiondocuments/060612mccn_application.pdf

[32] Dual Eligible Demonstration Projects Accessibility Related Network Readiness Review Criteria – High Level with Detail. (2012, October 5). *Disability Rights Education & Defense Fund*. Available online: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

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2. Care plans must be living documents with regular opportunities for revisiting, re-examining, and adjusting them to address the current needs and priorities of the consumer. Consumers should be able to independently trigger such a re-evaluation of the care plan.

3. MCE care managers should be required to meet with existing community-based care managers (with the consumer present) to make a plan to coordinate their activity.

Self-Direction and Person-Centered Care

Although the State and the MCEs currently participating in the ICP have committed to supporting the concept of self-directed care, consumers' experience during the implementation of ICP proves that there is still a gap in understanding what it means to actually deliver self-directed care.

A commitment to self-directed care must be rooted in a person-centered model of care. Person-centered care embodies the principles of personal independence, choice and self-determination, as framed by the independent living movement and articulated in the Americans with Disabilities Act and the Supreme Court's Olmstead decision. Person-centered care models and self-direction for people with disabilities is a challenging frontier for Medicaid managed care programs. Based on their own experience, people with disabilities can provide unique insights into the ways the service delivery system can fit their needs, and are the most likely to notice and flag barriers to access and other pitfalls that could interfere with successful coordination of services. We endorse the recommendation of the National Council on Disability that

"[c]onsumers representing a wide range of disability perspectives should be included in decision making at every step in the process that ultimately shapes programs: from development and implementation of a research agenda through policymaking to program design, oversight, and evaluation."

To achieve this complex goal, we recommend the following:

1. MCEs should be required to train staff in the principles of self-direction and independent living.

2. The State must require MCEs to allow, and place on barriers in the way of accessing, self-directed personal assistance services.

3. MCEs must have policies in place that allow consumers to exercise their own choice of care manager, clinicians, and treatment options. While MCEs must balance this with their responsibilities for care coordination, the consumer advisory committee should review and if necessary revise policies concerning choice of providers, including changing primary care physicians.

4. Consumers must be permitted full participation in care team meetings and access to all medical records pertaining to their care, available in accessible formats, including electronically, in a timely manner.

5. Consumers with self-directed personal assistants should be permitted to choose to participate in voluntary training programs for themselves and their PAs.

6. Consumer input should guide the State and MCEs in crafting service packages that include access to disability-specific preventive services and nonclinical interventions. This may require nontraditional use of

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health care dollars – for example, funding interpreter-support service provider services for Deaf-Blind persons to carry out Instrumental Activities of Daily Living.

Cultural Competency

Cultural competency is essential for all health programs, but particularly important for serving seniors and persons with disabilities who require LTSS. To be respectful to consumers and to fully engage them as partners in coordinated care all MLTSS programs must ensure the provision of services in a manner that is physically, linguistically and attitudinally appropriate. Both the ICP and MMAI require MCEs to ensure the cultural competence of all MCE and provider staff.

Several areas of cultural competency are of particular relevance to SPD Medicaid beneficiaries who require LTSS. When a health system addresses these areas of cultural competency, it is able to address the disparities in health and health care for the SPD population.

The most obvious area of cultural competency for people with disabilities is the physical accessibility of provider facilities and equipment. However, studies have also shown that the attitudes of health care practitioners may play a role in sustaining disparities. Healthy People 2010 raised the alarm that "an under-emphasis on health promotion and disease prevention activities" could cause disparities in health for people with disabilities. Further studies have confirmed that people with disabilities are less likely to receive screenings and preventive care and that people with disabilities are less likely to receive the most effective cancer treatments than patients in the general population.[33]

We recommend HFS use the following guidance to develop appropriate language for all contracts with MCEs, and in contracting with CMS to address the cultural competency areas that are uniquely relevant to the SPD population:

1. Compliance with federal and Illinois standards of accessibility beyond the Americans with Disabilities Act (ADA) as applicable

2. Compliance with the Americans with Disabilities Act (ADA) standards, regulations and guidelines:
   - We recommend that all MLTSS projects require MCEs to develop an ADA compliance plan; this is currently required of the MCEs in the MMAI demonstration project.
   - We recommend that the State develop a working group to develop standards for a comprehensive ADA compliance plans. This working group should include legal counsel from law firms and advocacy groups already familiar with ADA compliance (i.e. Equip for Equality, the ACLU-Illinois, Access Living, Health & Disability Advocates, and others).
   - We recommend that all MLTSS contracts include language that holds MCEs accountable in providing proactive notification of physical and programmatic reasonable accommodation rights and details on how to request accommodations, accompanied by a variety of explicitly **non-exclusive** examples of accommodations such as transfer assistance, modified appointment/exam room booking procedures, American Sign Language interpretation, and notices and health care information in alternate formats.[34]

[33] Lisa I Iezzoni, "Eliminating Health and Health Care Disparities Among the Growing Population of People with Disabilities," Health Affairs, 30, no. 10 (2011): 1947-1954 http://content.healthaffairs.org/content/30/10/1947.full.pdf+html

[34] Dual Eligible Demonstration Projects Accessibility Related Network Readiness Review Criteria – High Level with Detail. (2012, October 5). *Disability Rights Education & Defense Fund*. Available online: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

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- We recommend that the State require MCEs through contract language to incorporate disability civil rights and disability cultural competency into provider training, network building, and quality reporting.
    a. Cultural competency plans must address the accessibility of facilities, the availability of multi-lingual provider staff and/or translation services, but should also include training to alert providers to the role of their own attitudes toward people with disabilities may play in existing health disparities
    b. All measures of access to care must be broken down to show the experience of people with disabilities in order to monitor disparities within each plan's membership. The results of these reports must be shared with the State and the consumer advisory committees.
    c. Lower scores on access to preventive services specifically for people with disabilities should detract from an MCE's overall pay for performance scores.

3. Compliance with safe lifting laws and guidelines in order to achieve "an improved safety culture that reinforces and supports the prevention of patient harm.[35]" There are safe lifting laws in Illinois, federal legislation and guidelines, and professional standards that MCEs and their contracted providers should adhere to. The State should contract with the University of Illinois, School of Public Health to develop a toolkit for Illinois' managed care system to ensure adherence to relevant safe lifting laws and standards[36].

C. Grievance and Appeals Process

Appeal and grievance rights must also be guaranteed as a means of ensuring that consumer voice is protected in all care and coverage decisions. The State should monitor the grievance and appeals mechanism to ensure that consumers are aware of it, are comfortable using it, and are satisfied with the process and outcomes. An effective grievance and appeals process includes uniform and transparent criteria for prior authorization, utilization review, and any other determinations of medical necessity. The process should be open to continuous improvement based on the experiences of consumers, MCEs, and HFS.

Recommendations:

1. Individuals who disagree with a decision or whose claim for assistance is denied or not acted on promptly should be entitled to a timely and adequate notice of decision and an opportunity for an administrative hearing that complies with due process and provides all Medicaid fair hearing protections in 42 CMR 431.200 et seq., including the right for medical services to continue pending appeal and for judicial review of a final agency action.

2. Consumers should have the benefit of the more protective of the rules governing care covered within the Medicaid and Medicare programs.

[35] Join Commission Center for Transforming Healthcare. (2011). "Safety Culture." Available online: http://www.centerfortransforminghealthcare.org/projects/detail.aspx?Project=6

[36] The University of Illinois, School of Public Health's Department of Environmental & Occupational Health Sciences is the local expert in this area. Research Assistant Professor Joe Zanoni, PhD, is a recommended contact for further information: 312-996-2613 jzanoni@uic.edu

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3. If a hearing involves medical issues such as a determination of medical necessity, the individual should have the right to an independent medical assessment.

4. An oversight agency or ombudsman should fill a consumer assistance role in the appeals/grievance process, including assisting consumers in exhausting options outside of the formal process, protecting appeal and grievance rights, and, at the option of the consumer, assisting with investigations of grievances.

5. The State must establish ongoing training of their own Administrative Law Judges and managed care grievance and appeal personnel on disability civil rights and *Olmstead* requirements [37]

6. MCOs must provide plans and a timeline for training internal beneficiary complaint and appeal personnel on accessibility obligations and community integration priorities and principles (i.e., it must be made clear that reasonable accommodation is a legal requirement and not just a "customer service option").[38]

[37] Disability Rights Education & Defense Fund (DREDF). (2012). Dual Eligible Demonstration Projects Accessibility Related Network Readiness Review Criteria – High Level with Detail. Available online: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

[38] Disability Rights Education & Defense Fund (DREDF). (2012). Available online: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

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5. Network Adequacy/Access to Care

The Medicaid population who require LTSS are a diverse group that are often in poor health and have many different providers involved in their complex care. As a result, LTSS consumers need dependable access to providers. In order to ensure network adequacy and access to care, we recommend the following:

1. Determination of eligibility for LTSS should remain with Illinois' Care Coordination Units (CCU) for older adults, and with the Department of Human Services, Division of Rehabilitative Services (DRS) for persons with disabilities.
   - CCUs have over 30 years of experience in providing eligibility determinations for older adults seeking LTSS through the Community Care Program.
   - DRS has over 30 years of experience in providing eligibility determination for persons with disabilities seeking LTSS through the Home Services Program.

2. The LTSS determination of eligibility process should result in the development of a care plan for the consumer based upon the current waiver programs' available services, and as applicable to the consumer's individually assessed LTSS needs. This LTSS care plan should serve as a quality safeguard for consumers who require LTSS, and this care plan should be used as a 'floor' for LTSS services: MCEs may provide additional services beyond the LTSS care plan, but at a minimum the LTSS care plan must be implemented.
   - Prior to the reduction or termination of LTSS services in the care plan the MCE must arrange for a re-determination of eligibility with the CCUs or DRS.

   - In the event that a Medicaid beneficiary's LTSS care plan is reduced or terminated against a consumers perceived needs, "Fair hearing procedures must comply with due process rights guaranteed by the Fourteenth Amendment of the Constitution, as interpreted in *Goldberg v. Kelly,* 397 U.S. 254 (1970). This must include the right to continue receiving long-term care services unchanged while a fair hearing is pending regarding the [MCE] plan's proposed reduction or termination of these services, and timely and adequate notice of the proposed action. Many consumers transitioning to [MLTSS] have received stable personal care services for years and even decades, because their chronic conditions have not changed. As proposed, an [MCE] plan may reduce or even terminate these long-term services, and need not continue them while a hearing is held and decided, simply because an arbitrary "authorization period" for these services happened to expire. The right to a pre-termination hearing is the most fundamental requirement of due process as interpreted by the United States Supreme Court.[39]"

3. Prior to the placement of an individual into a nursing facility, the MCE must report cases to HFS and to a designated independent Ombudsman, or other advocacy organization, and allow for time for investigation and representation.[40]

[39] New York state's Ad Hoc Coalition of Consumer Advocacy Organizations (2012). http://wnylc.com/health/file/339/. Ad Hoc Coalition of Consumer Advocacy Organizations in New York State. Letter to the Centers for Medicare and Medicaid Services.
[40] New York state's Ad Hoc Coalition of Consumer Advocacy Organizations (2012). Page 3: http://wnylc.com/health/file/339/.

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4. HFS must address the critical issue of wait time for a timely determination of eligibility for LTSS. Consumers have experienced month long wait times through DRS, and weeks long through the CCUs; this is unacceptable for individuals who are in need of LTSS.

   This is especially important in the managed care system that is being developed, as HFS has articulated the goal of providing more care in the community-setting. Without a timely determination of eligibility for LTSS, setting up appropriate community-based services is a major challenge that will negatively affect the consumer and the MCOs. In order to address this we recommend:
   - HFS use some of the up-front savings from care coordination to pay for additional individuals to be trained in determining eligibility both at the CCUs and DRS.
   - HFS, or another State entity, should research and review the current determination of eligibility structure with DHS, DOA and the Governor's Office and produce a report on the current functioning of the system and provide recommendations for reform of the system to better meet the needs of the Medicaid LTSS population.

5. HFS should allow supplemental benefits for individuals requiring LTSS that go beyond the regular Medicaid LTSS benefits package. We support Illinois MMAI proposal to offer supplemental services, this is especially important in the context of rebalancing; MCEs should have the flexibility to offer services beyond the traditional Medicaid Waiver programs.
   - According to a recently released Kaiser Family Foundation brief on the 26 states who proposed a Medicare-Medicaid Alignment Initiative (MMAI), almost 75% of states proposed to allow MCOs to provide additional benefit packages beyond traditional Medicare and Medicaid[41].

6. The State should require MCEs to hire or contract with Community Health Workers (CHWs) to participate on, or collaborate with, the coordinated care teams. CHWs are public health workers who are trusted members of, or have an unusually close understanding of, the community they serve. As a result, CHWs serve as an effective liaison between health services and providers and the community members seeking services[42]. CHWs are a valued part of health teams and acknowledged by private insurance companies[43], state governments[44], and current health care literature[45].

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[41] Musumeci, M. 2012, October. Kaiser Family Foundation. "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS". Available online: http://www.kff.org/medicaid/upload/8369.pdf

[42] American Public Health Association. (2007).

[43] Blue Cross & Blue Shield of Minnesota Foundation. (2010). Community health workers in Minnesota: Bridging barriers, expanding access, improving health. Available online: www.bcbsmnfoundation.org/download.cfm?oid=11844

[44] Commonwealth of Massachusetts. (2009). Community Health Workers in Massachusetts: Improving Health Care and Public Health. Available online: http://www.mass.gov/eohhs/docs/dph/com-health/com-health-workers/legislature-report.pdf

[45] Rosenthal, Brownstein, Rush, C.H, et al. (2010). Community Health Workers: Part of the Solution. Health Affairs; Brownstein, Hirsch, Rosenthal, et al. (2011). Community Health Workers "101" for Primary Care Providers and Other Health Care Systems. Journal of Ambulatory Care Management.

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a. 5 states are requiring MCOs to include CHWs in their MMAI proposals: Massachusetts, New Mexico, Oregon, Rhode Island and South Carolina[46].

7. HFS should implement the recommendations regarding network adequacy and access issues from the independent evaluation of the ICP. The advisory committee to the evaluation team has addressed the following key issues during ICP implementation that the State should learn from for future programs:
    - Difficulty developing adequate networks of physicians
        i. Some consumers had a long-term relationship with a doctor who was not in their managed care network
        ii. Some physicians in the MCO networks were not taking new patients
    - Long wait times for physician appointments and longer travel times to offices, especially for specialists
    - Long turnaround times for prior approval of services, especially for behavioral health
    - Problems with timely payments to providers in the early months of implementation
    - MCO drug formularies caused some consumers to switch drugs or pay more out-of-pocket for their prescription
    - Some consumers had to switch to a less convenient pharmacy (shorter operating hours, fewer locations)

Americans with Disabilities Act

Additionally, many Medicaid beneficiaries are persons with disabilities (this includes seniors with functional limitations), and this requires that special attention is paid to compliance with the Americans with Disabilities Act. Illinois' Medicare-Medicaid Alignment Initiative Proposal includes the following language: "Plans will work with providers to comply with the American Disabilities Act (ADA) and to demonstrate the capacity to deliver services in a manner that accommodates special needs." We would like to see additional details in contracts between HFS and the MCEs, and in HFS oversight of the MCEs. We recommend the following to address ADA compliance:

1. HFS should develop standards relating to accessibility, appropriate experience and medical expertise and integrate these standards into existing time and geographic availability standards in order to meet the numerous medically complex and chronic conditions that characterize the LTSS population[47]

2. In order to ensure that LTSS population needs are met, MCOs must be given incentives to contract with existing specialty care centers, specialists with appropriate expertise, and sufficient contracts with ancillary providers and vendors to take care of specific LTSS areas of need before and as they arise.[48]

3. HFS should develop their own physical and programmatic accessibility compliance guidelines and standards, or if MCEs are allowed to develop their own guidelines and standards, HFS should establish baseline elements that must be upheld.[49]

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[46] Musumeci, M. 2012, October. Kaiser Family Foundation. "State Demonstrations to Integrate Care and Align Financing for Dual Eligible Beneficiaries: A Review of the 26 Proposals Submitted to CMS". Available online: http://www.kff.org/medicaid/upload/8369.pdf

[47] Disability Rights Education & Defense Fund (DREDF). (2012). Dual Eligible Demonstration Projects Accessibility Related Network Readiness Review Criteria – High Level with Detail. Available online: http://dredf.org/healthcare/2012-docs/Readiness-standards-DUALS-10-5-12.pdf

[48] Disability Rights Education & Defense Fund (DREDF). (2012).

[49] Disability Rights Education & Defense Fund (DREDF). (2012).

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4. MCEs should periodically review their provider networks to ensure that individual providers have the capacity to respond appropriately to members' needs. Providers' physical accessibility, policies, procedures, and practices should be sufficient to meet the needs of the LTSS population, including those with functional impairments and complex physical and mental conditions.[50]

5. MCOs must produce policies, practices and procedures to address beneficiaries who have functional impairments by consulting with the member, or their identified family member/representative, to identify reasonable accommodations and modifications so the member is able to receive equally effective health care services. [51]

6. The State should monitor care plans and hours to ensure that access to necessary LTSS home care services are maintained or improved.
   - Contracts with MCEs should specify that all unmet ADLs and IADLs as identified in the state's initial assessment screening (determination of eligibility) are met by MCO care plans.

[50] Disability Rights Education & Defense Fund (DREDF). (2012).
[51] Disability Rights Education & Defense Fund (DREDF). (2012).

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6. Continuity of Care

Illinois is mandating the transition from a fee-for-service system to a managed care system for Medicaid beneficiaries. For MMAI, the State is applying for a 1915(b) waiver in order to mandate the Medicaid portion of services to be delivered through managed care.

Many Medicaid beneficiaries have complex health conditions and have spent time identifying a team of providers (doctors, specialists, hospitals, home care workers, and more) who have developed treatment plans, and built rapport and trust with the beneficiary[52]. The movement from fee-for-service to managed care may disrupt these existing networks of providers and include different treatment criteria.

It is essential for the Medicaid beneficiary's existing team of providers and treatment plans to be taken into account during the transition to an MCE. This is particularly important for beneficiaries who need LTSS, as these individuals tend to have complex conditions and as a result are the most vulnerable to a change in their health care.

Illinois has proposed to go beyond the protections in Illinois' Managed Care Reform and Patient's Rights Act (215 ILCS 134/25) by proposing the following additional continuity of care protections for Medicaid beneficiaries transitioning into the managed care system through the MMAI:

- "In addition to a 180-day period in which Enrollees may maintain a current course of treatment with an out-of-network provider, they will be able to maintain existing PCP arrangements for 180 days and all current providers will be offered Single Case Agreements to continue to care for that Enrollee beyond the 180 days if they remain outside the network...
- All prior approvals for drugs, therapies or other services existing in Medicare or Medicaid at the time of enrollment will be honored for 90 days post enrollment and will not be terminated at the end of 90 days without advance notice to the Enrollee and transition to other services, if needed;
- Plans shall assume responsibility for an Enrollee receiving medical care or treatment as an inpatient in an acute care hospital on the effective date of enrollment; and
- Plans shall assume full responsibility for pre-existing conditions upon effective date of enrollment.[53]"

We recommend Illinois adopt the above language for all MLTSS programs, not just the MMAI, with the following changes: the transition period for providers and treatment plans should extend at a minimum for **12 months**[54].

- The 180-day post-enrollment transition period of providers who are out-of-network should be extended to **12 months**.

- The 90-day post-enrollment period for allowing beneficiaries to continue all prior approvals for drugs, therapies or other services should be extended to **12 months**.

- Further, beneficiaries who reach the end of an authorized treatment period during this 12 months should be approved for continued treatment or related treatment that is a reasonable or necessary part of the on-going treatment plan.

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[52] National Health Law Program. (2012). 5 Key Contract Terms for Duals Eligible MOUs. http://www.healthlaw.org/images/stories/NHeLP_5_Key_Contract_Terms_for_Duals_MOUs.pdf

[53] Proposal: Illinois Medicare-Medicaid Alignment Initiative. (2012). Pp. 23-24 http://www.chcs.org/usr_doc/Illinois_Proposal.pdf

[54] National Health Law Program. (2012). 5 Key Contract Terms for Duals Eligible MOUs. http://www.healthlaw.org/images/stories/NHeLP_5_Key_Contract_Terms_for_Duals_MOUs.pdf

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We support Illinois' proposals and guidance for providers in ensuring continuity of care during the transition to a managed care system. In addition to what Illinois has proposed, we also recommend the following:

1. HFS should use a 'smart assignment' process[55] when assigning Medicaid beneficiaries to an MCE. The 'smart assignment' system places beneficiaries into the MCE with the greatest number of that beneficiary's providers already in-network. Washington State has proposed to use this process for beneficiary enrollment into a Dual Eligible alignment health plan[56].
   - HFS should not allow MCEs with sub-standard networks to participate in this auto-assignment
   - Beneficiaries should not be assigned to MCEs whose providers have reached an acceptable provider to patient ratio; or whose providers have stated they are not accepting new patients (with the exception of a patient of the provider at the time of assignment).

2. All MCEs continuity of care period should apply to all of the MCEs' subcontractors.

3. During the transition period, out-of-network providers should be reimbursed for covered services at whichever rate is higher: the fee-for-service rate, or the plan network rate.

4. HFS should make available independent consumer assistance for beneficiaries who have the choice of MCE health plan. Beneficiaries should be advised on the plan to best meet their needs, taking into account: their ongoing health care needs, including participation of providers and service coverage policies.
   - HFS has proposed a 'neutral enrollment broker' for the MMAI[57]; we recommend this become standard for enrollment into all MLTSS programs.
     i. The State should utilize recommendations and lessons learned from the ICP enrollment broker experience.
     ii. We recommend talking with Thresholds, the Progress Center for Independent Living and Access Living about consumers' experience with the ICP enrollment broker.

5. HFS should require all MCEs to complete an assessment based on the beneficiary's application, diagnosis and claims data to identify high needs beneficiaries who may need assistance in a timelier manner than others; this should trigger a 'rapid contact' to these beneficiaries. This contact should ensure coordination with existing treatment and providers, and also refer the beneficiary to the MCEs' formal health assessment[58]. This goes beyond the ICP and MMAI requirements for risk stratification based on a health needs assessment; the rapid contact trigger allows for immediate identification and follow-up with at-risk individuals after transition to a new health plan.

[55] National Health Law Program. (2012). 5 Key Contract Terms for Duals Eligible MOUs. http://www.healthlaw.org/images/stories/NHeLP_5_Key_Contract_Terms_for_Duals_MOUs.pdf
[56] Health Path. (2012). Washington State. Health Homes Frequently Asked Questions. http://www.hca.wa.gov/documents/health_homes/FAQHealthHomes.pdf
[57] Proposal: Illinois Medicare-Medicaid Alignment Initiative. (2012). http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/IllinoisProposal.pdf
[58] National Health Law Program. (2012). 5 Key Contract Terms for Duals Eligible MOUs. http://www.healthlaw.org/images/stories/NHeLP_5_Key_Contract_Terms_for_Duals_MOUs.pdf

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Lastly, we would like to acknowledge and support HFS' requirement that LTSS providers (both nursing home and community-based) must[59]:

1. Be part of one or more care coordination network [Care Coordination Entity network, Managed Care Community Network, or Health Maintenance Organization network]

2. Be part of an interdisciplinary team in order to address an individual's needs holistically, and to achieve better health outcomes and quality of life

3. Collaborate with other providers and ensure effective care transitions among providers and across settings in order to create an integrated service delivery system to prevent unnecessary utilization of hospitals and emergency departments.

4. Provide "greater access to preventive and primary healthcare services, reduced use of emergency rooms, reduced hospital readmissions, and support for independent living in the community"[60]

[59] The Future of Care Coordination for Seniors and Persons with Disabilities. (2012). Illinois Department of Healthcare and Family Services. Available online: http://www2.illinois.gov/hfs/SiteCollectionDocuments/Future_of_CC.pdf
[60] The Future of Care Coordination for Seniors and Persons with Disabilities. (2012). Slide 13: http://www2.illinois.gov/hfs/SiteCollectionDocuments/Future_of_CC.pdf

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7. LTSS Provider Standards

Regarding provider standards, the State's MMAI RFP asks MCEs to:

- Implement a Quality Assessment and Performance Improvement program (3.2.1.4)
- Perform Quality Assurance evaluations of providers (2.6.5)
- Ensure cultural competency throughout their provider networks (3.2.1.14)
- Ensure quality nursing care for enrollees in nursing homes or receiving HCBS (3.2.2.10)
- Use traditional safety net providers (3.2.2.16)
- Ensure ADA accessibility of providers and support providers in achieving accessibility (3.2.2.20 and 2.6.5)
- Monitor specific quality measures and provide feedback to providers regarding their performance (3.2.4.1)

We recognize that the State has laid out high expectations for MCEs to ensure that enrollees have access to quality providers. We do believe, however, that more guidance from the State regarding its partnership with MCEs to support access to quality providers is necessary in order to establish a standard level of quality across all managed care programs.

While MCEs must prove that they can monitor the performance of their providers and hold providers accountable to standards through selective contracting and pay-for-performance programs, providers can only truly control the quality of their own performance. Analyzing and holding the performance of Medicaid service providers to a standard quality level will require cooperation between the State, the MCEs, and the providers.

According to a recently released AARP/Mathematic report[61], there are no national standards for measuring MCE performance as it relates to LTSS. However, states who implement MLTSS programs use a variety of different tools to measure LTSS provider quality and performance. The AARP report provides information on the approaches and measures used in Minnesota, Tennessee, Texas and Wisconsin; state Medicaid agencies are creating their own standardized LTSS quality measures.

An Effort to Develop a National LTSS Quality and Performance Measurement Set

In an effort to develop a more streamlined approach to LTSS quality and performance evaluation, LeadingAge in collaboration with CliftonLarsonAllen LLP recently released a "Managed Care Readiness Toolkit.[62]" The Toolkit serves as a guide for skilled nursing facilities, supportive service providers, continuing care retirement communities, independent and assisted living, and aging service providers.

Part 7 of the Toolkit is entitled "Quality Measures for LTSS Providers Under Managed Care/Health Care Reform". This section integrates and prioritizes LTSS quality metrics from over ten quality measure sets for health care. These LTSS quality measure sets include: Centers for Medicare and Medicaid Services (CMS), Healthcare Effectiveness Data and Information Set (HEDIS), Minimum Data Set (MDS), National Quality Forum (NQF), Long-Term Quality Alliance (LTQA), and Advancing Excellence.

[61] Lipson, et al. (2012). Pp. 21-22: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf

[62] The Managed Care Readiness Toolkit was initially offered to LeadingAge and Life Services Network members and is not easily accessible online yet for non-members. Please contact us to obtain a copy of the Managed Care Readiness Toolkit.

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75 individual measures were identified and grouped into seven domains; the first six domains are based upon a New England Journal of Medicine article on value-based purchasing[63]:

1. Safety
2. Patient- and caregiver-centered experience and outcomes
3. Care coordination
4. Clinical care
5. Population or community health
6. Efficiency and cost reduction
7. Staffing

Within each domain, measures were prioritized: Primary, Secondary or Tertiary. Measures that appeared in 3 or more measure sets were counted as Primary; appearances in 1-3 measure sets were Secondary; appearances in 1 measure set were Tertiary. Some adjustments were made based up on the expertise of the group who aggregated these measure sets.

The Managed Care Readiness Toolkit does not acknowledge measures of compliance as defensible measures of quality; this includes: the Five-Star rankings, survey deficiencies, and Nursing Home Company scores. These metrics are important, however, for performance and should not be written off completely.

We recommend that the State develop a workgroup around LTSS quality standards. The workgroup should be charged with reviewing currently proposed and implemented MLTSS quality standards in Illinois, and then looking at interacting this with the LeadingAge compilation of National Measure sets. The Leading Age work on LTSS quality measures is the most comprehensive aggregation of nationally recognized LTSS measures and should serve as a starting point for Illinois' approach to ensuring LTSS provider quality.

Universal Standards for Personal Assistants and/or LTSS Providers

Integrating consumer-directed personal assistants into coordinated care is a challenge for which there is no clear model from other states. It is therefore imperative that the State take special steps to protect consumers' access to a stable, quality workforce of personal assistants as MCEs experiment with new models of MLTSS.
We recommend the following:

1. DORS PAs must maintain collective bargaining rights in order to ensure a stable, quality, and fairly compensated workforce for people with disabilities.

2. Voluntary training opportunities for home care workers should be available to all PAs.

3. HFS should require MCEs to have exclusive contracts with the State of Illinois for PA services. Contracts should specify that MCEs will pay the State for those services out of their capitated rates. The contract should stipulate that the MCO must pay to the State the hourly rate set in SEIU's collective bargaining agreement for DORS PAs for wages, health insurance, training, and other benefits. Capitation rates to MCEs must account for these costs and not incentive cuts to PA services.

[63] VanLare, J., and Conway, P. (2012). "Value-Based Purchasing—National Programs to Move from Volume to Value." New England Journal of Medicine (367; 4).

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4. The State should require MCEs to contract only with private HCBS providers that the State has certified comply with all regulations governing the existing programs.

5. Contracts with MCEs should specify that MCEs pay private HCBS providers rates not less than the rate set by the State. For example, MCEs must pay a rate at least equal to the rate set by the Department on Aging for Community Care Program providers, as set forth in IAC 89 Section 240.1910.

6. MCEs should, at minimum, authorize the care plan and hours determined by the State's independent LTSS determination of eligibility entities (i.e. the Care Coordination Units and the Department of Human Services, Division of Rehabilitative Services). Subsequently, providers must be able to service the member per the care plan.

7. Providers should be required to send a substitute if regular workers are sick or unavailable.

At a broader, managed care systems level, we recommend:

1. The State should coordinate with MCEs to collect and monitor data on provider performance. While the MCEs are responsible for building a broad, high quality network, the State should maintain a role in identifying problems with providers, especially when specific communities have frequently poor performers.
    - Based on MCE data-sharing, the State should identify gaps in infrastructure—HIT, staff, training, physical plant—that providers need in order to participate successfully in coordinated care.
    - If problems with provider quality are found, the State should convene a working group of providers, MCEs, consumers, and State agencies to make a plan to improve quality of in-network providers and recruit existing, high quality providers into networks that have gaps.

2. The State and MCEs should identify 'safety net providers,' including public providers, FQHCs, and hospitals that meet the definition in the SMART Act and craft performance evaluation and quality improvement plans that address their particular challenges:
    - Increased coordination and better access to primary and preventive care may increase utilization and costs at safety net providers initially, since they focus more on those services than on specialty services.
    - Low volume providers' financial sustainability may be at greater risk if admissions are reduced without enough time to adapt to new Medicaid models of care delivery, especially in rural areas.
        - The State should develop pay-for-performance systems that account for the challenges facing safety nets, such as attaching incentives to primary care and downside risks to specialty care, and P4P incentives that reward improvement before using absolute benchmarks.

3. The State should align performance measures between MCEs, Medicare, and commercial insurers to create a common goal for providers to work toward and to reduce the wasteful burden of administering multiple performance measures and quality reporting systems.

Contact: Kristen Pavle (kpavle@hmprg.org) or Sharon Post (Sharon.Post@seiuhcil.org)

8. Evaluation/Quality Measurement

"Recognize that performance measurement is not possible without LTSS-focused measures.... Performance measurement is a critical element of any managed care program, giving states, providers, consumers, and the managed care entities themselves valuable information about the quality and utilization of care provided. This information can be used to track performance over time, identify areas for improvement, facilitate comparisons across plans, and determine priorities for special initiatives." P. 20 of PDF http://www.cms.org/dsi_doc/MLTS_Roadmap_112210.pdf

We applaud Illinois' MMAI proposal for being 1 of 3 states who included an explicit evaluation component. Illinois has proposed to contract with an outside entity to evaluate the MMAI demonstration. In order to ensure that the evaluation for the MMAI demonstration is useful for the LTSS population, we recommend the following:

1. Quality measures should take into account how personal relationships with providers and access to assistive technology contribute to the general well-being and quality-of-life of individuals with disabilities. If these measures are not included in P4P programs and other evaluations of the plans, there will be no accountability for MCEs that ignore those needs, and consumers' quality of life could deteriorate.

2. The State should require MCEs to collect and report quality data with specific analysis of utilization and quality indicators for people with disabilities and seniors. Quality improvement processes will use this data to identify gaps in service and coordination for people with disabilities.

3. The State should establish clear and accountable quality standards that address the specific concerns of people with disabilities, including ADA accessibility of providers and maintaining consumer control. Consumer satisfaction measures must be included in quality measures to evaluate the level of independence and well-being experienced by people with disabilities in each plan. These are important outcomes that cannot be measured with encounter data and medical information alone.

4. The State should utilize the Managed Care Readiness Toolkit developed by Leading Age and referenced above under section 7. LTSS Provider Standards, subsection "An Effort to Develop a National LTSS Quality and Performance Measurement Set". The Managed Care Readiness Toolkit integrates over 10 existing LTSS nationally recognized measure sets into one measure set and should serve as a guide in developing appropriate LTSS specific evaluation and quality measurements.

Contact: Kristen Pavle (kpavle@hmprg.org) or Sharon Post (Sharon.Post@seiuhcil.org)

I4A *ILLINOIS ASSOCIATION OF AREA AGENCIES ON AGING*
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Testimony for the Illinois Long Term Care Council Public Forum

December 12, 2012
Sheraton Chicago Hotel and Towers

Good Afternoon. My name is Mike O'Donnell, Chairperson of the I4A Legislative Committee. I will present testimony on behalf of the thirteen Area Agencies on Aging in Illinois.

- The Illinois Department on Aging and Area Agencies on Aging should play a critical role in facilitating the statewide implementation of Long Term Services and Supports for individuals enrolled in managed care through the Integrated Care Program and the Medicare-Medicaid Alignment Initiative. The Department on Aging can ensure an inclusive and transparent implementation process for the delivery of quality, cost-effective services.

- Area Agencies on Aging have a statutory mandate under the Older Americans Act to develop a comprehensive and coordinated system of long term services and supports in every Planning and Service Area to enable older adults to live in their own homes with health, independence, and dignity for as long as possible.

- Area Agencies on Aging have over 38 years of experience administering grants and contracts with 259 community-based provider agencies. Area Agencies on Aging and their provider networks serve over 511,000 older adults and 43,000 caregivers annually.

- Area Agencies on Aging in Illinois are administering and developing Aging and Disability Resource Center Networks in collaboration with the Illinois Department on Aging and Centers for Independent Living. The Aging and Disability Resource Center (ADRC) is a national model that has been included in the Affordable Care Act as a single or coordinated point of entry for Long Term Services and Supports for older adults and persons with disabilities.

- Area Agencies on Aging and their ADRC networks can carry out multiple functions to implement managed care in collaboration with traditional community partners (including contracted Care Coordination Units) to provide assessments, eligibility determination, care planning, and care coordination. These care coordination networks can provide conflict-free case management.

- Area Agencies on Aging and ADRC networks provide a variety of services – beyond those authorized under the Medicaid-waivered Community Care Program - to enable Managed Care Organizations to respond holistically to the needs of older adults and persons with disabilities enrolled in manage care within comprehensive plans of care. These services include:

- Information and Assistance;
- Benefits eligibility screening;
- The ***Enhanced Services Program (ESP)*** – a comprehensive, statewide resource data base of Long Term Services and Supports for older adults and persons with disabilities.
- Senior Health Assistance Program;
- Outreach;
- Partnerships with community organizations with the cultural competency to serve limited-English Speaking older adults and persons with disabilities;
- Transportation to access non-emergency, out-patient healthcare services;
- Nutrition assessments and education;
- Home delivered meals and well-being checks;
- Evidence-based programs such as the ***Chronic Disease Self-Management Program*** and ***Diabetes Self Management Program*** which empower adults with chronic conditions and disabilities to take charge of their health; and
- Education and respite services for caregivers

- Area Agencies on Aging have the experience and skills to assure quality and accountability. AAAs administer millions of dollars of federal and state grant assistance to community organizations throughout Illinois. They employ staff to regularly monitor grants administration and service delivery for hundreds of community agencies under Area Plans approved by the Illinois Department on Aging.

- The Illinois Aging Network brings added value to Managed Care by ensuring that community-based long term services and supports are linked seamlessly to individuals enrolled in the Medicare-Medicaid Alignment Initiative.

- Area Agencies on Aging and their ADRC Networks have earned the trust of older adults and their families over the past 40 years. MCOs can engage AAAs and their ADRC Network partners to provide quality customer services to their members, including information and assistance, problem solving, complaint investigation and advocacy.

Thank you for the opportunity to testify.

Contact Information:

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Testimony of Beverley L. Laubert
Ohio State Long-Term Care Ombudsman
Before the Illinois Long-Term Care Council
December 12, 2012

The Ohio Office of the State Long-Term Care Ombudsman advocates for individuals receiving home care, assisted living, and nursing home care. We do that by working to resolve complaints about services, helping select a provider, and offering information about benefits and consumer rights. As managed care systems are developed for long-term services and supports, it is my position that long-term care ombudsman programs are the natural fit for consumer advocacy. My testimony will describe briefly the development of Ohio's Integrated Care Delivery System - the state's approach to care for individuals dually eligible for Medicare and Medicaid – and the importance of an independent advocate for consumers.

The Ohio Governor's Office of Health Transformation set out the following description in its stakeholder engagement report earlier this year:

Ohio's proposed ICDS will create organized systems of care that provide comprehensive services to Medicare-Medicaid Enrollees across the full continuum of Medicare and Medicaid benefits, including long term supports and services (LTSS). Through the ICDS Program, Ohio expects that more Medicare-Medicaid Enrollees will be able to receive the medical and supportive services they need in their own homes and other community-based settings, rather than in more costly institutional settings.

Other goals of the Program are to:

- *Provide one point of contact for beneficiaries;*
- *Utilize managed care to improve care coordination via a person-centered, team-oriented approach that holistically addresses individuals' needs in a setting they choose;*
- *Provide a delivery system that is easy to navigate for the beneficiaries and providers;*
- *Reduce the overall cost of care, benefiting the beneficiary, Medicare and Medicaid; and*
- *Provide a seamless transition between settings and programs as a beneficiary's needs change.*

Historically, long-term care was divided between care in the home or community-based setting and care in a facility-based setting. The Money Follows the Person demonstration provided a structure for connecting nursing home and community but the focus on services and quality is primarily on home care. With the Integrated Care Delivery System, for the first time, there will be a comprehensive system that has the flexibility to move among all available services with the emphasis on the needs of individuals, not the location.

The facility-based provider community will need to adapt to welcome care management without relinquishing their responsibilities. In our Money Follows the Person demonstration, one service is Transition Coordination – assisting residents to find places to live, ensuring that they obtain needed benefits, and establishing a household. One challenge was assuring that social service staff in nursing homes fulfilled their responsibilities for discharge planning. Likewise, care managers should provide a new umbrella of coordination without taking over the role of nursing home staff.

The long-term care ombudsman can provide a wealth of information about the quality of services. As managed care organizations contract with providers and as consumers make choices among available providers, the ombudsman should provide data about complaints, help navigate the regulatory system, and otherwise support person-centered choice.

Shaping the delivery of advocacy services for individuals enrolled in managed care should include several considerations. Five years ago, the National Association of State Units on Aging and the National Ombudsman Resource Center assembled a strategic work group to talk through the ombudsman role in a modernized long-term care system. The work focused on home care services and transition from nursing homes. The principles apply in managed care as well.

Systemic advocacy and programmatic roles

Consumer advocates, including the ombudsman, need to be "at the table" as the system is designed. Ombudsmen can contribute experiences with service selection and barriers to eligibility for public benefits and can make recommendations about monitoring quality. Given policy makers' emphasis on lower cost alternatives to nursing home care in the past decade, ombudsmen and family members of nursing home residents are often the sole sources of information about resident experiences in nursing homes while they live there.

Resources that ombudsman programs need to carry out the identified roles and functions

Ombudsmen who live in the traditional world of facility-based advocacy need to expand knowledge and skills to these new areas. Training for ombudsmen is needed in laws and regulations governing home care providers as well as the requirements the state establishes for managed care plans, especially related to quality oversight. Just as we know how and when to involve the regulatory agency for nursing home problems we are unable to resolve, we must be conversant with regulations for these other entities.

A significant task for states and managed care plans is to define contract requirements for providers. As issues arise for consumers whose care is subject to those contracts, ombudsmen will need access to legal counsel for advice and guidance. Legal support will also be important for assisting consumers to appeal adverse decisions by the managed care plans; ombudsmen should cultivate referral relationships with legal

services providers. We have some experience with Medicare Advantage plans into which nursing home residents are enrolled but we have found in Ohio that resolving complaints is an area of specialization not all ombudsmen possess.

Potential sources of funding and how funding can be obtained from these sources
Medicaid administrative funding for ombudsman programs is an underutilized source of support that needs more attention. The Centers for Medicare and Medicaid Services, the Administration on Aging, and the National Association of State Ombudsman Programs continue to discuss and define eligibility for administrative funds and we have seen success in several states. It is essential that this work continue and at a faster pace, as the unique role of the ombudsman as a navigator, watchdog, and broker among agencies is key in the efficient and effective administration of the Medicaid program.

In Ohio, ombudsman funding comes from a variety of state sources – general revenue, a facility-based provider bed fee, and revenue from the Money Follows the Person demonstration for regional ombudsman programs that provide transition coordination services. In developing a funding strategy, I urge you to structure revenue in a way that does not compartmentalize dollars and services. For example, federal funding for the ombudsman program is restricted to advocacy in facility-based long-term care settings but in Ohio although facility-based providers pay a bed fee, those funds are used to build capacity, thereby supporting ombudsman activity in any venue.

Potential conflicts of interest
In order for ombudsmen to be effective advocates, there must be systems in place to identify and remedy conflicts of interest. For example, if an Area Agency on Aging provides services or case management and employs an ombudsman, procedures should be put in place to ensure that the ombudsman is able to be freely advocate for the consumer. Communication with consumers must reveal the potential conflict of interest and the remedy; ultimately the consumer needs to decide whether to trust the relationship. A back-up plan for advocacy should be established. For example, in Ohio, regional representatives of my office are required to refer certain issues to me; sometimes state staff will handle the problem and sometimes state staff will oversee the regional ombudsman. We found it important to establish guidelines in ombudsman regulations for consistency.

In summary, I applaud you for seeking the input of diverse panels of witnesses and being deliberate in your development of the consumer advocacy role. As you go forward, I urge you to guarantee that new responsibilities for the ombudsman program are accompanied by new revenue. As ombudsmen, we tend to see the gaps and want to fill them no matter what; consequently, we find ourselves stretched so thin that we can't be effective. I am fortunate in Ohio to have a state-level corps of six ombudsmen. As direct-service staff grows, state-level staff is needed to provide support – training,

oversight, and technical assistance. I hope my suggestions are helpful and I thank you for the opportunity to provide input; I wish you well.

Testimony for the Illinois Long Term Care Council
Governor's Conference on Aging Public Forum
Regarding Managed Care and Long Term Care Service Delivery
Submitted by Mary Ann Bibat, Vice President, Senior Services
Catholic Charities of the Archdiocese of Chicago
December 10, 2012

My name is Mary Ann Bibat and I am the Vice President overseeing Senior Services for Catholic Charities of the Archdiocese of Chicago. Catholic Charities is a 95-year-old, faith-based organization that is the social services arm of the Catholic Church in Cook and Lake counties. For nearly 30 years, Catholic Charities has been a coordinator of and provider of community based care on behalf of the State as the Care Coordination Unit (CCU) in four different communities in Cook and Lake counties. As such, we have a responsibility to the 33,000 vulnerable Illinois seniors and their families whom we serve each year to be their voice in this process of moving to Managed Care. Thank you for the opportunity to be this voice today.

Catholic Charities believes that the transition to Managed Care will affect the delivery of Long Term Care (LTC) services provided by both LTC facilities as well as community based services and supports in two phases.

The first phase is in the fact that put simply, it represents significant change to the already frail seniors who are served in these programs. The vast majority of these seniors will require a high level of individual care and attention to ensure their understanding of every new process. Their acceptance and comprehension is absolutely necessary for their continued health and safety, and will help ensure they do not experience a hastened need for other more extensive services.

The second phase is in the necessity of understanding the strategies required to ensure every senior's safety, and providing the depth and breadth of services to do so. A thorough awareness of participant needs and, in the case of community based care, the established ability to access community resources that keep people in their homes and out of nursing homes and hospitals are essential.

CCUs are community-based organizations that have been successfully and economically providing these services. Integrating their expertise into the new Managed Care plan by the Managed Care Organizations only makes sense. For the protection of the vulnerable seniors and others in these programs, I thank you for making use of the expertise CCUs bring to the table.

Catholic Charities also recommends that this Council shape delivery of advocacy services for persons receiving Managed Care services through establishing program standards and training curriculum for the Home Care Ombudsman Program. We further recommend that this Council ensure the effectiveness of LTC Ombudsmen relative to Managed Care through statutory changes, such as those proposed by the Older Americans Act Amendments of 2012, U.S. SB3562.

Catholic Charities fully supports the three goals of moving to the Managed Care approach: improved healthcare, more control over costs and cost shifting, and improved communications among Healthcare systems. We are wholly committed to continuing the work we have begun with the State in implementing the new system.

Tami Wacker

From: Gail Kear <gkear@lifecil.org>
Sent: Monday, December 17, 2012 3:23 PM
To: Tami Wacker
Cc: 'annford@incil.org'
Subject: Illinois Long Term Care Council Public Forum - comment

Importance: High

Dear Ms. Wacker,

I very much appreciated the opportunity to attend the Illinois Long Term Care Council Public Forum, held on December 12 during the Governor's Conference on Aging. I spoke to you briefly at the end of the session, and you asked me to email my comment to you.

LIFE Center for Independent Living has for many years had contracts with the Illinois Department of Human Services to provide Personal Assistant and Community Reintegration services for persons with disabilities. It is my understanding that one or both of these services would be included in the Medicare/Medicaid managed care contracts. It is also my understanding that managed care bidders were advised that Centers for Independent Living should be considered as vendor agencies for the provision of these community-based long-term services and supports. Your panel asked yesterday whether the transition to managed care is happening too quickly, and the replies you got from state agency and managed care company representatives suggested that it is not.

I respectfully offer a different perspective to this question, the perspective of a small, not-for-profit service provider agency. Changing from a DHS grantee to a managed care vendor, and changing from a grant reporting system to performing Medicaid billings, would constitute a MAJOR change in how my Center provides these services and how we are funded to do so. Approximately 20% of my entire operating budget is currently made up of the two grants, Personal Assistant services and Community Reintegration/Money Follows the Person services, that would be potentially displaced by managed care vendor services – and with no guarantee that we would even have a managed care contract! Twenty-two percent of my entire staff's time (2.33 FTE) is devoted to these two programs; will they have jobs when managed care takes over this program? Will my Center have the income, and the cash flow, to cover their payroll?

To date I have been unable to learn when all this would start or what services we would provide or how much we would be paid or any of the other information critically needed to adequately plan or prepare for these coming changes. I am frankly quite anxious about the fiscal stability, even viability, of my Center as we navigate through a change of this magnitude. I know from talking to other Executive Directors of Centers for Independent Living that many, if not most, of them feel the same way.

In addition, as an organization responsible to educate persons with disabilities about the resources they need to live independently, and to advocate for their rights, we have little information to communicate to them about their health care opportunities and rights when they are enrolled in managed care.

I encourage the Council to assure that future managed care vendors and members receive timely and accurate information about the coming changes under managed care so that we can all plan, prepare, and assure successful transitions to a new and potentially better way of providing long term services and supports for persons with disabilities.

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