Illinois Department on Aging

OLDER ADULT SERVICES ACT

(P.A. 093-1031)

2015 REPORT TO THE GENERAL ASSEMBLY

January 2015

Table of Contents Page

Executive Summary

Early in 2014 the Older Adult Services Advisory Committee (OASAC) participated in a planning process to define key priorities for the Committee. During the planning process the Committee reviewed the vision and guiding principles for OASAC, the role of OASAC, and identified seven top priority areas that would be their primary focus for the period of January 1, 2014 through December 31, 2015. These priority areas are:

1. 1115 Waiver
2. Balancing Incentive Program (e.g. Uniform Assessment Tool, Conflict Free Case Management, No Wrong Door System)
3. Care Coordination
4. Transitional Care
5. Funding for Home Community Based Services (HCBS)
6. Adult Protective Services
7. Expanded community role for Long Term Care Ombudsman

This report provides an update on the State's progress with regard to each of these priority areas. Throughout the year OASAC members were briefed on these topics through presentations, discussions and documents. OASAC members continue provide feedback at the OASAC meetings and have been invited to serve on the Governor's Office of Health Innovation and Transformation (GOHIT) Services and Supports Workgroup meetings. Many members of OASAC attended public stakeholder meetings hosted by GOHIT.

During 2014 the OASAC Executive Committee developed recommendations for a formal stakeholder engagement process to ensure that consumers, providers and advocates have an opportunity to give feedback on the implementation of these transformative initiatives. Recommendations from OASAC with regard to the development of a robust stakeholder engagement process are included in this report.

OASAC also formed a work group to advise the State on issues pertaining to the Personal Attendant/Consumer Directed service that is proposed under the 1115 Waiver. The activities and recommendations of this work group are discussed in this report.

The Older Adult Services Advisory Committee met four times during 2014 (February 24, May 19, August 25 and November 17). The Executive Committee also met four times (January 13, April 21, July 21 and October 20). A list of OASAC Committee members, meeting agendas, minutes, handouts and materials that were presented at each OASAC meeting are posted to the Illinois Department on Aging website.

Work Completed

1115 Waiver

The goal of the 1115 Waiver is to incentivize the delivery system and payment innovation of the services offered by the state; increase access to community based options; and positively impact social determinants of health. The consolidation of Illinois' nine existing waivers under a single waiver will help increase flexibility and choice of long term care supports for the aging and disabled population. The State of Illinois submitted an 1115 Waiver application to Centers for Medicare & Medicaid Services on June 4, 2014. The waiver calls for four pathways to transformation of the long term services and supports system:

Pathway 1: Transform the Health Care Delivery System
Pathway 2: Build Capacity of the Health Care System for Population Health
Pathway 3: 21st Century Health Care Workforce
Pathway 4: LTSS Infrastructure, Choice, and Coordination

The Governor's Office of Health Innovation and Transformation (GOHIT) was created by the Governors Executive Order to lead and coordinate implementation of the transformation principles in the Innovation Plan; support stakeholder engagement; and create and operate an Innovation and Transformation Resource Center to provide technical assistance. GOHIT announced the formation of workgroups to discuss implementation issues that will affect the 1115 Waiver and the Alliance for Health Innovation Plan. The workgroup are as follows:

1. <u>Services and Support Work Group</u>
   Develop an implementation plan that assures access to services and supports for individuals based on functional need, rather than solely on disability. There are a total of 300 stakeholders under the Services and Support Work Group, this group is comprised of two subcommittees.
   i. Children's Services Subcommittee: Recommend implementation strategies to enhance the delivery system and full continuum of care for children with behavioral health needs.
   ii. Long Term Services and Supports Subcommittee: Develop recommendations to ensure ready access to the wide range of services and supports by individuals based on functional need, and not solely based on disability. Develop service definitions, business processes for service access and ongoing systems management and monitoring.
      - Service Definitions Breakthrough Group: Review service definitions and provider qualifications for the consolidated set of services included under the 1115 Waiver.

- Conflict-Free Case Management/Person Centered Planning (CFCM/PCP) Breakthrough Group: Development of policy that is consistent with the BIP requirements and CMS HCBS Waiver regulations.

iii. Developmental Disabilities Subcommittee: Develop recommendations to address systems challenges for persons with developmental disabilities.

iv. Behavioral Health Subcommittee: Develop recommendations to integrate behavioral health with primary care; remediate disparities in access to healthcare services; increase coordination across physical health, mental health, substance use and intellectual disability/developmental disorders; expand services and the provider network to fill identified gaps; design program and service structures which incentivize timely access and identification of behavioral health issues across health settings and the lifespan; establish behavioral health policies for prevention; expand eligibility for waiver services to better serve an expanded mental health population, increase Medicaid Rehabilitation Option fee-for service rates to align payments closer to cost of care; and the addition of housing case management and tenancy support services.

2. Delivery System Reform
   Purpose: Recommend implementation strategies to transform the fee-for-service payment and delivery system to an advanced system of care where patient outcomes and provider payments are aligned.

3. Data and Technology
   Purpose: Recommend strategies to ensure that data and technology are maximized, drive innovations in healthcare, and successfully integrate disparate service and providers.

4. Workforce
   Purpose: Recommend strategies for building a 21st century health care workforce that is aligned with the needs of the providers, addressing workforce shortages in high need urban and rural areas, and preparing the workforce to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand.

5. Public Health Integration
   Purpose: Recommend strategies for enhancing the ability of the health care system to engage in population health management by leveraging public health resources, and encouraging linkages between public health and health care delivery systems.

The Long Term Services and Supports Subcommittee, Service Definitions Breakthrough Group has developed common definitions of services across Illinois' nine waiver programs, and has had preliminary discussions concerning provider qualifications and limits of service.

PA 098-0935 amended the Disabled Persons Rehabilitation Act by adding a Home Care Consumer Bill of Rights to the legislation (signed 8/5/14). In response to this legislation Illinois has drafted a Consumer Bill of Rights for consumers of home and community based services

that address rights to basic safety, information about the availability of services, the right to participate in the planning of services, the right to dignity and individuality, and the right to redress grievances. Additionally, the CFCM/PCP Breakthrough Group has drafted a vision statement for the implementation of person centered planning throughout its systems. It is anticipated that all of Illinois' human service agencies that deliver home and community based services will distribute this generic bill of rights to their population in addition to program specific brochures describing additional rights and responsibilities.

OASAC members have attended GOHIT stakeholder meetings and provided feedback on the service definitions under the 1115 waiver as well as the Consumer Bill of Rights. OASAC also provided recommendations on key service components of personal attendant/consumer directed care for the State's consideration in the implementation of the 1115 waiver.

Balancing Incentive Program (BIP)

The Balancing Incentive Program (BIP) was authorized under the Affordable Care Act (Section 10202) to assist states with improving access to Medicaid-funded home and community based long-term services and supports (LTSS) and to streamline program eligibility and service delivery to consumers between state agency programs. Participating states receive enhanced federal match funds to increase access to non-institutional long-term care services and supports (LTSS).

Illinois applied for and received an enhanced (2%) federal match to participate in the BIP to further rebalance the State's long term care delivery toward home and community based services. Illinois is projected to receive $90.3M in enhanced match over the award period (from July 2013 through September 2015) and plans to reduce the overreliance on institutional care through strengthening the community capacity and ensuring that individuals are afforded more community options prior to admission to an institutional setting.

The goal of the BIP project is to rebalance the LTSS system through the continued expansion of community based services and supports to meet the 50% benchmark of LTSS expenditures being directed to the community system by September 2015. In 2009, Illinois was at 27% benchmark of LTSS expenditures directed to the community services and supports. Currently, Illinois is at about 40% benchmark of LTSS expenditures directed to the community.

In exchange for the 2% federal match, states must implement three structural changes which include the implementation of a Core Standardized Assessment; the assurance of the provision of Conflict Free Case Management across LTSS; and the establishment of a No Wrong Door system for LTSS that is coordinated across disability populations.

1. Uniform Assessment Tool (UAT)

BIP requires the development of a core standardized assessment instrument to determine eligibility for non institutionally-based LTSS. The instrument(s) must assess consumers across a number of domains (activities of daily living, instrumental activities of daily living, medical

conditions, cognitive functioning, and behavioral concerns) in a uniform manner throughout the State to determine a beneficiary's needs for training, support services, medical care, transportation, and other services. BIP supports a holistic approach to the assessment process and service planning.

Illinois is committed to implementing a streamlined/standardized intake process that will reduce existing fragmentation and duplication while improving statewide coordination and ensuring consumers experience the same process regardless of how they access services. The **Level 1/Initial Screen** will identify those likely to be eligible for LTSS and it will be coordinated with other state IT infrastructures. Illinois will also ensure that consumers are linked to the appropriate entity for completion of the Level 2/UAT comprehensive assessment. The **Level 2/UAT** will determine functional eligibility for LTSS programs currently covered by the Determination of Need (DON) and identify unmet needs for other programs. This improved assessment process will view consumers holistically and lead to the development of a comprehensive person centered plan.

Illinois is in the process of procuring a Uniform Assessment Tool which will satisfy the BIP's core standardized assessment requirement. In 2014 the State of Illinois is expected to issue a contract to a vendor selected through the procurement process, to develop and implement the comprehensive Level 2/UAT. Workgroups will be forming to allow state agency staff as well as stakeholders, including OASAC, the opportunity to have input into this process.

2. Conflict Free Case Management (CFCM)

BIP regulation defines "conflict free" as the separation of case management and eligibility determination from direct service provision; as case managers not being able to establish funding levels for the beneficiary; and as case managers not being able to be related to the beneficiary or their caregivers. BIP requires states to establish firewalls and appropriate safeguards where conflict risks exist to assure consumer choice and protect consumer rights. The State of Illinois' case management systems are currently unique to each of the disability populations served under each of the home and community based services (HCBS) waivers and the Medicaid Rehabilitation Option. Four of the eight programs/service areas included in Illinois' BIP application are conflict free because the entities that provide case management services are separate from the entities that provide direct services. While state oversight of case management functions exists in the remaining four programs/service areas (Supportive Living Program, Adult Developmental Disabilities Waiver and services provided by the Illinois Division of Mental Health and Addiction Recovery Services), the State has developed several new cross-agency policies as part of its BIP CFCM protocol to strengthen and standardize existing oversight. In addition, the State is currently developing additional policies to comply with the conflict of interest provisions in the new Centers for Medicaid and Medicare Services (CMS) HCBS Rule.

Given the variance in the depth and scope of these activities across programs, the State is strengthening its LTSS oversight and monitoring functions by implementing the following six

administrative standardization policies across agencies and programs. These policies will apply to all five LTSS agencies in Illinois[1] and for services paid for under a fee-for-service or a managed care model. They will also support LTSS changes required by the new HCBS Rule and the State's pending 1115 waiver. To the extent possible, these changes will build on existing processes and state infrastructure.

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

3. No Wrong Door (NWD)

BIP requires the development of a statewide system to enable consumers to access all LTSS through a coordinated network or portal that will reduce existing fragmentation and duplication, improve coordination and provide a standardized intake process; provide application assistance; provide referrals for services and supports available in the community; and enable functional eligibility assessments. To be considered statewide, the BIP NWD system must include: a set of designated NWD Coordinated Entry Points (CEPs); an informative website about community LTSS options in the State; and a statewide 1-800 number that connects individuals to the NWD system or their partners. Illinois is working on expanding the Senior Helpline to meet the needs of the BIP 1-800 number and is also outlining the needs associated with the creation of the LTSS website. The designated NWD/CEP system in Illinois will be designed around a coordinated system of multiple entry points across the State and across agencies.

[1] Illinois Division of Developmental Disabilities, Illinois Division of Mental Health and Addiction Recovery Services, Illinois Department of Healthcare and Family Services, Illinois Department on Aging and the Illinois Division of Rehabilitation Services.

Illinois Department on Aging (IDoA) hired the Lewin Group to assess the current status of the Aging and Disability Resource Network and to assist in strengthening partnerships in line with the federal vision of building a system that serves people of all ages and types of disabilities. As part of this work, IDoA will hold a series of focus groups across the State to gather input about how partnerships in ADRC networks are working now, and what opportunities exist to strengthen them. OASAC will be an important part of this feedback process.

Care Coordination

P.A. 96-1501 (“Medicaid Reform") requires that 50% of Medicaid clients be enrolled in care coordination programs by 2015. Care Coordination must provide or arrange for a majority of care around the patent’s needs, including a medical home with a primary care physician, referrals to specialists, diagnostic and treatment services, behavioral health services, inpatient and outpatient hospital services, dental services, and when appropriate rehabilitation and long term care services. Care coordination must also include risk based payment arrangements related to healthcare outcomes, the use of evidence based practices and the use of electronic medical records. In Illinois, care coordination is provided to most Medicaid clients by a variety of “managed care entities,” a general term that includes Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), Managed Care Organizations (MCOs) and Accountable Care Entities (ACEs).

Care Coordinated Entities (CCEs) refers to a collaboration of providers (including hospitals, primary care providers, mental and substance abuse providers) that develop and implement a Care Coordination model that meets state requirements. The group of providers may create a new corporate entity or may contract with the state or subcontract with an existing health plan for back office functions. CCEs provide risk assessments and care plans specifically for individuals with severe mental illness. CCEs do not authorize services or pay claims to providers. CCEs only provide case management services for individuals with severe mental illness (this case management is in addition to the case management provided by the Care Coordination Unit under the Community Care Program). Individuals may be enrolled in CCE and receive CCP services.

Managed Care Community Networks (MCCNs) is a provider sponsored organization that contracts to provide Medicaid covered services through a risk based capitation fee. The MCCN’s must be certified by Illinois Department of Healthcare and Family Services (HFS); must be owned, operated, managed, or governed by providers, state funded medical schools, or county governments. MCCN’s have different reserve requirements than HMO’s. MCCN’s offer flexibility on risk based covered services.

Managed Care Organizations (MCO) is similar to an HMO, which has its own network of doctors and hospitals. Individuals that enroll in an MCO, receive all of their services from the doctors and hospitals that that are in the MCO network, unless they get approval from the MCO. MCOs are health delivery systems designed to provide coordinated care that will reduce

unnecessary utilization of services, control cost, increase and maximize quality. The benefits of managed care include better health for the member, better quality of life for the member, and reduction in the cost of the service over time.

Integrated Care Program (ICP) is a managed care program for older adults and adults with disabilities (age 19 and over) who are eligible for Medicaid (without a spendown), but not eligible for Medicare. The Medicaid Agency (MA) has contracted with two managed care plans (Plans) to administer the program (participants have the choice of plans). The ICP brings together local primary care providers (PCPs), specialists, hospitals, and other providers to provide more coordinated care around the participant's needs. ICP members have a choice of plans and PCP's; they receive better coordination of care; manage their own healthcare needs; and receive additional programs and services to help them live healthy and independent lives. ICP consists of two service packages: Service Package I includes medical and behavioral health services only; Service Package II includes long term care services and supports (LTSS), including nursing home care and community waiver services.

On February 22, 2013, Illinois and the federal Centers for Medicare and Medicaid Services signed a Memorandum of Understanding that approved the *Medicare/Medicaid Alignment* Initiative. Medicare-Medicaid Alignment Initiative (MMAI) is an effort to reform the way care is delivered to clients' eligible for Medicare and Medicaid services (dual eligibles) by providing coordinated care. MMAI has two components, the enrollment for the community which includes Medicare and Medicaid services for individuals living at home, but does not include Long Term Support Services (LTSS) and the enrollment for LTSS population which includes Medicare and Medicaid services for those individuals who are part of a Medicaid waiver program, including *CCP participants* and individuals residing in a nursing or supportive living facility. At least 135,000 beneficiaries in the Greater Chicago and Central Illinois region are expected to be enrolled into capitated health plans beginning January 1, 2014. The plans will be responsible for delivering all covered Medicare and Medicaid services to plan enrollees. Enrollees can opt out of MMAI *at any time*; those that receive LTSS will be <u>required</u> to participate in the MLTSS (Medicaid Long Term Support Services) program which began in Fall 2014.

Accountable Care Entities (ACEs) are provider based organizations (e.g. hospital groups) created to integrate delivery systems and coordinate care in the Medicaid program. ACEs will initially manage populations, who are children and their family members and have an option to enroll "newly eligible" adults under ACA and eventually assume increasing levels of risk associated with providing care. ACEs will include a minimum of the following types of providers (primary care, specialty care, hospitals and behavioral healthcare).

Transitional Care

Nursing Home Diversion Pilot

The Illinois Department on Aging is expected to receive approximately $9 million from the BIP funding to support the implementation and evaluation of a Nursing Home Diversion Pilot that is aimed at reducing the number of initial nursing facility placements at the time of hospital discharge, and to reduce the average length of stay in nursing facilities for short-term placements. IDoA approved and funded seven pilot partner agencies to join a collaboration that includes Centers for Independent Living, Community Mental Health Centers, Area Agencies on Aging, and Care Coordination Units, and housing partners. The Lewin Group was contracted to support the implementation and evaluation of the pilot. Pilot projects will serve individuals eligible for Medicaid, Medicare, and other publicly funded long term services and support programs as well as those who are ineligible for publicly funded LTSS programs.

In August 2014 State Agencies, Lewin group and the seven pilot sites met to discuss the development of a standard set of service that could be included in a core service package. The group agreed to include the following in the core service package:

1. A pre-discharge intervention at time of hospital admission that includes the use of a standardized person-centered planning/screening process to identify appropriate candidates for the Nursing Home Diversion project, and who is interested in receiving help.

2. The use of Options/Person-Centered Counseling to work with participants to develop a person-centered plan for connection to services, referrals and follow-up.

3. Mental health assistance must be provided to determine eligibility, access, and linkage to community mental health services, rehab services program, and to private providers. The State will provide assistance with managing and dispensing funds from a flexible spending account to pay for mental health services.

4. Rapid response home modifications need to be available to program participants and therefore the State must formalize agreements with area contractors and assistive technology to provide expedited home modifications and expedited consultations. The State must also provide assistance with managing and dispensing funds from a flexible spending account to pay for home modifications and assistive technology as needed.

5. Housing coordination is needed to support clients in identifying and accessing available transitional housing options in the person's own community; to secure housing vouchers for long term care housing needs; assistance with negotiations with landlords and/or facilities to maintain existing community housing during the time that individuals are in short-term rehab. Assistance with management and dispense of funds from flexible spending to support short-term or one-time expenses involved with maintaining housing or securing temporary housing.

At the November 17th meeting of the full OASAC, members had an opportunity to meet with state staff, the Lewin Group and some of the pilot sites to learn about the project and to provide feedback on the project.

Pathways to Community Living

The Pathway to Community Living was developed under the Money Follows the Person (MFP) Rebalancing Demonstration project. This initiative was created to help older adults and persons with disabilities move out of nursing homes and back into the communities. The program goals are to increase the use of home and community based services; to eliminate barriers that prevent or restrict flexible use of Medicaid funds for necessary long term care services in the settings reflecting individual choice; to increase ability to assure continued community-based long-term care services to eligible individuals after transition; and to ensure quality assurance and improvement continuously occurs for community-based long term care services.

Although the State continues to make progress towards the goal of 696 transitions, Illinois must accelerate efforts in order to meet at least 85% of transition goals. To date, we have focused on increasing our outreach efforts through completion of the MFP video, targeted outreach to nursing facilities that are not using the online referral system via the ADRC's and the Ombudsman, and HFS has collaborated with Illinois Department of Human Services, Division of Mental Health (DHS/DMH) DHS/DMH to expand MFP-Mental Health to a number of areas in the collar counties. Additionally, HFS has finalized the MFP/MCO flowchart and recently trained MCO staff on the collaborative model. The Statewide Housing Coordinator has developed MFP Fact Sheet for person with developmental disabilities and talking points for State Operated Developmental Centers (SODC) staff as well as to share with parents/guardians.

Colbert

The Colbert Consent Decree was filed on August 22, 2007 on behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County Illinois. The class members alleged that they were being unnecessarily segregated and institutionalized in Nursing Home facilities and forced to live with numerous other people with disabilities and in situations in violation of the ADA and Rehabilitation Act and they were denied the opportunity to live in an appropriate community integrated setting where they could lead more independent and productive lives. The consent decree was settled on December 20, 2011 and required the Defendants (Office of the Governor of the State of Illinois, Illinois Department of Human Services, Illinois Department of Public Health, and the Illinois Department of Healthcare and Family Services) to provide the necessary supports and services to allow class members to live in the most integrated settings appropriate to their needs in Community-Based Settings. Transition Planning and Implementation for Colbert class members began in February 2013 under the lead of the Illinois Department of Health and Family Services. Effective January 22, 2014, oversight of the Colbert Consent Decree Implementation has been transferred from the

Healthcare and Family Services to the Illinois Department on Aging. The Illinois Department on Aging created a new division for Colbert entitled the Office of Transition and Community Relations.

Funding for Home Community Based Services (HCBS)

Home and Community-Based Service (HCBS) waivers allow participants to receive non-traditional services in the community or in their own homes, rather than being placed in an institutional setting. Illinois currently operates nine HCBS waivers, each waiver is designed for individuals with similar needs and each offers a different set of services. Individuals must meet specific eligibility criteria to be eligible for an HCBS Waiver which includes that the individual must require an institution level of care (specified by each waiver) and service needs must be cost effective. The Department on Aging currently offers the following services under the home and community based waiver:

- Adult Day Service
- In Home Services
- Emergency Home Response Service

Under the 1115 Waiver, Illinois is requesting to be allowed to expand the services considered eligible for match to meet the waiver objectives and have identified current expenditures known as Costs Not Otherwise Matchable (CNOM). Negotiations with Federal CMS will be made and if CMS agrees to match these costs, they will be making an investment over the period of the waiver that lead to better outcomes and lower costs and this would free up state resources to also make targeted investments in programs and services designed to meet the goals of quality, transformation, and rebalancing.

In addition to waiver services funds are provided through the Federal Older Americans Act (with support from State funds). The Department serves as the single state agency to receive these funds under the Federal Older Americans Act for community supportive services. These funds are allocated to 13 Area Agencies on Aging to provide community based services to older adults in Illinois. These community-based services are offered to persons age 60 plus (age 55-plus for employment programs) throughout Illinois. Although donations are encouraged for services such as meals and transportation, there are no fees associated with these programs.

Adult Protective Services Program

The Adult Protective Services (APS) Program was designed to investigate reports of alleged abuse; intervene to prevent further mistreatment; and to allow individuals to remain independent to the maximum degree possible. Effective July 1, 2013, the APS eligibility criteria is that a person must be 60 years of age or older or age 18-59 and have a disability; have at least one allegation of abuse, neglect, exploitation (ANE); an identified abuser; and reside in a domestic setting at the time of the report. The Adult Protective Services Act defines "disability" as a physical or mental disability (including but not limited to a developmental

disability, an intellectual disability, a mental illness or dementia); and the disability must impair the alleged victim's ability to seek or obtain protection from ANE. During the transfer of responsibility from Illinois Department of Human Services Office of the Inspector General (DHS OIG) to the Illinois Department on Aging (IDoA) , IDoA received approximately 150 active cases. During FY 2014, approximately 2,600 ANE reports have been received and less than 20% involve adults with disabilities. The Adult Protective Services Program is administered by IDoA through 12 regional Area Agencies on Aging and 42 community provider agencies.

APS services include Intake, Comprehensive Assessment, Case Plan and Interventions, Follow-up Monitoring, and Multi-Disciplinary Teams. The APS caseworkers have specific investigation guidelines to follow depending on the priority assigned to each report; Priority I = 24 hours (which include life threatening situations), Priority II = 72 hours (mostly neglect and non life-threatening physical abuse), Priority III = 7 calendar days (mostly emotional abuse or financial exploitation abuse reports); and a total of 30 days to complete the investigation.

During the casework and follow-up of the investigation, the goal is to provide long term support and intervention to prevent further abuse/neglect by a) developing a case plan; b) arranging for services and c) monitoring progress. The follow up activities can take up to 12 months after casework and include ongoing contact with the individual; the continuation of the activities outlined in the casework period; monitoring the level of the individual's level of risk; and altering the case plan as needed.

Early Intervention services include medical care and expenses; legal assistance and fees; housing and relocation services; minor environmental aid; respite care, adult day services, in-home care; counseling, and translation services.

Certain professionals who provide services are mandated by law to report abuse but all persons are encouraged to report abuse. Reporters of abuse have certain rights and responsibilities (e.g. may make a report anonymously, identity is held in confidence, and reporter is protected from liability when reporting in good faith). Reporters of abuse may be instructed to contact law enforcement in some cases (usually Priority I cases). Reports of suspected Abuse, Neglect, or Exploitation of a person age 60 years old or a person 18-59 years with a disability, who live in a domestic setting are reported to the IDoA 24-hour hotline (1-866-800-1409). The suspected abuse of an adult between the ages of 18-59 with a disability living in a licensed facility is reported to the OIG hotline (1-800-368-1463). The suspected abuse of an adult age 60 or older living in a nursing home or licensed facility are reported to IDPH (1-800-252-4343) or to the Long Term Care Ombudsman Program (1-800-252-8966).

New mandates to the APS program include that APS agencies must immediately report suspicious deaths to law enforcement and the coroner or medical examiner. IDoA (APS Agencies) must also give notice of all substantiated findings of abuse by a guardian to the Probate Court with jurisdiction over the guardianship within 30 days. IDoA has Abuse Fatality Review teams that include an Advisory Council and Regional Review Teams. Some of the goals of the Fatality Review teams are to a) identify and review suspicious deaths of adults; b)

facilitate communication between officials responsible for autopsies and inquest and the persons involved in the reporting and investigating the abuse; c) evaluate the means by which the death could have been prevented; and d) make recommendations that may help reduce the number of deaths by abuse and neglect.

Several changes continue to take place under the APS program and many will be effective in calendar year 2015. Beginning January 1st 2015, IDoA must report to the Abuser Registry the identity and administrative finding of a verified and substantiated decision of abuse, neglect, or financial exploitation of an individual under the APS Act that is made against any caregiver. Effective calendar year 2015, cases of individuals who self-neglect will be funded. Self neglect cases fall under the Adult Protective Services Act, but the services provided for self neglect cases are very limited.

Expansion of the Long Term Care Ombudsman Program

The Long Term Care Ombudsman (LTCOP) program protects and promotes the rights and quality of life for people who reside in long term care facilities (nursing homes). The Long Term Care Ombudsman protect, defend and advocate for residents by informing residents and their families of their rights; resolving complaints; providing information on residents needs/concerns to their families, facility staff and their community; and advocating for good individualized care. An increased shift from providing care in institutional setting to receiving services in the home and community based setting means that there will be more people with vulnerabilities who will receive services in the home.

In 2013 the Illinois Act on the Aging was amended to expand the LTCOP to cover seniors and adults with disabilities who are on a medical assistance waiver administered by the state; and/or served by a managed care organization providing care coordination and other services. Expanding the Long Term Care Ombudsman Program into the community can strengthen the homecare/managed care consumer's voice and mitigate incidents of abuse and neglect. The role and problem solving skill set of the Ombudsman in the home care and managed care setting will be the same as it has been in institutional setting. That is, Ombudsman will act as advocates giving consumers a voice in the system and ensure that long term care systems are held accountable. Some of the responsibilities of the Ombudsman will be to response to inquiries; to identify, investigate and attempt to resolve complaints for or on behalf of participants. Ombudsman will have access to participants and their record if permitted. IDoA staff has developed tiered training for staff; conference trainings; and webinar trainings for Ombudsman Managers. The ombudsman program will increase public awareness by disseminating pamphlets, creating a bill of rights brochure, and developing an informational video that will be made available to regional ombudsman, home services counselors, ADRC's, CCU's and MCO's.

In December 2013, IDOA was awarded a CMS "duals demonstration" 3-year grant in the amount of $939,124. The purpose of this grant is to expand the IDoA Long Term Care Ombudsman Program to cover individuals receiving managed care services and is living in

community based settings. Coverage includes disabled adults between the ages of 18-59, and seniors 60 and older. Areas affected by Medicare/Medicaid Alignment Initiative are covered (i.e., Chicagoland and Central Illinois). Individuals who are not MMAI recipients but are receiving Medicaid Waiver services are also covered. Other state funds (i.e., Balancing Incentive Program, LTCOP Provider Fund) increase the total project amount to $4,646,239. State fiscal year 2014 startup grants were awarded to 10 applicants in the MMAI areas for June 2014. The purpose of these grants is to enable Ombudsman to purchase equipment, laptops, and hire staff. Ombudsman home and community expansion activities began 7/1/14 with the 10 MMAI grantees.

In December 2014, grant renewal increases for the 2nd year budget were made ($180,000). The increase will be used to fund MMAI Deputy State Ombudsman position; and there will be no decrease in direct ombudsman services. Expansion roll-out will continue in January 2015 with 7 additional grantees for non-MMAI (waiver only) areas around the state.

Impediments to Progress

Illinois faces several major challenges in rebalancing long term care. Primary among these are:

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

- The implementation of the BIP requires coordination amongst the state agencies/divisions that are responsible for the implementation of the three consent decrees (i.e., Colbert, Williams and Ligis). Additionally, Illinois is undertaking the expansion of managed care models throughout the state. These models include for-profit managed care organizations as well as non-for-profit, provider driven models.

- The aging and disability community infrastructure is undergoing massive change simultaneously. While these changes are positive and address some of the shortfalls of Illinois's current structure; the provider community is struggling to determine how they fit into the new system specifically, the expansion of managed care models for LTSS, the rebalancing initiatives that are underway, and the anticipated expansion of Medicaid resulting from the ACA implementation.

- In January 2014 CMS issued new regulations on person centered planning and settings for home and community based waivers which became effective on March 17, 2014. All states must submit a transition plan no later than March 17, 2015 or within 120 days of any waiver action (e.g., waiver amendment or waiver renewal), whichever comes first. States can submit either a waiver specific transition plan, or a statewide plan. Illinois opted to submit

the statewide plan and extensions for IDoA and DRS waivers (which were up for renewal) were requested. The extension was necessary in order to allow the State time to address the new federal regulations issued by CMS, and to prepare the statewide 5-year transition plan for all of its 1915 c waivers to come into compliance with these new regulations. At the same time, Aging and DRS staff are preparing 1915 c waiver amendments in the event that the 1115 is not approved. State staff, providers, and stakeholders alike are challenged by the complexity and pace of multiple state initiatives and federal requirements occurring simultaneously.

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

Recommendations

1. Stakeholder Engagement Process & Strategies

During 2014 members of OASAC met to define a stakeholder engagement process that could be applied in Illinois to provide opportunities for the aging and disability network of consumers, providers and advocates to give meaningful feedback to the State of Illinois on the many long term care initiatives were being introduced, often simultaneously. The stakeholder engagement process is intended to inform consumers, family caregivers, providers and legislators of initiatives in order to enable stakeholders the opportunity:

- To understand all aspects of the initiative and to have input particularly when the initiative impacts the business operations of providers;
- To provide input into the key, overarching quality measures to ensure they are meaningful, relevant to the initiative, holistic and improve consumer outcomes; and
- To ensure that variations in local need are considered as the initiative is being developed.

OASAC recommendations for a stakeholder engagement process are as follows:

- Identify the key stakeholder groups (especially those representing the consumers and family caregivers) at the beginning of the initiative when the outreach plan is developed.
- Give ample time for stakeholders to review and respond to the initiative.
- Develop handouts, fact sheets and FAQs that can be shared with various stakeholder committees/state agencies.
- Ensure material is consumer friendly, clear and concise, and culturally appropriate.
- Provide the opportunity for stakeholders to sign up for electronic alerts and calendar invites to meetings.

- Clarify the expectations for receiving feedback (e.g., length of comments and due dates).
- Utilize a variety of strategies to engage stakeholders (e.g., facilitated stakeholder meetings, smaller focus groups, webinars, online submission of comments, etc…).
- Utilize a range of strategies to publicize the initiative (e.g., community calendars, newspapers, ADRCs, senior centers, newsletters and list serves, AAAs, AARP, etc…).
- Disseminate meeting summaries to stakeholders. Group comments/questions by topic to improve the flow of material.
- Record meetings and post summaries on line for future reference.
- Conduct key Informant interviews with individuals and/or expert panels
- Conduct Surveys

In addition to the stakeholder engagement strategies defined above, OASAC also developed the following questions which may be used to guide discussions with State agencies, consultants, evaluators and others as new initiatives are being planned, implemented and evaluated. This is not an exhaustive list of questions, but provides a framework to shape discussions and is reflective of the values of OASAC members.

- What is the goal of this initiative?
- How will this initiative affect the consumers and their experience of care?
- How will the initiative support consumer choice & consumer direction?
- How will the initiative address the ACA Triple Aims of improvements in overall population health, better experience of care, and lower costs?
- How will this initiative affect providers?
- How are state agencies coordinating communication with each other and with stakeholders about this initiative?
- What quality measures and quality improvement mechanisms being proposed for this initiative?
- How is the initiative being evaluated?
- How will quality improvement be addressed?
- What strategies are being utilized to ensure consumer education and consumer input into the initiative?
- How will this initiative impact family caregivers?
- What are workforce issues related to this initiative?

2. Recommendations re: the implementation of the Personal Attendant – Consumer Directed Service Model

During 2014 OASAC formed a workgroup to address the Personal Attendant/Consumer Directed service as proposed under the 1115 waiver. The purpose of the workgroup is to review the issues associated with a Personal Attendant (PA)/consumer directed home and community based service and to make recommendations to the State with regard to this service. The workgroup membership includes representatives from the aging and disability network including providers, ombudsman, CCU, AAAs, academic and policy experts, labor, consumers, and state agencies. A list of the workgroup members and meeting dates is posted

on the Illinois Department on Aging website. This workgroup met several times between September and December to learn about consumer directed program models in Illinois, and to provide input on recommended practices regarding Personal Attendant/Consumer Directed Service models for older adults and persons with disabilities. The workgroup identified the following key principles for Personal Attendant/Consumer Directed Service models.

- Person centered planning
- Consumer protections
- Oversight and monitoring
- Capacity assessment
- Training
- Background checks
- Consumer awareness of choice
- Flexibility to use both Agency and PA in the plan of care
- Workforce protections

At the time of this publication, the workgroup is in the process of finalizing recommendations across each of the above referenced key principles. A preliminary draft of those recommendations was made at the full OASAC meeting on November 17. However, the full OASAC committee requested the opportunity to review and approve the final recommendations prior to distribution. These recommendations will be addressed at the next meeting of the full committee in February 2015.

OASAC FULL COMMITTEE MEMBERS

The Illinois Department on Aging, Healthcare and Family Services, Department of Human Services, Department of Public Health and Illinois Housing and Development Authority gratefully acknowledges the service of the Older Adult Services Advisory Committee. The State of Illinois benefits from the broad representation of the OASAC membership and their commitment to advise the Departments on all matters pertinent to the Act and the delivery of services to older adults. OASAC has been instrumental in the support of a transformation of Illinois' comprehensive system of older adult services from funding a primarily facility-based service delivery system to primarily a home-based and community-based system. Not only do the members attend OASAC meetings, but they also serve on other advisory councils and committees at the state and local level. They share relevant information with their networks, as well as other OASAC members. OASAC members also give of their time to review and respond to major initiatives, and to serve on workgroups as applicable in order to share expertise in program and policy development. The following individuals served on OASAC during 2014.

Stephanie Altman
Darby Anderson – Addus HealthCare
Carol Aronson – Shawnee Alliance for Seniors
John Becker – Senior Services Plus
Jennifer Belkov – Alzheimer's Association, Greater Illinois Chapter
June Benedick
Jean Bohnhoff – Effingham County Committee on Aging
Andy Chusid – Health Care Council of IL
Thomas Cornwell, M.D. – HomeCare Physicians
Cindy Cunningham – Illinois Adult Day Service Association
Frank Daigh
Robyn Golden – Rush University Medical Center
Jan Grimes – Illinois HomeCare and Hospice Council
Terri Harkin – Service Employees International Union (SEIU)
Mike Hughes – Lifescape Services
Susan L. Hughes, Ph.D. – University of Illinois at Chicago
Myrtle Klauer – Illinois Council on Long-Term Care
Michael Koronkowski – UIC College of Pharmacy
Jon Lavin – AgeOptions
Jay Lewkowitz – Oakton Place
Dave Lowitzki – SEIU Healthcare Illinois and Indiana
Phyllis B. Mitzen
Patricia O' Dea-Evans
Samantha Olds – Illinois Association of Medicaid Health Plans
Susan Real – East Central Illinois Area Agency on Aging
Geraldine C. Simmons – Law Office of Geraldine C. Simmons

Jason Speaks – Leading Age Illinois
David M. Vinkler – AARP Illinois Legislative Office
Cathy Weightman-Moore – Catholic Charities, Diocese of Rockford
Ancy Zacharia – HomeCare Physicians

OASAC WORKGROUP MEMBERS

Stakeholder Engagement Workgroup

Darby Anderson – Addus HealthCare
Carol Aronson – Shawnee Alliance for Seniors
Terri Harkin – Service Employees International Union (SEIU)
Myrtle Klauer – Illinois Council on Long-Term Care
Phyllis B. Mitzen
Samantha Olds – Illinois Association of Medicaid Health Plans
Susan Real–- East Central Illinois Area Agency on Aging
David M. Vinkler – AARP Illinois Legislative Office
Cathy Weightman-Moore – Catholic Charities, Diocese of Rockford

Personal Attendant/Consumer Directed Service Workgroup

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Sharon Post – HMPRG
Tameshia Bridges – PHI Midwest
Marsha Nelson – Shawnee Alliance for Seniors