COMMUNITY CARE PROGRAM SERVICES TASK FORCE

Report to Governor Bruce Rauner and the General Assembly
Executive Summary

The mission of the Illinois Department on Aging (IDoA) is to serve and advocate for older Illinoisans and their caregivers by administering quality and culturally appropriate programs that promote partnerships and encourage independence, dignity, and quality of life. IDoA’s mission is delivered primarily through the Community Care Program (CCP). The CCP supports eligible older adults, who are at risk of being placed in a nursing facility, remain in their own homes by providing in-home and community-based services. Enrollment in CCP has significantly increased in just the past ten years, which provides a more cost effective option to long term care placement.

In July 2017, the General Assembly established a 19-member Community Care Program Services Task Force (Task Force) comprised of advocates, providers and legislators. The Task Force was led by the IDoA to review CCP services for seniors and strategies to reduce costs without diminishing the level of care.

To prepare this report, the Task Force met seven times and held two public hearings. Four subcommittees were formed to dive into issues pertaining to Medicaid, Development and Service Expansion, Determination of Need (DON) Score, and Oversight and Monitoring. The subcommittees produced the recommendations contained in this report and are reflective of a general consensus of the Task Force members.

A few of the recommendations are highlighted below. The remaining recommendations are contained verbatim from the subcommittees in the applicable Appendix.

- Plan for known demographic shifts toward an older population in the next decade;
- Explore additional service options available through CCP to further deflect from nursing home placement;
- Maximize the percentage of Medicaid CCP participants that are enrolled and remain enrolled to maximize federal funding as well as provide annual reporting;
- Provide data to assure ongoing cost savings and effective services;
- Establish greater uniformity in DON scoring and participant care plan authorization as it relates to service cost maximum;
- Review the policy to ensure uniform requirements for home care providers and family care givers;

The Task Force also recommends further gathering of information of the following:

- Explore other Medicaid authorities, including a federal section 1115 Demonstration Waiver;
- Explore differential criteria of assessments for long term care vs. community care;
- Explore the feasibility of establishment of an income threshold for eligibility in CCP and non-Medicaid enrolled participants;
- Explore federal funding for electronic visit verification.

The Task Force also recognizes IDoA has accomplished much in recent years to lay the foundation for a system transformation. IDoA looks forward to continued collaboration with our network partners as we together accomplish respecting yesterday, supporting today, and planning for tomorrow.
Introduction
Governor Rauner introduced the Community Reinvestment Program as a new statewide initiative targeted to older adults who are not eligible for Medicaid, but who need assistance to live independently in the community. The initiative represented a long-term strategy to maintain funding for community-based support for our current aging population, as well as to address the anticipated growth.

Under the proposed initiative, non-Medicaid eligible clients would have their Determination of Need (DON) score applied to the new service cost maximum table to derive a new individual spending allocation. This initiative was meant to provide a greater flexibility of services through person centered planning. The Area Agency on Aging (AAA) Network would have been utilized as the mechanism for the coordination of preventative services.

Comparable to other states, Illinois’ approach would maintain a service package for individuals that do not meet Medicaid financial eligibility requirements. This approach upholds the Department’s commitment to maintaining individuals in their own home and community and delay the number of admissions in nursing facilities. Currently a large portion of the Medicaid budget, over $1.5 billion, is dedicated to Medicaid Long Term Care.

The FY18 budget did not provide funding for this initiative. However, in July 2017, the General Assembly established a 19-member Community Care Program Services Task Force comprised of advocates, providers and legislators led by the Illinois Department on Aging (IDOA) to review the Community Care Program (CCP) and to develop and recommend solutions to reduce costs without diminishing the level of care that IDoA provides.

Senate Bill (SB) 0042, Public Act 100-23, requires that the Director of the Illinois Department on Aging shall establish a Community Care Program Services Task Force (Task Force) to review community care program services for seniors and strategies to reduce costs without diminishing the level of care. The Task Force is required to report its findings and recommendations to the Governor and the General Assembly no later than January 30, 2018.

Public Act 100-23 dictates that the Task Force shall consist of the following persons who must be appointed within 30 days after the effective date of the amendatory Act of the 100th General Assembly:

1. the Director of the Department on Aging, or his or her designee, who shall serve as chairperson of the task force;
2. one representative of the Department of Healthcare and Family Services appointed by the Director of Healthcare and Family Services;
3. one representative of the Department of Human Services appointed by the Secretary of Human Services;
4. one individual representing Adult Day Care Centers appointed by the Director of Aging;
5. one individual representing Care Coordination Units appointed by the Director of Aging;
6. one individual representing Area Agencies on Aging appointed by the Director of Aging;
7. one individual from a statewide organization that advocates for seniors appointed by the Director of Aging;
8. one home and community-based care employee appointed by the Director of Aging;
9. one individual from an organization that represents caregivers in the Community Care Program;
10. two members of the Senate appointed by the President of the Senate, one of whom shall serve as co-chairperson;
11. two members of the Senate appointed by the Minority Leader of the Senate, one of whom shall serve as co-chairperson;
12. two members of the House of Representatives appointed by the Speaker of the House of Representatives, one of whom shall serve as co-chairperson;
13. two members of the House of Representatives appointed by the Minority Leader of the House of Representatives, one of whom shall serve as co-chairperson; and
14. two members appointed by the Governor.

The members of the Community Care Services Program Task Force are as follows:

- **Jennifer Reif**, Chair, Deputy Director, Illinois Department on Aging
- **Honorable Dale Righter**, Co-Chair, State Senator
- **Honorable Heather Steans**, Co-Chair, State Senator
- **Honorable Terri Bryant**, Co-Chair, State Representative
- **Honorable Robyn Gabel**, Co-Chair, State Representative
- **Honorable Dave Syverson**, State Senator
- **Honorable Iris Martinez**, State Senator
- **Honorable David Olsen**, State Representative
- **Honorable Anna Moeller**, State Representative
- **Darby Anderson**, Executive Vice President/Chief Development Officer, Addus HomeCare, Inc.
- **Ron Ford**, CEO, Help At Home, LLC
- **Mary Joyce Gallagher**, Executive Director, Senior Service Area Agency on Aging, Chicago Department of Family and Support Services
- **Dan Holden**, Waiver Manager, Division of Medical Programs/Bureau of Long Term Care, Illinois Department of Healthcare and Family Services
- **John Hosteny**, Director, Corporation for National & Community Service’s Illinois Office
- **Christopher Kantas**, Associate General Counsel, Office of the General Counsel, Governor Bruce Rauner
- **Brandy Schank**, Case Manager Coordinator, DuPage County Senior Services, Case Coordination Unit
- **Marc Staley**, Deputy Director, Governor’s Office of Management and Budget
- **Lyle VanDeventer**, Manager, Persons with Disabilities Program, Illinois Department of Human Services
- **Kathy Weiman**, CEO, Alternatives (for the Older Adult, Inc.) Care Coordination Unit
Public Act 100-23 requires the Community Care Program Services Task Force to perform the following duties:

1. Review the current services provided to seniors living in the community;
2. Review potential savings associated with alternative services to seniors;
3. Review effective care models for the growing senior population;
4. Review current federal Medicaid matching funds for services provided and ways to maximize federal support for the current services provided;
5. Make recommendations to contain costs and better tailor services to Community Care Program participants’ specific needs;
6. Review different services available to keep seniors out of nursing homes; and
7. Review best practices used in other states for maintaining seniors in home and community-based settings including providing services to non-Medicaid eligible seniors.

The Department on Aging has been tasked with providing administrative support to this Task Force, and has compiled the following report based on stakeholder input and discussions from public meetings and hearings. The Department is committed to continuing the exchange of ideas, and fostering the engagement of stakeholders as we together transform the CCP to strengthen care available to older Illinoisans.

The following report is organized into three sections:

1. Background; a general overview of the CCP, demographics, budget, and other challenges.
2. Proposals by Task Force Subcommittee Members and Stakeholders; the larger CCP Task Force was broken down into four subsequent focus groups to discuss for further development:
   a. Medicaid
   b. Development and Service Expansion
   c. Determination of Need (DON) Score
   d. Oversight and Monitoring
3. Conclusion; a summary including all suggested actions noted throughout the report. Additional appendices as noted throughout this document provide additional detail and context to support the recommendations and data presented in this report.

**Background**

The mission of the IDoA is to serve and advocate for older Illinoisans and their caregivers by administering quality and culturally appropriate programs that promote partnerships and encourage independence, dignity, and quality of life. IDoA strives for efficient and effective access to services that prevents or delays nursing facility placement and maximizes an individual’s ability to remain as independent as possible within their community.

IDoA’s mission is delivered primarily through the CCP. The CCP supports eligible older adults, who are at risk of being placed in a nursing facility, remain in their own homes by providing in-home and community-based services.
Established in 1979 by Public Act 81-202, the Illinois Department on Aging’s CCP supports senior citizens, who might otherwise need nursing facility care, to remain in their own homes by providing in-home and community-based services. The program is aimed at assisting seniors to maintain their independence and providing cost effective alternatives to nursing facility placement.

The CCP provides services to any individual who meets all current eligibility requirements. The CCP is one of Illinois’ nine 1915(c) waivers for home and community-based services under the Medicaid Program. Program services in CCP include: Adult Day Service (ADS), Emergency Home Response Service (EHRS), Automated Medication Dispenser (AMD), and In-Home Service (IHS).

**Adult Day Service (ADS):** ADS is designed for older adults who want to remain in the community but who cannot be home alone during the day due to a physical, social and/or mental impairment. Adult day service also provides respite for family caregivers, especially those who are employed outside the home, and socialization for isolated adults.

**Emergency Home Response Service (EHRS):** EHRS is a 24-hour emergency communication link to assistance outside the home for older adults with documented health and safety needs and mobility limitations.

**Automated Medication Dispenser (AMD):** AMD is a portable, mechanical system for individual use that can be programmed to dispense or alert the participant to take non-liquid oral medications in the participant’s residence through auditory, visual or voice reminders, provide tracking and caregiver notification of a missed medication dose and provides 24 hour technical assistance to the participant and responsible party for the AMD service. The Department recently amended its CCP administrative rule to specifically address the provider requirements for AMD service provision. The Department anticipates the initiation of AMD services in early spring of 2018.

**In-Home Service (IHS):** IHS assists in household and daily living tasks such as cleaning, planning and preparing meals, doing laundry, shopping, and running errands. Homecare aides also assist participants with personal care tasks such as dressing, bathing, grooming, and following special diets.

Steps Illinois has taken:

a. Over the past year, IDoA has closely collaborated with the Illinois Department of Health and Family Services (HFS) on assuring that CCP participants remain on Medicaid once enrolled. HFS provides IDoA with the names of CCP participants that have an upcoming Medicaid redetermination to ensure that participants complete the necessary paperwork to remain on Medicaid. HFS has provided several trainings to IDoA’s Care Coordination Units (CCUs) on the Medicaid application process, redetermination process, and the new ‘manage my case’ functionality in the ABE system.
b. Implementation of the nursing home deflection pilot and the ongoing efforts to rebalance Illinois' Long-Term Care (LTC) system through the foundation built by the federal Money Follows the Person Demonstration Program, the Balancing Incentive Program (BIP), and the ongoing implementation of Olmstead Consent Decrees.

c. Revisions to the Choices for Care Program to ensure timely completions of hospital pre-screens to allow for discussion of all options, including community-based options prior to nursing facility placement and inter-agency collaboration with HFS and the Department of Human Services (DHS) as well as collaboration with the nursing facility industry and the Illinois Health and Hospital Association to streamline processes.

d. Implementation of an automated critical event reporting system for CCP to ensure follow up on critical incidents that potentially impact CCP participants’ ability to remain in the community and the provision of risk mitigation strategies to avoid LTC placement. Over the past six months, Department staff have completed ten regional meetings to facilitate the successful implementation of critical event reporting and follow up efforts.

e. Expansion of the Department’s training division to focus on quality assurance and monitoring within the Aging network, the implementation of evidence based practices and interventions.

f. Advocacy and coordination with the Illinois Housing Development Authority Task Force regarding the continued expansion of American Disability Act accessible housing for seniors to age in place.

Since 2000, Illinois’ older population (60 years of age and older) has grown from 1.9 million to 2.5 million. It now represents 19.6% of the population in Illinois. By 2030, it is estimated that the 60 years of age and older population will increase to 3.6 million and will represent 24% of Illinois’ population.

Therefore, it is no surprise that enrollment in the Department on Aging’s CCP has also significantly grown over the past 10 years. In 2007, the CCP program served 45,746 participants, and expanded to 83,590 in 2016. This is an 83% increase of growth over a decade.
The chart above shows an estimation of the increase in Illinois’ senior population through 2030. Source (Centers for Disease Control- https://wonder.cdc.gov/controller/datrequest/D7)
The chart above shows the Illinois population by age from age 40 – 100 as of the 2010 Census. This graphic demonstrates the number of Illinoisans that may be eligible for CCP by 2030 based on age alone. Data from the Kaiser Commission on Medicaid and the Uninsured suggests that 70% of persons age 65 or older will need some kind of Long Term Service and Supports (LTSS).

According to a 2016 report from the Centers for Medicare and Medicaid Services (CMS), Long-term Services (LTS) accounted for almost 25% of Medicaid spending with slightly over half (53%) spent on Home and Community Based Services (HCBS) in Federal Fiscal Year (FFY) 2014. According to CMS data FFY 2013 was the crossover point – the point at which HCBS exceeded institutional care expenditures for the first time since Medicaid was enacted in 1965.

Illinois continues to make considerable progress towards rebalancing its LTC system towards increased spending on the community versus institutional spending. One of the benchmarks included in the BIP was the requirement for BIP states to achieve 50% of their spending on community HCBS. As of September 2016, Illinois was at 47.47% of its benchmark of LTSS expenditures directed to the community and continues to work toward the goal of 50%. (2017 OASAC Report to the GA)

The legal requirement to provide services in HCBS settings is based on the 1999 United States Supreme Court decision in Olmstead v L.C. In this case, the Supreme Court held that states are required to provide community-based services for people with disabilities who otherwise would be entitled to institutional services when such placement is appropriate; the individual does not oppose such placement; and the placement can be reasonably accommodated, considering state resources and the needs of other individuals with disabilities. Subsequent actions have confirmed that Olmstead applies to nursing facility residents or persons at risk of nursing facility placement.

Other federal requirements shape the provision of HCBS, particularly Medicaid waiver programs. CFR 42 441.725 describes the requirements of a person-centered process for developing a waiver service plan. These requirements include offering HCBS setting choices and service alternatives, while capturing the participant’s preferences and needs.

CFR 42 441.710 outlines the required characteristics of an HCBS setting. This rule was established in 2014 and states were given until 2022 to ensure that waiver services are provided in non-institutional settings per these new guidelines. The impact falls largely on provider owned and controlled settings, both residential, such as assisted living, and non-residential, such as adult day services.

HCBS are less expensive than nursing facility care. The level of care threshold (Determination of Need (DON) score of 29) for Medicaid funded nursing facility care and participation on the HCBS Elderly Waiver are identical. Since Medicaid’s inception in 1965, states have been required to provide nursing facility services as part of their State Plan, which means that all persons who meet minimum need criteria and who are eligible for Medicaid are eligible to receive those services. In 1983, Congress authorized states to offer HCBS, but these services are optional and not required State Plan benefits. As a result, nursing facilities are the main setting for LTSS delivery.
Methodology

Individual Task Force members were charged with the research, development, and formation of ideas and suggestions to be submitted to the Task Force Committee of the Whole. IDoA supplied data, research, and supporting information and documentation as requested. Members deliberated numerous proposals and ideas over a five-month period from August 2017 through December 2017.

At the October 17 meeting, the Task Force created four subcommittees to further explore and consider the feasibility and impact of all recommendations. Members with subject-matter expertise, experience, and knowledge were assigned to the following subcommittees: 1) Medicaid, 2) Program Development and Service Expansion, 3) DON Score, and 4) Oversight and Monitoring.

Subcommittee chairs then presented their final recommendations to the Task Force at the November 14 meeting for review and discussion. Recommendations to be included in a draft report were finalized at the December 14 meeting.

The statute did not outline requirements for the IDoA to consult with stakeholders. However, IDoA is committed to continuing the exchange of ideas, and fostering the engagement of stakeholders. The stakeholders included the following:

- Consumers;
- Organizations representing consumers; and
- Experts in the field to provide insight concerning the needs of Illinois residents seeking services and supports to allow the individuals to remain at home and in their communities.

IDoA developed a process to engage and consult with stakeholders in the development of this report. Details about the stakeholder engagement process are found in Appendix C. Stakeholder engagement activities included:

- Two days of public comment, with input from organizations and individuals; 39 individuals were in attendance, and 10 provided comments.

The following stakeholder input contributed to the evaluation of the current state of CCP in Illinois, as well as the development of potential actions to address the challenges and opportunities that exist to Illinoisans. IDoA is grateful to all of those who have participated in this process.
Recommendations from Task Force Members

For full recommendations from the Task Force members please see Appendix B1-B4.

Conclusion

This report reflects the discussion by the CCP Task Force to create a vision for sustaining the CCP. More specifically, strategies to prepare for the future demand for HCBS services for the aging population, the development of efficient and innovative programs while not diminishing the level of care. The demographics of the aging population, the evolving legal and regulatory requirements to provide services in less restrictive settings, combined with the fact that HCBS are more cost-effective than institutional care, create a sense of urgency in this effort.

IDoA has accomplished much in recent years to lay the foundation for a system transformation:

- Evaluation of the nursing home deflection pilot;
- Analysis of performance data and enhanced monitoring of the Aging Network;
- Increased focus on quality, including implementation of an automated critical event reporting system;
- Increased reliance on data for policy decision making;
- Implementation of person centered planning practices;
- Development of standardized training curriculum for CCUs and in-home providers (in process); and
- Development of an updated IT support system across all programs.

On a final note, increasing access to CCP as an alternative to nursing facilities means that the pathways by which people access information and services need to be more visible, integrated, and consistent. Through stakeholder engagement as well as qualitative and quantitative research conducted through this process, it is IDoA’s hope that effort and engagement will bring alignment and support action toward a system that ensures the full participation of all people in community life.

IDoA looks forward to continued collaboration with our network partners as we together accomplish respecting yesterday, supporting today, and planning for tomorrow.
Appendix

**Appendix A** - Statutory Authority

**Appendix B** – Verbatim written recommendations provided from Task Force Members and Subcommittees

- Appendix B1 - Medicaid Subcommittee Report
- Appendix B2 - Development and Service Expansion Subcommittee Report
- Appendix B3 - Determination of Need (DON) Score Subcommittee Report
- Appendix B4 - Oversight and Monitoring Subcommittee Report

**Appendix C** - Testimony submitted at Public Hearing
References


Code of Federal Regulations 42 441.301(4). 2014. CMS Home and Community Based Services Final Rule

Illinois Department on Aging. 20 ILCS 105. Section 4.01- 4.02.

Appendix A

ARTICLE 70. COMMUNITY CARE PROGRAM SERVICES TASK FORCE

Section 70-5. The Illinois Act on the Aging is amended by adding Section 4.02g as follows:

(20 ILCS 105/4.02g new)

Sec. 4.02g. Community Care Program Services Task Force.

A. The Director of Aging shall establish a Community Care Program Services Task Force to review community care program services for seniors and strategies to reduce costs without diminishing the level of care. The Task Force shall consist of all of the following persons who must be appointed within 30 days after the effective date of this amendatory Act of the 100th General Assembly:

1) the Director of Aging, or his or her designee, who shall serve as chairperson of the task force;
2) one representative of the Department of Healthcare and Family Services appointed by the Director of Healthcare and Family Services;
3) one representative of the Department of Human Services appointed by the Secretary of Human Services;
4) one individual representing Adult Day Care Centers appointed by the Director of Aging;
5) one individual representing Care Coordination Units appointed by the Director of Aging;
6) one individual representing Area Agencies on Aging appointed by the Director of Aging;
7) one individual from a statewide organization that advocates for seniors appointed by the Director of Aging;
8) one home and community-based care employee appointed by the Director of Aging;
9) one individual from an organization that represents caregivers in the Community Care Program;
10) two members of the Senate appointed by the President of the Senate, one of whom shall serve as co-chairperson;
11) two members of the Senate appointed by the Minority Leader of the Senate, one of whom shall serve as co-chairperson;
12) two members of the House of Representatives appointed by the Speaker of the House of Representatives,
13) one of whom shall serve as co-chairperson;
14) two members of the House of Representatives appointed by the Minority Leader of the House of Representatives, one of whom shall serve as co-chairperson; and
15) two members appointed by the Governor.

B. The Task Force shall:
   1) review the current services provided to seniors living in the community;
   2) review potential savings associated with alternative services to seniors;
   3) review effective care models for the growing senior population;
   4) review current federal Medicaid matching funds for services provided and ways to maximize federal support for the current services provided;
   5) make recommendations to contain costs and better tailor services to Community Care Program participants’ specific needs;
   6) review different services available to keep seniors out of nursing homes; and
   7) review best practices used in other states for maintaining seniors in home and community-based settings
   8) including providing services to non-Medicaid eligible seniors.

C. The Department on Aging shall provide administrative support to the Task Force.

D. Task Force members shall receive no compensation.

E. The Task Force must hold at least 4 meetings and public hearings as necessary.

F. The Task Force shall report its findings and recommendations to the Governor and General Assembly no later than January 30, 2018, and, upon filing its report, the Task Force is dissolved.

G. This Section is repealed on March 1, 2018.

For Full Reference to SB 0042 please see:
Appendix B

Appendix B1

MEDICAID SUBCOMMITTEE REPORT

Subcommittee Members:
Senator Iris Martinez
Representative Robyn Gabel
Lori Hendren, AARP Illinois
Joyce Gallagher, Chicago AAA
Alexandra Cooney, Chicago AAA

RECOMMENDATIONS:

1. Immediately create a strike force of trained contracted or volunteer outreach workers to sign up as many eligible seniors as possible and provide adequate compensation for Medicaid enrollment with existing CCUs who are not fully funded for this time-consuming task.

2. HFS, DHS and IDoA should coordinate a streamlined process for accessing ALL benefits. This includes the creation of consolidated forms and acceptance of these forms across all State agencies reflected in all applicable Administrative Code.

3. Pursue investigation of 1115 and 1915(i) waivers to maximize eligibility, enrollment and retention and capture additional Federal Medicaid resources to increase services for Illinois Seniors and their family caregivers with expanded transportation and service options. Consider legislation to incorporate the proposed new waiver possibilities.

Appendix B2

DEVELOPMENT AND SERVICE EXPANSION SUBCOMMITTEE REPORT

Subcommittee Members:
Darby Anderson, Addus HomeCare
John Hosteny, Corporation for National and Community Service
Senator Heather Steans

1. CCP Demonstration (Efficiency)
   - Increased service options to deflect/defer nursing home placement
   - Expansion of the Senior Companion Program
   - Increase the mix of services in the care plan
• Utilize Flexible Senior Services

The Department has announced that although they still expected to implement a CRP-like demonstration project before the end of the calendar year, they do not yet have any documentation as to the operating policies or parameters of how the demonstration project will be conducted.

Assuming that this information will not be available for review by this sub-committee or the larger CCP Task Force in advance of making a recommendation report to the General Assembly, we are making the following recommendations regarding the overall demonstration project design that need to be followed to support the demonstration project proposed by IDoA.

• Objective of the project is to test the cost efficiency of alternative ways to meet client activity of daily living (ADL) needs beyond the three core CCP services while maintaining quality and satisfaction of care among participants.

• Participation of clients must be voluntary and should be open to both Medicaid and Non-Medicaid enrolled clients.

• Case Managers developing care plans in the project should have the freedom to authorize services without regard to the cost of those services other than keeping the total cost of care within the existing service cost maximum.

• All services authorized by case managers as referenced above, must be safe for clients and providers must meet general provider requirements related to employee background checks and organizational structure.

• The Department must engage an experienced independent consultant to develop relevant outcome measures as well as aide in the project design to ensure measurable and statistically valid results.

2. Expansion of Adult Day Services

Adult Day Services provide a high-quality and more effective way to provide long term care services to many CCP clients, particularly those with Alzheimer’s and other forms of dementia. Considering the cost benefits of ADS and the quality advantages in serving certain CCP consumers, the creation of more ADS programs across the state should be encouraged. We make the following recommendations to facilitate growth of ADS programs in Illinois.

• Adjust the required experience of ADS operators from two years to one year.

• Adjust the experience requirement to allow companies that have two years of experience operating a program related to ADS to qualify under the experience provision of the
Administrative rule. Related experience should include hospitals, assisted living facilities, senior centers, and nursing homes.

- Evaluate a program or small business partnerships offering grants or small business loans to assist qualified companies start or expand their ADS programs in areas currently without ADS coverage.

- ADS rates for both hourly rate and transportation should be evaluated, including the potential for regional rates that address the issues of client density and volume, local labor cost mandates, and transportation challenges.

3. Consider an Income Limit for Eligibility (Efficiency)

The proposed recommendation is for eligibility with income below 400% of the poverty level. This income threshold is based on standard amounts to cover basic needs.

4. The Department should actively outreach and communicate with CCP family caregivers who are not employed by CCP service providers to acquire input on policies, service practices and suggestions on program improvements. (Effectiveness)

The Department currently conducts consumer surveys aimed at measuring satisfaction levels of recipients of care. It is assumed that in many cases family members of consumers contribute to or perform the responses to such surveys.

Recommend that the survey process be reviewed and adapted in a manner that unpaid family input could be obtained through survey process. Consider funding Area Agency on Aging listening sessions targeted at obtaining non-paid family caregiver input on the subject of current program supports and policies

5. Illinois should plan for growth to increase savings to taxpayers, rather than, create cuts that will cost taxpayers in Long Term Care costs.

This recommendation is difficult to address in the context of any tactical actions; however, we recommend that it be addressed in an opening statement in the report to the General Assembly.

The aging of our population, increased life expectancy and significant reduction in retirement income, savings and pensions represent one of the most significant challenges facing our society. State and the federal government need to plan for the increasing long-term care needs of older adults, both low income and middle class, through a variety of initiatives and innovative approaches and not year to year patchwork budgeting. It needs to be recognized that overall spending in Long Term Care will not decrease in the future and that we cannot look to “sustain” funding for current programs. The best we can expect is to bend the overall cost curve by employing cost effective service delivery through innovation in all of long-term care services. Coordination of Long Term Care Services, especially HCBS, into the larger health care system
and aligning the financing of social model and health care services would contribute significantly to this effort.

6. Effective Information Technology Support Systems

Case management systems related to Aging Programs should be a priority on Illinois’ roadmap for IT system development. Major improvements in management, billing, and communications software are long overdue. CCUs and all service providers have relied on ancient and unreliable systems for many years. This creates unnecessary administrative burdens and errors. It can also have serious negative effects on clients.

Although there have been discussions and announcements as to priority of IT system development, there has been little follow up with regard to progress. For example:

What is the status of the UAT instrument and related software applications?
What is the status of the system that was under development for CRP and CCP?
What is the agenda of the IDoIT team and how is their work prioritized?

Efficiencies in CCP would result from the development of a suite of compatible programs to perform the following basic functions:

- Billing
- Case Management
- Database of client information through effective integration of systems across state agencies and providers

CCUs and providers must be included to participate in extensive training during the pilot or beta phase, however, to the extent possible, they should be involved in early development and testing.

7. Bridge Transitions Program

Although the results from post-acute transitions such as the Bridge model are impressive, it is difficult to directly tie the efforts of such a program to savings within CCP. Savings generated through lower rates of hospital readmission, emergency room and skilled nursing facility utilization for CCP clients are not savings that attribute back to the state of Illinois. These savings are ultimately savings to the Medicare trust fund, the primary payer for the older adults served by CCP.

Effective programs, like the Bridge Model, should already be deployed within the MMAI program in Illinois and could be a model for the role played by CCUs referenced in recommendation 34) above.
To address the growing LTC needs of the aging population as identified in recommendation 32) we must better spend ALL health care resources. HCBS LTC services coordinated with the health care system have been proven to drive lower physical health costs, particularly in a dual eligible or senior population, but the financial incentives of state and federal payment sources have to be appropriately aligned to develop effective coordination.

Appendix B3

DETERMINATION OF NEED (DON) SCORE SUBCOMMITTEE REPORT

Subcommittee Members:
Kathy Weiman, Alternatives (for the Older Adult)
Brandy Schank, DuPage County Senior Services
Lori Hendren, AARP
William Wheeler, ICCCU
Marsha Nelson, ICCEU
Jeanice Yancik, ICCEU

- Immediate Systems Improvement:
  o Enhance Uniform Training
  o Quality Monitoring
  o Accessible Training

- Policy or Legislative Changes:
  o Allow Differential 'DON' Criteria
    ▪ Nursing Home vs. Community
    ▪ Plan for Demographic Trends

These recommendations are based upon saving more than $120 million (or 15% of the current program costs) through more consistent application of the DON score. These dollars could then be moved toward
a) Increased service options.
b) Increased deflection of nursing home residents to community-based care.
c) Savings and sustainability as we plan for the next two decades.

I. Enhance Uniform Training (systems change, possible policy)
As presented in earlier documentation, there is a wide variance in the average DON scores and subsequent Service Cost Maximums (SCM) across the 13 service areas in Illinois. Currently, the training occurs primarily through webinars and through each Individual Care Coordination Unit’s (CCU) training process. This is insufficient to support a statewide definition and process for administering the DON.
We recommend:

- Provide more intensive training on the implementation of the DON that has objective, measurable outcomes.
- Considering involving the ICCCU network with IDoA to provide hands on training across statewide regions, then only Springfield or online.
- Consider “Train-the-Trainer” approach to designate approved trainers around the state. This will allow for more effective and less costly training in each of the regions.
- Use best practice, evidence based training approaches, such as stepped, face-to-face training, intermediate webinars, competency testing, on-site follow up and annual discussion/training.
- We recognize that external or outside trainers could be a good option, however, it is more costly and will take more time to develop a quality training system with entities with the DON and all its iterations.
- Consider policy to increase training requirements for certification and compliance requirements for a CCU as related to training.

II. Provide Increased oversight /Monitoring (systems change, possible policy)

The current system asks each CCU (in a vacuum) to administer the DON in a consistent manner across the state. As well, each CCU has limited or outdated data and information from which to monitor their own implementation process. The current monitoring is conducted by a contracted, external entity and focuses on timelines/paperwork compliance vs. quality scoring/application to an effective plan of care. Though the years, there has been assessment “drift” by each CCU from the originally validated design of DON scoring.

We recommend:

- Address the drift from standard implementation through sample reviews of completed assessments.
- IDoA and/or other entities (such as AAA’s, contracted monitor, etc.) provide monitoring or auditing of CCU quality and outcomes.
- The monitoring should focus on the application of the scoring, how the score translated to the plan of care and subsequent service cost maximum.
- Work with the network of CCU’s and best practice models to develop a monitoring tool. This tool would identify and capture both quality and compliance outcomes.
- Consider policy for implementation of a quality outcomes monitor system and follow through.
- Further develop or create guidelines for application of DON scoring as related to approving funded supports under the Service Cost Maximum. These guidelines would assist to reduce unnecessary appeals and foster consistency of application. As well, these guidelines could be built in to the software used to complete the assessments.

III. Accessible data (system change, possible policy possible legislative)

Currently, CCU’s receive data intermittently as well past the time period captured. This does not allow for continuous improvement nor systems changes. As well, the current databases CCU’s use for entering DON’s and care plans does not allow access to data as needed. All data has to
be requested and may arrive months (or years) later. None of the data, to our knowledge, is shared with the public or posted on the IDoA website.

**We recommend:**

- Quarterly data for IDoA that is publicly posted for accountability. This could be something as simple as regional variance from recommended range of scores.
  - Conduct benchmark studies regarding:
    a. Outcomes of the Managed Care initiatives.
    b. Outcomes of home based care.
    c. Home Based Care costs vs. Nursing home care costs
    d. Savings achieved through Home Based Care
    e. How do resources (savings) translate to outcomes (quality)
- Work with Area Agencies, the CCU’s, or interested stakeholders to develop benchmarks and outcomes.
- Use data to develop focused training, (see Recommendation 1).
- Underlying all of the above improvements in both Section II and Section III is the creation of software system(s) that will enable CCU’s, providers, IDoA and others to manage activities protect clients, and communicate with each other.

**IV. Allow for Differential ‘DON’ Criteria Based on Setting (legislative)**

Currently, the DON score for eligibility for the waiver services under the Community Care Program is the same as the criteria for eligibility for nursing home care. This is required under Home and Community Based Services Waiver Program, 1915c, “Individuals must require an institutional level of care as specified in each waiver.” As such, it is easier to meet nursing home criteria when community based services may be as effective.

As well, we know that currently there are a high number of individuals with low DON scores currently in nursing homes due to mental health issues or lack of housing.

**We recommend:**

- Include a study of the impact on need for increased mental health support and/or increased housing capacity.
- Current analysis of numbers who could be served in the community (rather than nursing home) if these supports were in place.
- Identify other service gaps that may be keeping people in nursing homes without available community supports.
- Look to the “Deflection Pilot” model to identify and transition individuals from nursing home to community based supports.

**1. PLAN FOR DEMOGRAPHIC TRENDS, (legislative)**
The Community Care Program was initially developed to poise Illinois for the dramatic increase in numbers of older adults starting in this decade. And here we are. We know there will continue to be this increase for the next two decades as the baby boomers continue to “age.” This could include phasing down the program as the numbers decline subsequent to this current demographic, upward trend.

We recommend:
- A legislative acknowledgement of the changing demographics and built in increases to program supports that allow for a) costs of living and b) increases in numbers.
- Increased support for Care Coordination Units to both implement existing tasks as well as additional tasks required for compliance to federal mandates. CCU’s are currently stretched to support growing numbers with increased requirements. These occur with no change in reimbursement rates.
- Realistically project numbers going forward with reasonable cost adjustments for services going forward. Consider the $120 million in savings through increased accountability and additional savings from nursing home deflection as part of the budget development.

Appendix B4

OVERSIGHT AND MONITORING SUBCOMMITTEE REPORT

Subcommittee Members
Ron Ford, Help At Home, LLC
Representative Anna Moeller
Representative David Olsen

Study on the ROI on GRF Component of CCP


The report is dated but still relevant, as the information is Illinois and CCP specific, and validates the cost benefit of the Community Care Program.

The full report is attached.

The report stated that there is powerful evidence supporting the use of Home and Community Based Services, such as the Community Care Program, in that the growth rate for overall Medicaid long term care costs is generally lower among programs that have made substantial investments in home and community based services than those who have not.
The summary information below from the 2010 HCBS Strategies Illinois CCP report, indicated a savings to the State of Illinois of $260 million dollars in 2010 dollars. Nursing Facility state estimated expenditures were reduced $539 million and offset by increases Community Care Program and other costs of only $278 million.

All Amount in Millions

Summary of Comparison Versus Actual Participants and Expenditures

Actual Medicaid NF Residents in 2008 72,647
Medicaid NF Residents Adjusting Using 1980 Prevalence 121,908
Estimated Reduction 49,261

SLF Program Participants in 2008 5,965
CCP Program Participants in 2008 66,618
Actual Total Participants (NF + SLF + CCP) 145,230
Estimated Additional Participants 23,322

Actual Medicaid Nursing Facility Expenditures in 2008 $1,590
Projected Medicaid NF Expenditures Using 1980 Prevalence $2,668
Estimated Savings from NF Reductions $1,078
SLF Expenditures in 2008 $77
CCP Expenditures in 2008 $327

Estimated Savings After Deducting CCP Costs in 2008 $674

Estimated State Fund Savings from NF Reductions in 2008 $539
State SLF Expenditures in 2008 $38
State CCP Expenditures in 2008 $240

Estimated State Fund Savings After Deducting CCP Costs in 2008 was $260 Million.

Recaps of other studies pointing to the return on investment in expanding home and community based services, such as the Community Care Program.

- In February 2016 the U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long Term Care Policy did a report titled “Does Home Care Prevent or Defer Nursing Home Use?”
The findings of the report indicated that States with increased larger spending on home and community based services had lower nursing home placements with an average savings of over $13,000 per user.

- In 2014 Grand Valley State University, Kirckhof College of Nursing did a peer review article titled “How Increasing Personal Care Services Might Delay or Prevent Nursing Home Placement”
  The study based on average NHP, nursing home placement, and Home and Community Based Waiver services for 32 participants and calculated the savings of using home and community based services offset by decrease nursing home placement to be $960 per individual per month.

- Lastly, AARP Public Policy Institute did a study, in 2015, involving 38 states, for the report titled “State Studies Find Home and Community-Based Services to be Cost- Effective”
  The Major finding was “many states have evaluated publicly funded Home and Community Based Services programs, resulting in a recent collection of 38 studies, done within the past five years. “The studies that evaluated the cost effectiveness of home and community based services supported Medicaid “balancing” and other efforts to move more resources to home and community based services rather than institutional care.”

The studies consistently provided evidence of cost containment and a slower rate of spending growth in states that have expanded home and community based services.

**CMS Subsidized Telephony Cost**

The Illinois Department on Aging Community Care Program has had a unfunded mandate requiring providers to implement Telephony since 2012.

CMS under the 21st Century Cures Act will reimburse states for 90% of the cost of Telephony. A few states that have previously implemented an EVV solution but are now considering an alternative strategy that will allow them to leverage the matching funds from CMS. To name a few of those states, WA, MO, TN, and SC are reconsidering their previous decisions, presumably to utilize the federal dollars that are available to them, Illinois should also consider taking advantage of accessing Federal Matching Funds to pay for the cost of telephony implementation and ongoing expenses.

The Cures Act is effective Jan 1, 2019, many of the states that haven’t declared an official model yet will pursue a model that meets criteria for Federal funding. Many states have/are hosting stakeholder feedback sessions seeking input in the preferred model. Several RFP’s are expected in Q1 2018 and we’ll have a better indication as to which states will follow a path that allows them to qualify for Federal funds.

Some of the states that adopted an EVV mandate ahead of the Cures Act rethink their strategy and potentially shift to a model that does allow them to take advantage of the Federal funds.

**Home Care Electronic Visit Verification**
Electronic Visit Verification (EVV) for Medicaid Personal and Home Health Care Moves Forward; Limits HCBS Waste/Fraud While Expanding Health IT Services

- With increased use of Medicaid Home and Community Based Services (HCBS), Electronic Visit Verification (EVV) systems and related technology will gain momentum as states look to limit waste fraud and abuse in such services. Additionally, through the 21st Century Cures Act, states are required to implement EVV for Medicaid personal care and home health services beginning in 2019.
- Currently, all states provide at least one HCBS service in their Medicaid program. Additionally, 16 states have either already implemented or tested implementation of EVV over the past decade to limit waste and fraud within their programs. Given the transition to HCBS and the requirements of the Cures Act, we believe that all Medicaid programs will implement some form of EVV system that will lead to increased efficiency and limit fraud.
- The 21st Century Cures Act requires states to use EVV for Medicaid provided personal care services and home health services. While states can design their own program, individuals providing the service must electronically confirm specific information with regards to their visit. No cost for this service will be incurred by providers and can easily be implemented regardless if they are fee for service (FFS) or in the managed care setting. Furthermore, CBO estimates show $290 million in savings over a ten year period through implementation of EVV.
- **Next Steps** - EVV systems must be approved and in place by 2019 for Medicaid personal care services, and 2023 for Medicaid home health services. With those dates in mind, we expect states that have not moved forward with implementation will begin the RFP process and begin contracting with EVV service providers. States have been given free rein to develop their own program and no further regulations are expected at the federal level.
- Marwood Group believes that the amount of Medicaid services provided in the home setting will continue to rise. With this increase, states will move forward with implementing required EVV systems in order to limit waste fraud and abuse benefiting both Medicaid programs and their providers. As more states move towards implementing EVV services in 2019 through 2023, we see this as a positive for HCBS providers and companies that provide EVV services.

Over the past decade, at least sixteen states (CT, FL, IA, IL, KS, LA, MO, MS, NM, OK, OR, RI, SC, TN, TX, and WA) have either implemented or attempted to implement an Electronic Visit Verification (EVV) system for Medicaid services provided in the home setting. Since then, two major catalysts have occurred creating opportunity in the EVV space and their related products. First, the expansion of home and community-based services (HCBS) in lieu of institutional care and second, EVV implementation requirements created by the 21st Century Cures Act. As states across the country look to reduce costs related to Medicaid spending, the use of HCBS waivers are becoming more popular. HCBS waivers can include a wide range of services.
depending on the state, generally they include personal care, home health, adult day services, home-delivered meals and habilitation. Currently, all states provide at least one HCBS service and most have seen both cost savings and beneficiary improvements in health care quality and health outcomes. Given the waste, fraud and abuse that has historically been associated with care provided in the home setting, Congress passed mandatory EVV requirements for states that provide this type of care.

The 21st Century Cures Act, which was signed into law last year includes mandatory EVV implementation requirements for states in order to limit waste, fraud and abuse found in Medicaid home care services. States have the freedom and flexibility to design their own EVV systems, but those systems will need to be in approved and in place by 2019 for personal care services, and 2023 for home health services. As more states move towards HCBS services, EVV services are now required to be implemented in order to receive Medicaid reimbursement. Moving forward the federal government would fund 90% of costs related to design and implementation and 75% of operational costs.

The State of Illinois should investigate the potential reimbursement for Telephony implementation and ongoing costs.
The language covering EVV implementation costs at 90% and operational costs at 75% is below.

“(6)(A) In the case in which a State requires personal care service and home health care service providers to utilize an electronic visit verification system operated by the State or a contractor on behalf of the State, the Secretary shall pay to the State, for each quarter, an amount equal to 90 per centum of so much of the sums expended during such quarter as are attributable to the design, development, or installation of such system, and 75 per centum of so much of the sums for the operation and maintenance of such system.

While today the State of Illinois is incurring no cost related to telephony, as the expense is the responsibility of providers, getting reimbursed for 90% of the cost could all the states to decrease provider expenses and lessen the need for future reimbursement rate increases.

Additionally, the Illinois Department on Aging should reconsider the requirement of client land line being utilized for telephony. Many clients do not have land line telephones and instead rely on cell phone usage. In instances where CCP clients do not have a land line providers are required to install a fixed visit device and pay an additionally monthly fee of $7 per month. Eliminating the mandatory land line use would reduce provider expenses and not affect the integrity of the electronic visit program.

In a time where land line use is becoming less and less common this change appears a reasonable request.

Care Plan Methodology Concerns

- Training Staff / Case Managers, to identify what is necessary and beneficial to remain independent would be vital to establishing care plans
- Increase the audit of care plans
- Department to clearly state goals concerning case size by agency

The Department on Aging reports on Utilization by Planning Statistical Area PSA and Case Coordination Units CCS indicate a wide range of utilization of the service cost maximum and the DON score, as of January 2017.

<table>
<thead>
<tr>
<th>PSA</th>
<th>Clients</th>
<th>Non-Medicaid Clients</th>
<th>Clients</th>
<th>Medicaid Clients</th>
</tr>
</thead>
</table>
A review should be considered to determine what different PSAs assign larger care plans (higher service cost maximum %) than other PSAs.

Are care plans developed uniformly throughout the state?

Why do some PSAs have a higher Medicaid versus a General Revenue Fund %, is the variance solely related to client transfers to Managed Care?

**Family or Preferred Caregiver oversight**

Family or Preferred Caregivers are an important part of the Community Care Program for many seniors.

Family or Preferred Caregivers require additional oversight, as they client they serve are less likely to report incidents.

Family or Preferred Caregivers, who are non-compliant and threatened with termination, typically have the client request a new provider and change employers, which does not solve the compliance issue.

Clients always have freedom of choice in selected the provider who best meet their needs.

The Department on Aging should review family or preferred caregiver requirements and consider not allowing non-compliant direct caregivers who are family or preferred to continue to provide services by changing provider employers. The client may change providers, of course, but would require a new direct caregiver in the cases of caregiver non-compliance.
Appendix C

10/17/2017
Comments on the Community Care Program

Hello, my name is Jessica Grabowski and I am the Executive Director of Coordinated Care Alliance. Coordinated Care Alliance is a nonprofit, membership of agencies in Illinois. These 35+ agencies have come together to form a state-wide partnership to expand the portfolio of services offered in Illinois for improved care for older adults and individuals with disabilities.

I suggest Illinois invest in transitional care to contain costs and enhance services.

Providing transitional care services for older adults from the hospital or skilled nursing facility settings is a proactive approach. We already know approaches used when a person is already in a nursing facility are reactive, costly and less effective. Research shows, the first week of discharge from a healthcare setting is the riskiest for a patient for readmission. While in a hospital and for 30 days post discharge, the individual has a cognitive decline. This means that older adults may not comprehend everything they are informed of or taught in the hospital setting. They are also at risk for adverse effects such as making medication errors, falling or lack of capacity to follow through with their discharge plan. Frequently, these individuals end up being readmitted and sent to a skilled nursing facility at great cost to Illinois.

With an evidence based transitional care program, like The Bridge Model of Transitional Care, a coordinator sees patients at a hospital or skilled nursing facility bedside and then follows them intensively for 30 days post discharge. For 30 days, this coordinator mitigates adverse effects, gets them connected to long term services and supports as appropriate and ensures these individuals stay safely in the community.

Care Coordination Units are best suited to implement this work:

- CCUs are already on site at hospitals and skilled nursing facilities
- This work is conflict free as it is enhancing Choices for Care by complementing the existing IDOA structure. This evidence based model and intervention would be used along-side with Choices for Care
- The Coordinator of the transition assists the patient and family to navigate through the current fragmented care settings. They connect the patient/family to all state, federal and local community services and resources available to them before they discharge and post discharge. Hospitals often discharge individuals to a Skilled Nursing Facility instead of home because they are unaware of all the options that are available through the state/federal/local community resources. Care Coordination Units are already designated to comprehensively connect individuals to these resources and supports.
- Other states, like Nevada, Washington, and Georgia, have already seen the long-term benefits of being proactive and are implementing this program through their AAAs.
This proactive approach is aligned to the purpose of the IDOA Task Force regarding the Community Care Program:

1. It will save the state money through
   - reduced hospital readmissions
   - reduced long term skilled nursing facility stays
   - prevention of adverse outcomes such as falls or medication mismanagement, and

2. It will enhance the quality of supports and care through
   - reduced client and caregiver stress
   - reduced adverse events, and
   - increased time in their own community.

Per Telligen, one Care Coordination Unit who has implemented The Bridge Model of Transitional Care at a local hospital, has reduced readmissions by 36 percent and 20 percent in pneumonia and COPD readmissions respectively. Therefore, keeping these individuals safely in the community. Providing transitional care services to older adults in Illinois will reduce state costs and will greatly improve quality of life for not just older adults but also their caregivers. Please consider implementing a model of Transitional Care into your priorities for Illinois’ older adults.

Thank you,

Jessica Grabowski, AM, LCSW
Executive Director
Coordinated Care Alliance
Health & Medicine Policy Research Group Comments on Community Care Program

October 17, 2017

Dear Director Bohnhoff:

Health & Medicine Policy Research Group promotes social justice and challenge inequities in health and health care. We are an independent policy center that conducts research, educates and collaborates with other groups to advocate policies and impact health systems to improve the health status of all people. Health & Medicine's Center for Long-Term Care Reform promotes a just system of long-term services and supports that enables people to live according to their own goals and values, without exploiting others.

A priority of the Center is to protect and strengthen the health care safety net that can support individuals, families, and communities to overcome barriers to health and well-being presented by poverty, sickness, and discrimination. As experiences across the lifespan determine a person’s medical, social, and financial position in older age, the protection of vulnerable older adults is a crucial nexus for the work of Health & Medicine.

We agree that Illinois’ home- and community-based services programs need reform to accommodate growth in the level of need among older adults and changes in the delivery system, including the shift to value-based payment that requires integration of long-term services and supports and medical care.

Health & Medicine has advocated, through the Older Adult Services Advisory Committee in particular, to adapt the Community Care Program (CCP) and all LTSS programs to the needs of a growing older adult population. Changes to the CCP will be successful only if the policies are well-crafted, the Aging Network is strong and capable of responding to new demands, and new strategies of reform are built on an existing evidence-based. As founding members of the Bridge Model National Office, whose mission is to develop a seamless continuum of health and community care through the implementation of the Bridge Model, an evidence-based, person-centered, interdisciplinary model of transitional care, we support the work of OASAC newly formed subcommittee addressing transitional care and SNF deflection.

The health care experience is taxing and confusing for patients and their families. The complexity often leads to disengagement and poor adherence to the plan of care. The Bridge Model is designed to integrate into any health care system in order to address these issues. Bridge uses social workers to provide transitional care services, and leverages psychotherapy techniques to increase patient activation and follow-through. This approach of addressing both medical and social issues leads to many positive outcomes, including significantly lower readmission rates and decreased stress for patients and family caregivers.
Rooted in the social determinants of health, psychosocial factors such as food security, housing stability, social support, transportation, or health literacy play a significant role with regards to readmission rates. Research among older adults has shown about 40–50% of readmission rates are due to psychosocial factors (Altfeld et al., 2013). The Bridge Model specifically addresses these psychosocial barriers with a social worker trained as a Bridge Care Coordinator and has demonstrated 20-60% reductions in readmissions for complex cases (Bowlwell et al., 2016; Rosenberg et al., 2016). Providing transitional care services for older adults from the hospital or skilled nursing facility settings is a proactive approach. In this approach, older adults are connected to home and community-based services within a few days post-discharge and a trained Bridge Care Coordinator listens, validates, and improves self-efficacy and patient engagement throughout the transitional care process.

If the Department’s goal is to prepare for the long-term sustainability of HCBS programs while providing for a flexible array of services to meet the needs of older adults with functional impairments living in the community, then it must have partners in the Aging Network that have the resources to take on new responsibilities and invest in creative, cost-effective programs to serve growing numbers of vulnerable older adults. To meet needs of this growing population, adequate resources must be allocated to the Aging Network to test new approaches to both delivering and funding long-term care. Now is certainly not the time to cut funding. **Health & Medicine joins the Department, alongside others, in advocating for the implementation and evaluation of proactive transitional care initiatives to strengthen the continuum of care, coordinate across different provider settings, and support the needs of our older adults transitioning between settings.**

We appreciate the opportunity to provide comments in response to the working group devoted to amending CCP. References can be available upon request.

Sincerely,

Renae Alvarez, MPH
Director, Center for Long-Term Care Reform