About Health and Medicine Policy Research Group

Health and Medicine has a thirty three year history of evaluating local health policy as an independent, voluntary policy center with a mission to promote social justice and challenge inequities in health and health care. Health and Medicine has long been familiar with the developments that have shaped the availability of health care to the poor in the region, and has maintained its influence by developing groundbreaking standards for public programs.

Health and Medicine has repeatedly developed effective partnerships with community-based organizations, while at the same time, maintaining access to the corridors of power in the city, county and state. Health and Medicine is uniquely positioned to provide state and local linkages between the public and private sectors, and between policy leadership and community and grassroots opinion.

Health and Medicine currently serves in two key capacities: to promote dialogue on health reform among diverse constituencies, and to interpret the needs of the state, city and county for reconfigured health programs. Not only does Health and Medicine contribute to local policy development, but also provides national thinkers with the rationale for our local agendas.

Health and Medicine’s 2014 agenda focuses on seven areas: (1) research, analysis and advocacy to support the strengthening the Cook County health care safety net; (2) analysis of the implications of national and state health sector events, particularly national health reform and state Medicaid reform, for Chicago, Cook County and Illinois; (3) policy research on state long-term care programs and development of long-term care policy for Illinois’ elderly and disabled; (4) research, policy analysis and policy development to support the health and well-being of youth involved in the juvenile justice system in Cook County and across Illinois; (5) healthcare workforce development including: creation of opportunities for young health professionals in training to commit themselves to projects that serve the underserved (Schweitzer Fellows Program) and for pre-college students from under-represented communities to enter health professions (Chicago Area Health Education Center- AHEC), and the development of policy to promote community health workers as integral to health care delivery, and; (7) expansion of service delivery models, particularly the establishment of freestanding birth centers. In addition, Health and Medicine will continue to advance options for a statewide health reform agenda.

Health and Medicine Policy Research Group gratefully acknowledges funding for this report provided by the Chicago Community Trust. The views and opinions presented are solely those of the authors and do not necessarily represent those of the Chicago Community Trust.

© Health & Medicine Policy Research Group
29 E Madison Street, Suite 602
Chicago, IL 60602
(312) 372-4292
info@hmprg.org
State Health Reform in Illinois: Fitting the Pieces Together

Introduction
Health and Medicine Policy Research Group (HMPRG) monitors developments in policy and practice with a special focus on the impact on long-term care, on the health care safety net, and the healthcare workforce. In Illinois, multiple reforms are rolling out simultaneously and interactively. For providers, consumers, state agencies and other stakeholders these changes can seem chaotic, even contradictory at times. Yet the buy-in of all of these actors is crucial for any individual reform or, more importantly, the package of reforms as a whole, to be a success.

Stakeholders have many reasons to be skeptical. There is no blueprint or roadmap to a high-quality, equitable, cost-effective health system. The plan emerging in Illinois is not one a transcendental planner would have created, nonetheless it is an effort on the part of the State to take advantage of opportunities that have the potential to build toward a system that serves clients better and contains health care costs. However, many of the reform initiatives are responsive to federal funding opportunities and have specific requirements and timelines that align uneasily with the needs and expectations of other programs and their constituencies. Other reforms are necessarily constrained by the realities of public budgets and political power. The State agencies tasked with implementing various reforms aren’t always aware of or coordinated with one another, resulting in duplication, lost opportunities for collaboration, and inefficiencies. When they are well-aligned, it may still not be clear to stakeholders how multiple reform strategies add up to an integrated whole.

Thus, individual reforms may appear too limited, while the entire spectrum of reform may not be apparent to stakeholders or look like a dangerously unstable contraption that could do as much harm as good. If the system really is fundamentally transforming, then the rational response is to adapt to the change and see where one can add value in the new system (and thereby also reap financial reward). If promises of system-wide transformation sound implausible, the rational response may be to defend one’s own turf within the status quo, knowing enough others will do the same and no real change will take hold. There are groups and individuals in Illinois on all sides of this balance, but in general most seem to be engaging in the process to try to make it work for the people they serve.

From the fortunate position of policy analysts without turf to protect, the scope and depth of initiatives to reform the long-term services and supports, the safety net, and the healthcare workforce, are encouraging. This policy brief provides background and analysis on Illinois’ key health reform initiatives and makes the case for engaging them as an integrated program of systematic reform.

Reflecting Health and Medicine’s policy focus, the analysis highlights the interconnected reforms affecting long-term services and supports, the health care safety net, and the workforce providing services within a changing delivery system. We look first at the state-level conveners of reform efforts and stakeholders, then briefly describe the large-scale state-wide initiatives for reform and the foundational initiatives without which large-scale reform will falter. Finally we outline the inter-related
LTSS, safety net, and workforce reforms moving forward in Illinois, all of which require broad and deep stakeholder input to produce effective change.

Conveners

Illinois has had a number of robust planning and implementation efforts both related to ACA reforms and other, parallel health system initiatives related to long-term services and supports, the safety net, workforce, the move toward managed care, and other efforts meant to align planning and funds with the needs of the state’s health system and workforce. Two large overarching initiatives, the Health Care Reform Implementation Council, which the Governor set up to help with implementing the Affordable Care Act, and the Governor’s Office for Health Innovation and Transformation, set up for longer term health planning and implementation, helped bring together different partners and stakeholders. These two convening groups are described briefly below and more importantly, they have facilitated both planning efforts and applications for Federal Funding, including the $2 million Illinois Alliance for Health Planning grant, which has resulted in an application for a 4-year $100 million implementation grant (State Innovations Model testing grant, or SIM grant), and the 1115 Path to Transformation waiver application, which requests an additional $5 billion in federal Medicaid funding over 5 years (described below).

Health Care Reform Implementation Council (HCRIC)
Governor Pat Quinn signed an Executive Order on July 29th, 2010 to create the Illinois Health Care Reform Implementation Council. The Council, made up of the leaders of State Departments that have any connection to health reform activities, has helped the state implement the health care reforms contained in the federal Affordable Care Act (ACA) and provided recommendations that have helped guide other planning efforts, including a January, 2014 HCRIC Workgroup on Workforce report and recommendations.

Governor’s Office of Health Innovation and Transformation (GOHIT)
The Governor’s Office of Health Innovation and Transformation (GOHIT), created in January, 2014 by Governor’s Executive Order, is responsible for directing Illinois’ health reform initiatives, particularly those related to the State’s Alliance for Health Innovation Plan. The Alliance for Health was developed with a six-month planning grant awarded from the Center for Medicare and Medicaid Innovation (CMMI) in 2013. GOHIT is responsible for leading and coordinating implementation of the initiatives and policy changes in the Innovation Plan, supporting stakeholder engagement, and creating and operating an Innovation and Transformation Resource Center to provide technical assistance.¹ Currently GOHIT is working with state agencies and other stakeholders in five workgroups (approximately 900 are currently involved) to develop implementation plans to meet the goals of the Alliance Plan and the 1115 Waiver.

¹ For more on the Innovation and Transformation Resource Center see page 36 of the Alliance for Health Innovation Plan and page 16 of the 1115 Path to Transformation Waiver
Statewide Initiatives

Alliance for Health: State Innovation Model Grant
On February 21, 2013, Illinois was awarded a State Innovation Model planning grant from the federal Center for Medicare and Medicaid Innovation (CMMI). This funding supported planning efforts for delivering high-quality health care, lowering costs, and improving health system performance. Illinois used the CMMI grant to bring together a broad array of stakeholders, including health plans, providers, payers, purchasers, advocates, and public health professionals, to develop innovative strategies to improve the healthcare delivery system. The Alliance developed a plan that builds upon the delivery and payment system reforms already underway in the state, including changes implemented under Illinois' Care Coordination Innovations Project, and the CMS Coordinated Care for Medicare-Medicaid Enrollees Demonstration, as well as innovations being spearheaded by commercial insurers. The Alliance plan was published in December of 2013 and the State of Illinois submitted an application for an implementation grant from CMMI, in the amount of $100 million in July 2014.

“Path to Transformation” Medicaid Section 1115 Waiver (1115 Waiver)
Building on the work identified in the Alliance for Health plan, from November 2013 to March 2014, the State developed a waiver application for submission to the Centers for Medicare and Medicaid Services. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs and that differ from federal program rules. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as: expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible; providing services not typically covered by Medicaid; and using innovative service delivery systems that improve care, increase efficiency, and reduce costs. Illinois’ proposal includes using federal funding to implement reforms that will: 1) improve healthcare delivery systems; 2) help integrate population health efforts into healthcare delivery; 3) invest in the healthcare workforce; and 4) improve long-term services infrastructure, choice, and coordination.

For more on the impact of the 1115 Waiver and the Alliance for Health on long-term services and supports and the health care safety net, see the chart in Appendix A.

Foundational Initiatives

The statewide, comprehensive reforms envisioned in the 1115 waiver and the Alliance for Health Plan build on a series of previous and concurrent reforms. We identified several ‘foundational initiatives’ for long-term services and supports and for the safety net without which those broader proposals cannot achieve their ambitious aims.
**Overarching Initiatives:**

**Managed Care**

Illinois is in the process of transitioning at least 50% of its Medicaid population into risk-based care coordination models by January 2015, as mandated by Public Act 96-1501 (known as the SMART Act). The move toward managed care is said to be part of the move away from traditional fee-for-service models that have been criticized for rewarding providers for a higher quantity of services, and toward more integrated models that reward value and improved outcomes.² Under a fee-for-service model, providers receive payments from the State for each discrete service they provide to Medicaid enrollees, with little consideration of whether those services are coordinated with services the enrollee receives from other providers. Managed care programs aim to incentivize coordination of different services—from primary care to post-acute and long-term services and supports—and avoid the unnecessary and duplicative services that are paid for through a fee-for-service system.

**Capitation**

One way managed care programs build those kinds of incentives is to shift from fee-for-service to capitation, in which the State pays a Managed Care Entity (MCE) a flat, per-member-per-month rate and the MCEs pay providers for services to their members. MCEs have a strong incentive to keep costs below their capitation rate, so they are expected to invest in care coordination practices that may help improve the health of the patients in their panel, thus reducing their need for more costly care.

Of course, there is a danger that this incentive goes too far in the opposite direction, encouraging MCEs to cut back even on necessary services in order to protect their own bottom line. Most MCEs in Illinois are publicly-traded for-profit companies that are accountable to shareholders who demand that they produce a competitive product that produces returns on investment. It will be important for the State, consumers, and other stakeholders to exert at least an equal and opposite pressure to provide quality services so that MCEs are incentivized to create financially viable care coordination models that are truly responsive to the needs of their members.

Some of this kind of accountability to consumers can be generated from within the managed care infrastructure. All managed care programs in Illinois include quality metrics and pay-for-performance programs. Typically, the State withholds a portion of the capitation payment and plans can earn back that withheld payment and receive additional bonus payments for achieving or exceeding quality benchmarks. The State will also eventually use quality data collected from MCEs to influence auto-assignment decisions and to educate consumers who are choosing Medicaid health plans. Careful monitoring and stakeholder engagement is necessary to determine, over the course of these programs’ implementation, if these efforts to mitigate the negative incentives from capitation and create incentives to improve quality are effective.

The GOHIT Quality Metrics Subcommittee provides opportunities for stakeholders, including self-advocates, to have input as the State refines the specific accountability processes and metrics necessary for adequate oversight and improvement of MCO performance.

Minimum medical loss ratios (MLR) in the plans’ contracts with the State require them to spend at least 85% of their capitation rate on services for enrollees. If plans do not meet the minimum medical loss ratio, they must rebate the difference to the State. Along with pay-for-performance metrics based on quality measures, medical loss ratios are designed to mitigate the incentive to deny or refuse reimbursement for services under capitation.

The MLR is also an important indicator of MCO performance. The State contracted with actuaries to determine the capitation rate—that is, the estimated cost of providing the services and supports that managed care enrollees need—and if MCEs are regularly spending less than their capitation payments on services, stakeholders and policy makers should inquire as to what their models are missing. Quality metrics are already revealing some level of unmet need in the Integrated Care Program. An outstanding question for MCEs, the State, consumers, providers, and advocates is: How could MCEs be pro-actively investing in longer-term infrastructure improvement to meet those unmet needs if they are not spending the minimum MLR on covered services? Both health plans in the Integrated Care Program have rebated capitation payments back to the State in their first two years of activity. Although the State and some stakeholders may see that as savings, most advocates would prefer to see those dollars stay in the delivery and care coordination system.

Quality metrics and medical loss ratios are internal to the managed care system. Other initiatives in the State can play a role in correcting the potential perverse incentives of capitation. This report includes a section specifically on long-term services and supports reforms that include the development of person-centered service planning and delivery, conflict-free case management, coordinated and streamlined entry portals for LTSS, and a universal assessment tool. Capitated managed care programs can be more effective for consumers within a person-centered system that puts the consumer at the center of decision making, facilitates access to services in the community, eliminates as much as possible conflicts of interest that risk putting financial interests above consumer preferences, and holistically and accurately assesses functional eligibility. Advocates who are engaged in efforts to reform the long-term services and supports system are, and should continue to be, asking how managed care entities will function within the systems we are building through programs like the Balancing Incentives Program. See “Long-Term Services and Supports Initiatives” beginning on page 8 for more about specific LTSS initiatives that can build in protections for access to care and consumer direction under both managed care and fee-for-service systems.

3 Contracts for ICP plans include a medical loss ratio of 88% and are available here: http://www2.illinois.gov/hfs/ManagedCare/Pages/default.aspx
The three-way MMAI contract between the State, Federal CMS, and the Plans requires a medical loss ratio of 85%. The MMAI contract is available here: http://www2.illinois.gov/hfs/SiteCollectionDocuments/MMAIllinoisContractDemonstrations.pdf
Kinds of Managed Care Entities
Currently Health Maintenance Organizations (HMO), run by insurers, and Managed Care Community Networks (MCCN), run by providers, receive capitated payments for members in the Integrated Care Program (ICP), the Medicare-Medicaid Alignment Initiative (MMAI), and CountyCare and for Family Health Plan Members and newly eligible adults under the ACA. Illinois is also experimenting with new kinds of provider-driven managed care programs that are not yet capitated. Coordinated Care Entities (CCE) allow providers to form networks that target specific sub-populations of seniors and people with disabilities (SPD), or that coordinate care for children with complex health needs. Successful CCEs will demonstrate effective techniques for serving populations such as individuals with serious mental illness, older adults, or dual eligibles.

Accountable Care Entities (ACE) are also organized by providers and will coordinate an array of Medicaid services. Instead of targeted special populations, ACEs will initially enroll children and their family members, with an option to enroll "newly eligible" adults under ACA. ACEs may be paid on a fee-for-service basis initially but must transition to shared savings within the first 18 months, partial-capitation after 18 months, and full-capitation after 3 years.

One provider-sponsored managed care entity worth highlighting is CountyCare, a managed care community network led by Cook County Health and Hospital System (CCHHS). CountyCare was created under a Medicaid 1115 Waiver allowing it to enroll people a full year before the January 2014 national enrollment started, and is now paid a capitated rate by the State to manage all services for its members. CountyCare began enrolling newly eligible “ACA adults” in 2013 and many of those new enrollees have serious mental illnesses (SMI) and substance use disorders (SUD). CCHHS already provides health care services for detainees in the Cook County Jail (many of whom have SMI or SUD) through Cermak Health Services. Although they will receive services through the County system, some of the Cermak clients will enroll in CountyCare and some will enroll in other plans. A key challenge (and opportunity) for the County system as a plan and as a provider will be providing mental health and substance use disorder services, including long-term services and supports, in coordination with other plans and providers. Read more about CountyCare in the Safety Net section, starting on page 15.

Managed care and the health care safety net
For safety net providers who are not as familiar with the new capitated model and, perhaps more importantly, the process of contracting with one or more MCO, one challenge is ensuring that their organization is well informed of how contracting works and that they are not jeopardizing their fiscal sustainability as they begin these contracts. Further, as safety net institutions shift away from their typical role of providing care to uninsured patients, it remains crucial that those who are not insured

---

4 Managed care community network is defined in Title 89 Section 143.100
have access to care and that safety net institutions do not create internal two-tiered systems by prioritizing newly insured patients, whose care will be reimbursed.6

Managed care and long-term services and supports
A well-administered managed long-term services and supports system should support and accelerate the rebalancing reforms the State is implementing. As described above, in a traditional managed care arrangement, the state pays a capitated per-member-per-month payment to a managed care plan to manage all of the care of a Medicaid patient. This is a transformation of the traditional fee-for-service system and is designed to improve health outcomes through care coordination and prevention, reduce unnecessary hospital, emergency room and institutional care, and save healthcare costs.

The promise of managed long-term services and supports lies in the shift in incentives that encourages better services in more integrated settings, rather than rewarding the volume of services provided with little regard for quality or consumer experience. Capitation offers the advantage of allowing health plans to fund services according to identified needs, not along budget lines and departmental silos. That means that if a health plan saves money from preventing an unnecessary nursing home placement, it can seamlessly invest those savings in improved home- and community-based services.

However, the promise of capitation is not fulfilled automatically when the State shifts payment methods. We have already described the potential for capitation to incentivize reductions in services, and managed care entities are also on a learning curve in Illinois. Having flexibility to spend a capitated payment on services and supports that are not covered in fee-for-service Medicaid will only benefit consumers if that spending is approved and it is directed toward the services consumers actually need and prefer. Protecting consumer direction and consumer rights, which are goals of the Balancing Incentives Program and new CMS rules for HCBS waivers (described below), will be important counterparts to the introduction of capitated managed care.

There is also a risk that the positive incentive to move people out of nursing homes will result in shifting caretaking costs onto families who may be unable to bear them. Capitation encourages MCEs to provide LTSS in the lowest cost setting, but other measures will be needed to hold them accountable for successful transitions to the community. Illinois should be learning what makes a successful transition and what does not as we implement the Olmstead consent decrees and continue operating the Money Follows the Person Program and applying those lessons to overseeing MCEs.

For the majority of Medicaid enrollees managed care will be the delivery platform for the services they receive. Therefore, all other reforms to the service delivery system will need to clearly articulate the role of managed care entities.

---

For more on the impact of managed care on long-term services and supports and on the health care safety net, see chart in Appendix A.

The Illinois Framework

The Illinois Framework for Healthcare and Human Services is a multi-agency collaborative for coordinating the use of technology and shared data across Illinois’ federally funded healthcare transformation initiatives. A short-term priority for the Framework is facilitating data exchange and coordinated processes within the Medicaid system. Longer-term, linking Medicaid data systems with other health care and human services programs in a coordinated, interoperable system will be a vital tool to measure the performance of managed care entities and other Medicaid vendors in improving population health and to develop the right incentives to support and accelerate effective reforms.

A major theme cutting across all health care reform in Illinois is breaking down silos. Every major reform initiative will require collaboration between different state agencies, diverse and sometimes competing health care and human service providers, local health departments and other agencies, as well as advocates and consumers. The Framework is the vehicle to allow diverse systems and organizations to work together by creating connections between them. Furthermore, the Framework’s emphasis on both interoperability and data-driven tools will play a key role in ensuring that system-wide reforms can be monitored, evaluated, and continuously improved.

The Illinois Health Information Exchange

Moving from paper to electronic health records and creating interoperable systems for sharing health information across providers and between providers and consumers has been a national priority for years. Supported by 2009’s federal HITECH Act, Illinois has built the Illinois Health Information Exchange (ILHIE), a statewide, secure electronic network for sharing clinical and administrative data among health care providers in Illinois. ILHIE allows health care providers and professionals to exchange electronic health information in a secure environment, which helps prevent duplicate tests and procedures, and ensure the accuracy of prescriptions and other medical orders. Any reform addressing care coordination, population health, or quality improvement will depend on interoperable electronic record exchange between providers, public health departments, and researchers. Therefore, ILHIE is an important foundational initiative supporting system-wide health system transformation.

Long-Term Services and Supports Initiatives

The broad goals of the Long-Term Services and Supports (LTSS) pathway of the 1115 waiver are to improve access to home- and community-based services that allow older adults and people with disabilities to live in the most integrated setting possible, and to improve the quality of those services. These goals will not be achievable if other LTSS reform initiatives are not successful. The next section
describes some of those foundational initiatives and how they can build on each other to support the comprehensive reform goals of the 1115 waiver and the Alliance for Health Plan.

Before describing the foundational initiatives that build toward the system-wide LTSS reforms envisioned in the 1115 waiver and Alliance Plan it’s worth reflecting on the work already done by the Human Services Commission Rebalancing Workgroup. The workgroup was tasked with identifying strategies that “significantly expand community options” for individuals with special needs to live in community settings. One focus of the workgroup’s recommendations was the coordination of managed care, Medicaid, and health care reforms to optimize their impact on rebalancing the Illinois LTSS system. The intent of this policy brief is to present various reform programs as belonging to a cohesive whole, and the workgroup’s call for increased coordination of planning, implementation and reporting of the rebalancing efforts is worth remembering.

Balancing Incentive Program, Aging and Disability Resource Centers & CMS rules on person-centered planning

The Federal Balancing Incentive Program (BIP) authorizes enhanced Medicaid matching funds to States to increase access to non-institutional long-term services and supports (LTSS) as of October 1, 2011. Illinois’ BIP application was approved June 12, 2013. The Balancing Incentive Program requires three structural changes to the State’s LTSS system: (1) Coordinated points of entry to LTSS with ‘no wrong door’ (2) Conflict-Free Case Management such that direct service providers do not also conduct assessments and perform case management, and (3) use of a core standardized assessment instrument to holistically assess individuals functional eligibility for services and inform a person-centered planning process.

The first BIP structural reform, coordinated point of entry with no wrong door will be operationalized through Aging and Disability Resource Centers (ADRC), ‘one-stop shops’ for consumers that have been developing under the leadership of the Illinois Department on Aging in partnership with the aging and disability community. ADRCs have expertise in community-based social services that include Medicaid funded services, but also include other funded services like those provided through the Older Americans Act. As such the ADRC network will also become an important entry portal for the Medicaid managed care entities that are charged with coordinating medical, long-term, and social services for their members.7

The second structural reform is complicated by the simultaneous implementation of BIP reforms and new CMS rules defining person-centered planning for HCBS waiver services. Those new rules require that 1915(c) and 1915(i) waiver service planning processes are directed by the individual with long-term support needs. The rule describes the minimum requirements for person-centered plans developed through this process, including that the process results in a person-centered plan with individually

7 For more on the role of ADRCs in BIP implementation, see the Illinois BIP Application, http://mfp.illinois.gov/assets/BIP_app_508.pdf
identified goals and preferences. This planning process aligns with the BIP goals by assisting individuals in achieving personally defined outcomes in the most integrated community setting, ensuring delivery of services in a manner that reflects personal preferences and choices, and contributing to the assurance of health and welfare.

However, the new HCBS rule defines ‘conflict-free case management’ much more strictly than the BIP rules and this presents a challenge for implementation. BIP rules allow for mitigation of conflicts through increased state oversight of assessments, service plans, and consumer experience. The new HCBS rule does not make room for state oversight as a conflict-mitigation strategy. Mental health and substance use disorder stakeholders have expressed special concern that conflict-free case management rules could interfere with a consumer’s preference to have a provider act as case manager. A wide variety of effective conflict mitigation strategies can help states combine a prudent conflict of interest policy with a meaningful commitment to consumer control. Illinois’ BIP team is in communication with federal CMS regarding the impact of the HCBS rule.⁸

The third BIP structural reform, a core standardized assessment instrument, is also a key element of the LTSS Pathway of the 1115 waiver. Through BIP, the State is already developing a universal assessment tool (UAT), which it expects to facilitate the 1115 waiver’s proposal to consolidate Illinois’ nine HCBS waivers to create a more holistic, need-based, equitable, and efficient system for accessing home- and community-based services. The rollout of the UAT will need to be coordinated with the ongoing development of the ADRC network to ensure that ADRC staff are properly using the new assessment tool.⁹

The BIP is also closely tied with current Long Term Care Rebalancing initiatives in Illinois such as the Money Follows the Person program. The structural reforms and additional federal funding from BIP will facilitate the ongoing community transitions in the Money Follows the Person program and support transitions and necessary services for individuals in institutions that the State is closing. BIP reforms are also being coordinated with processes in place to implement the three Olmstead consent decrees in place in Illinois (and with the MCOs participating in the community transitions).

BIP implementation in Illinois is already supported by a stakeholder group. To facilitate that coordination, representatives of the plaintiffs in the Olmstead consent decrees and the MCOs are on the BIP Stakeholder Group. Recognizing that the BIP structural reforms will interact, sometimes uneasily, with other LTSS changes in Illinois, the BIP Stakeholder Group has been combined with a stakeholder subgroup of the GOHIT Services and Supports Workgroup, the Conflict-Free Case Management and Person-Centered Planning Breakthrough Group.

---

⁸ See GOHIT Services and Support Workgroup, LTSS Subcommittee, Conflict-free Case Management and Person-centered Planning Breakthrough Group July 25, 2014 presentation, slides15-22
⁹ For more on the Uniform Assessment Tool, see the BIP Application and the 1115 Waiver Application. The State received many public comments on the 1115 draft application concerning the UAT. Those public comments are summarized here.
Illinois Rebalancing Initiative

In January 2012, Governor Pat Quinn announced plans to begin closure of certain State-operated developmental centers (SODC) and psychiatric hospitals (SOPH). Describing these facilities as ‘outdated,’ the State plans to transition residents to group homes that better integrate people with disabilities into the community. Moreover, by serving individuals in less costly settings the State expects to be able to provide services to more people who need them, which aligns with the 1115 waiver goal of reducing the Prioritization for Urgency of Need for Services (PUNS) waitlist for services and supports for people with developmental disabilities.

At least four facilities were identified for closure initially including Jacksonville Developmental Center in west central IL, Tinley Park Psychiatric Hospital in metro Chicago, Murray Developmental Center in southwest IL, and Singer Center in the Rockford area.

Although the Rebalancing Initiative has been coordinated with other LTSS reforms, notably BIP and the implementation of the Olmstead consent decrees, the closure of the state-run facilities has been very controversial. A group representing parents of residents at Murray Developmental Center, for example, sued to stop the closure, arguing that their children could not receive the services they needed in group homes or other community-based settings. The Judge who rejected the request acknowledged that the closure would cause “distress and disruption” to the families. Judge Marvin Aspen also found that the interests of the State in integrating people with disabilities into the community and serve more people by improving efficiency outweighed those concerns.

Certain disability rights advocates strongly supported the closures of state operated institutions on the grounds that the segregation of people with disabilities in institutions is fundamentally opposed to the principles of independent living.

The debate about closing state-operated developmental centers is not over. Six facilities remain with no plan to close them, and the process by which residents transition out of the facilities that are closing and receive services in the community is complex and will be affected by all of the other reforms described here. Furthermore, advocates are watching closely to see if the promise of financial savings from closing facilities will in fact be put into community based services.


11 Ibid.


13 Note that in 2014, the Illinois General Assembly passed SB822 which requires the State to reinvest proceeds from the sale of State mental health facilities into community services.
Olmstead consent decree implementation and CMS rule on community-based setting

The LTSS reform initiatives described so far, along with managed care, include moving individuals out of institutions and into the community as an explicit goal. Through BIP and managed care contracts, the federal and state governments are creating powerful incentives to shift from institutional to community-based services. By closing state-operated institutions and tightening regulations for community-based settings and person-centered planning, government is directly altering the landscape in which long-term services are provided.

An even stronger push toward community living for recipients of LTSS comes from frustration with government inaction, however. Between 2005 and 2007, several advocate groups, including Equip for Equality and Access Living, became so discouraged with the lack of progress in improving access to community living for people with disabilities that they filed three class action lawsuits against the State of Illinois on behalf of people living in institutions. Those lawsuits, described below, alleged that the State of Illinois violated the U.S. Supreme Court’s Olmstead decision by denying residents of institutions the right to receive services in the most integrated setting appropriate to their needs. The landmark 1999 Supreme Court decision, Olmstead v. LC, affirmed the American with Disabilities Act’s ‘integration mandate’ which requires states to provide services to people with disabilities in the most integrated setting possible, and found that needless segregation of people with disabilities is a form of discrimination. Illinois settled all three Olmstead lawsuits in 2010 and 2011 and is currently implementing consent decrees for each case.

The Olmstead consent decrees, backed by court monitors, makes the imperative to reduce institutional bias and expand home and community based services more powerful. However, some advocates, providers, and health plans involved in implementing the Consent Decrees, in particular Colbert V Quinn, have noted that the State’s focus on the numerical targets for transitions in the implementation plans may in some cases be marginalizing the qualitative experience of the individuals making the difficult transition from institutions to the community.

- Colbert v Quinn: This class action a lawsuit was filed in 2007 on behalf of 16,000 Medicaid-eligible people living in Cook County nursing facilities and was settled in 2011. The Colbert Consent Decree requires the State of Illinois to provide opportunities for residents in skilled nursing facilities—including people with mental illness, people with physical disabilities, and older adults—in Cook County to move to community-based living. Illinois was found to be out of compliance with parts of the consent decree at the end of 2013 and changed the lead agency for implementation from the Department of Healthcare and Family Services to the Department on Aging to “provide greater program focus and also top level organizational attention.” Although the court monitor expressed satisfaction with many of the changes IDOA had begun, it still found the State in non-compliance in its June 3, 2014 Interim Report

to the Court based on its failure to meet the Consent Decree’s requirement of 300 individuals placed in community settings by November 8, 2013. Although the court monitor noted approvingly that the placement of 48 Class Members in April 2014 was a significant improvement over prior months, Health and Medicine repeats its recommendation that the plaintiffs, state agencies, and community providers develop measurements of successful transitions that include the quality of life of the individual living in the community and health outcomes. Experience using such measures in Consent Decree implementation can provide lessons for other care coordination programs.

- **Williams v Quinn**: This class action lawsuit was filed in 2005 on behalf of 4,300 residents of Institutions for Mental Disease (IMDs) statewide and was settled in 2010. The Williams Consent Decree requires the State to transition to integrated, community-based settings all IMD residents who want placement in the community over a five year period beginning in July 2011. The State’s Implementation Plan also affirms a commitment to “Recovery Principles, a set of fundamental beliefs that persons with mental illness can recover and live purposeful lives,” and to creating recovery-oriented systems enhancements to assure successful transitions to community living. However, the Williams Court Monitor noted in its second annual report in January 2014 that although the State had been meeting the Consent Decrees’ numerical targets, it had not been providing “the necessary intensity of services for class members with more complex needs,” resulting in individuals who could have moved to the community “continuing to languish in IMDs.” More work, assisted by stakeholder input, will be needed to fulfill the commitment to recovery and rebalancing in the Williams Implementation Plan.

It is worth noting that other reforms have potential to support and accelerate the goals of Williams. The 1115 waiver’s proposals to expand community-based behavioral health services align with the commitments to community-based, recovery-oriented services in the Williams implementation plan. The workforce expansion efforts underway also hold the promise of enhancing the community-based mental health provider network.

- **Ligas V Hamos**: This class action lawsuit was filed in 2005 (as Ligas V Maram) on behalf of people with developmental disabilities living in state-funded institutions or people who were likely to be placed in such institutions and was settled in 2011. The Ligas Consent Decree mandates the State of Illinois provide opportunity to live and receive services in community settings for the 6,000 persons with developmental disabilities living in Intermediate Care Facilities for persons with Developmental Disabilities (ICF/DD) who affirmatively request community-based settings. Ligas also requires the state to serve 3,000 individuals living in family homes who are on the PUNS waitlist within six months and continue to move individuals off the waitlist at a "reasonable pace" thereafter, and to expeditiously provide community services for people with developmental disabilities who are in crisis.

---

15 Jones, Dennis R. Williams v. Quinn, Case No. 05-4673, Annual Report to the Court, January 19, 2014, page 7.
Implementation plans govern each consent decree and the State’s progress is tracked by a court monitor. Therefore, the consent decrees substantially set the ‘rules of the game’ for short- and medium-term rebalancing plans, and other LTSS reforms must align with the process and goals outlined in the implementation plans.

At the same time, implementation of the consent decrees must comply with other rules governing home- and community-based services. For example, the same CMS rule that sets standards for person-centered planning also established definitions for community-based settings. A setting will only qualify as community-based if consumers have informed choices of settings and service options, a right to privacy and to having visitors, and control over their schedules and access to food at any time. Illinois will have to ensure that the home and community-based settings it expects to use for community transitions (as well as for nursing home diversion/deflection) comply with these new rules. States have until March 2015 to submit transition plans to meet the new HCBS settings rule and up to five years to implement the approved plan.

Section 811 Housing

Lack of affordable, accessible housing with access to support services when necessary is a serious barrier to successful community transitions and housing placement is a key challenge for all rebalancing programs, including consent decree implementation. In fact, the Colbert V. Quinn June 3, 2014 Interim Report to the Court noted that, “the availability and mix of community-based housing units is critical to Colbert success.” One way Illinois is addressing that challenge is its federal Section 811 grant for permanent supportive housing for people with disabilities.

Section 811 Supportive Housing for Persons with Disabilities program allows states to offer rental subsidies to people with disabilities who are within 30% of area median income, aged 18-62, who are eligible for LTSS (including waiver services or Medicaid Rehabilitation Option services for serious mental illness).

The Section 811 program has undergone radical change since its inception. The old Section 811 built non-integrated, disability-specific housing by providing capital advances to non-profit housing developers. The Frank Melville Supportive Housing Investment Act of 2010 reformed the Section 811 program to provide rental subsidies to people with disabilities to live in the community with control of their own unit through the Project Rental Assistance Contracts (PRAC) with state Medicaid agencies that partner with housing agencies. It is notable that the new HCBS rules that define community-based settings move in the same direction as the Melville Act by separating service from housing such that the service provider does not have undue control over consumers.

17 Discussion at April 15, 2014 Illinois Money Follows the Person Stakeholder Meeting
Illinois is one of about a dozen states that received a Project Rental Assistance Contract from HUD and an interagency panel is working on identifying locations for permanent supportive housing. Through the agreement, Illinois hopes to make about 830 units available for consent decree class members, MFP clients, and people moving out of state-operated facilities for people with developmental disabilities. Other possible target populations include individuals coming off the PUNS waitlist or people who meet the consent decree criteria but were only recently admitted to a nursing home. Special attention is needed for people with DD/ID, including Ligas class members, who have proven difficult to transition.\textsuperscript{18}

In an important overlap with safety net concerns, HFS recognizes that many new Medicaid enrollees under the ACA expansion have similar service needs to these targeted populations. Many have severe mental illness or substance use disorders and are also in need of stable housing with access to support services. Although the Section 811 program cannot serve everyone, it will be important to learn from the experience of seniors and people with disabilities, and especially to avoid re-creating a perverse incentive for the new Medicaid enrollees to be admitted to a nursing home in order to access housing and HCBS.\textsuperscript{19}

Experience with the Section 811 and community transition process will carry important lessons for implementation of the 1115 waiver, which includes significant expansion of community-based behavioral health services and integration of those services with physical health and social services. The 1115 waiver specifically addresses housing’s impact on health by creating outcome-based payments to MCOs and community-based behavioral health providers that develop effective strategies to maintain stable housing for people with SMI and SUD. Providers and MCOs are already experimenting with ways to improve services to this population under the Integrated Care Program, County Care, and the Innovations Project.\textsuperscript{20} The State’s rebalancing efforts along with the results of those managed care models can and should build on one another to inform the systematic reforms in the 1115 waiver and Alliance for Health Plan.

**Ombudsman program expansion**

The Long-Term Care Ombudsman Program was created to protect and promote the rights and quality of life for people who reside in long-term care facilities. In August 2013, legislation passed that allowed the Department on Aging’s Long-Term Care Ombudsman Program to expand into home and managed care.\textsuperscript{21}

\textsuperscript{18} Ibid.  
\textsuperscript{19} Ibid.  
\textsuperscript{20} For example, see: “Thresholds and IlliniCare Health Release Pilot Program Results that Improve Health, Decrease Costs for Medicaid Patients with Severe Behavioral Health Problems,” May 9, 2014. http://www.thresholds.org/2014/05/thresholds-and-illinicare-health-release-pilot-program-results-that-improve-health-decrease-costs-for-medicaid-patients-with-severe-behavioral-health-problems/  
\textsuperscript{21} Public Act 98-0380. Amendment to the Illinois Act on Aging (20 ILCS 105/4.04)
Amidst the many changes taking place in the LTSS system in Illinois, and given the large role of managed care entities in carrying out those changes, an effective, responsive ombudsman program will be crucial to ensure consumers are protected and to facilitate continuous quality improvement. Health and Medicine Policy Research Group’s recommendations for the expansion of the ombudsman program to managed care and HCBS can be found here.

Safety Net Initiatives

A large number of Illinoisans qualified for Medicaid under the ACA at the beginning of 2014, with 451,880 people gaining the full benefit of ACA Medicaid (including CountyCare, which began enrollment in January 2013), out of approximately 632,000 ACA eligible adults. In addition, as of April 19, 2014, 217,492 of 937,000 (23%) of Illinois’ Marketplace-eligible residents gained coverage through Illinois’ Federal Partnership Insurance Marketplace. Of those who have enrolled in a marketplace plan, 77% have received financial assistance.

While hundreds of thousands of people have gained insurance through Medicaid expansion and in the Marketplace plans, hundreds of thousands of Illinoisans remain uninsured, including those who are eligible for Medicaid or Marketplace plans but did not enroll, for reasons ranging from people who might: not understand enrollment; have submitted Medicaid applications that are waiting to be processed; be eligible for, yet unable to afford a Marketplace plan; fear of impact on family members, and others. An estimated 500,000 people remain uninsured in Cook County alone, according to a recent Board Chair report at a CCHHS. Importantly, undocumented immigrant residents in Illinois remain ineligible for coverage under ACA Medicaid. While there are plans to continue to enroll those who are eligible, there remains no public policy to provide health insurance coverage to those who are currently deemed ineligible. The large number of uninsured people underscores the current urgent need for a fully supported health safety net that helps assure that uninsured people have access to the human right to healthcare.

Cook County Health and Hospitals System (CCHHS) and CountyCare 1115 Waiver

CountyCare, which resulted from Cook County and the State’s application for a Medicaid 1115 Waiver for the county, resulted in tens of thousands of Cook County residents gaining health insurance coverage up to a year earlier than others who gained access to ACA Medicaid on January 1, 2014. The County now has exceeded its goal of 115,000 enrollees and continues to have applications processed for CountyCare, which transitioned to a provider-led Managed Care Community Network (MCCN) in July 2014, when their 1115 waiver expired.

A July report from CCHHS Chairman, David Carvalho and Vice-Chairman Jorge Ramirez, noted that there is a projected deficit of around $35 million since the beginning of the operation of CountyCare, but they also said that criticism that CountyCare is untenable long-term is unwarranted, adding that as it starts up and people gain coverage to previously unmet primary care needs, their health will improve, care will be managed, and costs reduced. The report notes that CountyCare has already vastly reduced the amount of uncompensated care at CCHHS, thus reducing the dependence of the system on County contribution by $40 million from fiscal year 2013. The report notes that CountyCare is vital to the fiscal stability of CCHHS.²⁶

As CCHHS moves toward an MCCN model, one that is administered by an MCO, a number of challenges present themselves. CCHHS will need adequate oversight of their contract with IlliniCare to ensure that the savings from improving care and health of patients are appropriately reinvested into improving care and the health of the patient panel. During the course of the three-year, $1.58 billion IlliniCare contract, (with the possibility for two one-year extensions, a modification from the original, 5-year, $1.8 billion contract, according to a recent report in Crain’s), CCHHS may also attempt to gain the necessary staffing, competencies, and systems to eventually manage the MCCN internally, without contracting with an MCO, which may provide greater efficiency by removing the cost of the outsourced MCO’s corporate profit.²⁷ This may allow these additional funds to be invested into improvement of patient care, prevention efforts, and CCHHS’ public health and ambulatory community-based infrastructure.

Supporters of the CCHHS system must continue to advocate for the investment of public dollars into the system to support the uninsured ($500 million) and the services, including the Cermak Jail and Cook County Temporary Detention Center health services (total of $70 million annually) and public health services ($11 million annually) that are core to the mission of the health system. The 2015 expected system deficit of $168.9 million will be provided by the County only if advocates work to ensure that County Board members vote for this subsidy. Advocates should make their voices heard with the Independent Board, which is adding four new members this fall, as it develops budgets and priorities, and with the full Cook County Board, which has final approval over the budget and membership on the Independent Board of the Health System.

“Path to Transformation” Statewide Medicaid 1115 Waiver

The State-wide Medicaid 1115 Waiver application, which was sent to the Center for Medicare and Medicaid Services (CMS) on June 4, 2014 and is currently being negotiated, has a number of initiatives that in addition to changing the way that Medicaid will be administered in the State, seek to provide funding and other supports to safety net institutions. Because the 1115 Waiver is focused on Medicaid, if approved, it will have a significant impact on safety net institutions and the populations they serve. Below are some of the main highlights of parts of the waiver that will impact safety net institutions.

- **Delivery System Reform Incentive Payments (DSRIP)** in the amount of $100 million per year each to both CCHHS and the University of Illinois Hospital and Health System (UIHHS).
  - Over the course of the waiver, CCHHS plans to use its $100 million in annual DSRIP payments to:
    1) lead a partnership to increase outpatient service availability and improve efficiency; 2) redirect resources to more appropriate locations for primary care, subspecialty consultation and diagnostics; 3) collaborate with the University of Illinois College of Nursing to improve CCHHS workforce capacity and competency; 4) develop a community health worker residency program and collaborate on other training programs to address workforce shortages; 5) integrate behavioral health and primary care; 6) promote continuity of care for the justice-involved population; and 7) address food insecurity.
  - Over the course of the waiver, UIHHS plans to use its $100 million in annual DSRIP payments to:
    1) create comprehensive, integrated health care delivery systems, along with payment reforms to support them; 3) ensure additional supports and services for people with specific needs; 4) ensure an adequate workforce that has the appropriate education, training, and compensation to staff integrated delivery systems and enhance public health; 5) expand the state’s leadership role in promoting continuous improvement in public health and health care systems.

- **Workforce Training:**
  Relevant to safety net health systems, Illinois’ 1115 waiver proposes to invest significantly in meeting health workforce needs, specifically targeting Health Professional Shortage Areas (HPSAs). This is described in more detail within the workforce section below, but briefly, the five main investment initiatives are:
  - $10 million annually in a loan repayment program
  - $10 million annually in a new GME funding program, modeled on the Teaching Health Center (THC) model that was set up with the ACA
  - $20 million for Safety Net and Critical Access hospital loan repayment pool
  - $26 million annually in incentive-based payments to facilities that meet specified health workforce needs in designated medical specialties
  - Investments in health workforce training and curriculum testing, of $25 million in year one, followed by $50 million for each of years 2-5 of the waiver
• **Hospital Access Assurance Program:** As Medicaid expansion reduces uncompensated costs, the passage of the ACA also included reductions in disproportionate share hospital (DSH) payments that provided payments to safety net hospitals. Still, hospitals will continue to have uncompensated costs both from Medicaid payments that don’t cover costs of care and from providing care to people who remain uninsured. The hospital assessment and Medicaid-funded upper payment limit (UPL) system of payments to hospitals which would be phased out as Illinois continues to move toward a capitated payment system within managed care, will be continued under a different structure within the 1115 waiver. The proposal is to use the current funding structure in the State’s Medicaid plan and move toward a system of reimbursement based on uncompensated care costs, helping support access to hospital services to those without insurance.

**Workforce**

State health reform is dependent upon a health workforce capable of delivering high-quality, culturally competent care in all communities. A number of state-level initiatives have been undertaken within the last few years, some of which have produced agendas that are currently being acted upon and others that are still underway (described below, including overlapping recommendations).

**HCRIC Workgroup on Workforce Report**

The HCRIC, which is described in detail above, included a Workgroup on Workforce, which produced a report focused on addressing workforce shortages in Illinois. The workgroup was charged with assessing healthcare workforce capacity in the state, identifying workforce needs to achieve health care reform, facilitated by the ACA, and to recommend both immediate and short-term strategies to meet these needs. The group published a report in January 2014 with 23 recommendations, divided into three categories: Policy Development, Scope of Practice, and Curriculum Development.

Significant overlap exists among the HCRIC and other health workforce efforts in the state. These include, but are not limited to: the development of the community health worker (CHW) model, a bridge course curriculum model of integrating the veteran military-trained health workforce, telehealth expansion, loan repayment programs, scope of practice review processes, interprofessional education, pipeline programs, and graduate medical education programs.

**Illinois Alliance for Health Plan**

To help meet Illinois’ health workforce needs, the Illinois Alliance for Health Plan has four main goals:

1. Create new and sustainable health care worker roles and ensure that all health care workers are paid at a living wage
2. Ensure that medical professionals work at the top of their training and education
3. Create capacity in underserved communities
4. Promote team-based care within integrated delivery systems
To this end, a number of policy recommendations were proposed, including revising scope of practice regulations to allow health workers to practice to the greatest extent of their competence. Noting the important role of different front line workers, the proposal emphasizes the importance of passing laws related to community health workers training and certification and work toward expanded training and integration of home care aides. The Alliance plan also emphasized the need to strengthen the health career pipeline, ensure a living wage for health care workers, sustainable funding for loan repayment for both primary care and specialty capacity, exploration of ways to integrate veterans with health provision background into the civilian workforce, and supporting allocation of GME dollars to encourage the medical home model.

“Path to Transformation” Statewide Medicaid 1115 Waiver

The State’s 1115 waiver application provides evidence of the significant need in Illinois for workforce investments, including that 28.5% of Illinois residents live in an area that has been designated as a primary care Health Professional Shortage Area (HPSA), compared to the national median of 18.6%. The State is also behind the national medians for physician assistants and nurse practitioners per 100,000 people. Because the waiver is specific to Medicaid, the authors also note that only 64.9% of Illinois physicians reported that they accept Medicaid patients in 2011, far below the national median of 76.4%.

- As listed before in the Safety Net section, Illinois’ 1115 waiver proposes to invest significantly in meeting health workforce needs, specifically targeting Health Professional Shortage Areas (HPSAs):
  - $10 million annually in a loan repayment program
  - $10 million annually in a new GME funding program, modeled on the Teaching Health Center (THC) model that was set up with the ACA
  - $20 million for Safety Net and Critical Access hospital loan repayment pool
  - $26 million annually in incentive-based payments to facilities that meet specified health workforce needs in designated medical specialties
  - Investments in health workforce training and curriculum testing, of $25 million in year one, followed by $50 million for each of years 2-5 of the waiver

- The 1115 waiver application also notes the state’s commitment to the following, via both the HCRIC and the IWIB:
  - Create new and sustainable health care worker roles and ensure that all health care workers are paid a living wage
  - Enable medical professionals to work at the top of their training and education
  - Create capacity to serve underserved communities
  - Promote team-based care within integrated delivery systems

- The 1115 waiver application provides some funding models for CHWs and encourages the use of CHWs, for example, the CHW residency program proposed for CCHHS.

Illinois Workforce Investment Board (IWIB) Health Care Task Force (Draft report):
The Illinois Workforce Investment Board (IWIB) established the Healthcare Task Force in April 2004 to develop recommendations for addressing the causes of healthcare worker shortages in Illinois identified
by the Critical Skill Shortages Initiative (CSSI) and other national and state studies and initiatives. When organized in 2004, the task force first undertook a study focused solely on the nursing profession. The IWIB facilitates workforce development services and programs to help meet the workforce needs of Illinois employers and workers. To meet this directive, the IWIB, in accordance with federal legislation, includes leaders from state, business, industry, labor, education, and community-based organizations. Through a working group structure and one standing steering committee, representatives from the mandated and optional private/public partner programs develop recommendations for the full IWIB’s consideration.

The IWIB Health Care Task Force, reconvened in 2013 to focus more broadly on general healthcare workforce needs, identifying major trends and new directions in the healthcare workforce, and to make recommendations to ensure Illinois has the healthcare workforce it needs. This effort has been led by the Illinois Department of Commerce and Economic Opportunity, in conjunction with the Illinois Department of Public Health.

The IWIB Health Care Task Force divided itself into five working groups:

- Working Group 1: Effects of Changes in Health Care Delivery on Occupational Demand
- Working Group 2: Scope of Practice Issues
- Working Group 3: Front-line Paraprofessionals
- Working Group 4: Inter-professional Education and Practice
- Working Group 5: Regional Strategies to Address Workforce Shortages

A final report and recommendations from the Health Care Task Force will be presented to the broader IWIB in September 2014.

Appendix B contains a chart summarizing the intersecting and complementary recommendations arising from these workforce initiatives.

**Community Health Worker Advisory Board Act**

In the Spring 2014 Session, the Illinois General Assembly passed House Bill 5412, DPH Community Health Workers, now Public Act 098-0796 Community Health Worker Advisory Board Act, which adopts the American Public Health Association’s definition of a CHW and establishes an advisory board to consider essential core competencies and develop a report with recommendations for a certification process for CHWs. The Bill was introduced by State Representative Robyn Gabel and was developed along with stakeholders, including the Community Health Worker Local Network and Health & Medicine Policy Research Group, in consultation with both the Governor’s Office and the Illinois Department of Public Health.

The State has prioritized the integration of Community Health Workers into interdisciplinary teams of care through a number of reports related to workforce, including the HCRIC Workgroup on Workforce Report, the forthcoming report from the IWIB Workforce Task Force, which included a working group focused on Front-line Paraprofessionals, the Alliance for Health Plan, and the Statewide Medicaid 1115
Waiver. Under the GOHIT Workforce committee there is a sub-committee charged with developing recommendations to the newly forming Advisory Committee.

There is relatively broad recognition of CHWs as valuable parts of interdisciplinary care teams, able to help people navigate the health system and to better assist people in addressing or adapting to the social determinants of health, and in so doing, improving health, reducing the costs of care, and improving the health of the public. By setting up certification, adopting a definition, and encouraging the adoption of the CHW model through prioritization in health reform initiatives, the State is hoping to make the CHW model more sustainable than its current usage in Illinois, which tends to be grant-funded, through making CHW services reimbursable by payers and helping employers to see the value of employing CHWs.

Other Cross-cutting Initiatives

State Health Improvement Plan (SHIP)
Illinois statute requires that the State have a State Health Improvement Plan (SHIP) that provides a list of priorities for public health improvement in the state, improving health systems, and focusing public health efforts on prevention. The SHIP’s vision is “Optimal physical, mental and social well-being for all people in Illinois through a high-functioning public health system comprised of active public, private and voluntary partners.” The SHIP includes an Implementation Coordination Council (ICC), which works to achieve state policy alignment with the SHIP, reaches out to potential partners, including private partners, monitors and evaluates progress, and coordinates state agency involvement.

In addition to nine specific health priority areas, there are five health systems priorities listed in the SHIP:

- Improve access to health services
- Enhance data and health information technology
- Address social determinants of health and health disparities
- Measure, manage, improve and sustain the public health system
- Assure a sufficient workforce and human resources

Implications for Policy-Makers and Advocates
An often stated goal of health care reform is ‘breaking down silos.’ The silos within the delivery system, however, have a tendency to re-emerge in various guises amid debate and implementation of reforms themselves. While it is impossible for each individual stakeholder in these debates can master the complex array of programs, rules, and issues involved in the health care delivery and financing system, we believe it is important to approach reform initiatives as parts of a potentially comprehensive whole. To that end of course, we recognize the importance of modesty and openness to critique and guidance from our readers. We have, of course, left out some important topics and neglected key areas of overlap
or interaction between various reforms and existing systems. It is our hope that this document start rather than end conversations and be viewed as neither definitive nor polemical, but as, broadly speaking, a cooperative intellectual exercise that can mirror and influence the decisions that will produce the next iteration of the health care delivery system that we will all one day rely on for our own health and well-being.
Appendix A

Reform Initiatives and Potential Impact on LTSS and the Safety Net

<table>
<thead>
<tr>
<th>Reform Initiative</th>
<th>Potential Effect on Long-Term Services and Supports</th>
<th>Potential Effect on Safety Net</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Coordination: Managed Care Organizations</td>
<td>• Medicaid-only older adults and people with disabilities must choose a Medicaid health plan</td>
<td>• Safety net providers must choose whether to contract with health plans</td>
</tr>
<tr>
<td>• Integrated Care Program (ICP) (Medicaid-only)</td>
<td>• Providers, including community-based LTSS providers, must choose whether to contract with plans</td>
<td>• Health plan contracts set rates, reporting requirements and possibly quality metrics</td>
</tr>
<tr>
<td>• Medicare-Medicaid Alignment Initiative (MMAI) (dual eligible)</td>
<td>• Plan staff will perform assessments and service planning (though not determine eligibility) for LTSS</td>
<td>• Patients may lose access to safety net providers they are accustomed to using if they aren't in-network</td>
</tr>
<tr>
<td></td>
<td>• Health plans have incentives to defect and divert people from institutional care</td>
<td>• Safety net providers will face additional administrative burdens from multiple billing, prior authorization, and contract management for multiple Medicaid plans</td>
</tr>
<tr>
<td></td>
<td>• New roles for plans, providers, state agencies, and consumers within networks designed to integrate primary, acute and LTC</td>
<td>• Managed care networks can provide new opportunities to form partnerships and coordinate with other providers</td>
</tr>
<tr>
<td></td>
<td>• Highly specialized services for people with developmental disabilities will eventually be included in managed care, a new challenge for which there are no clear, replicable models from other states or other populations</td>
<td>• Managed care organizations can reimburse for value-adding services that FFS Medicaid does not pay for, like community health workers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Many newly insured have complicated, heretofore untreated medical conditions placing strain on already stretched systems of care</td>
</tr>
<tr>
<td>Care Coordination: Providers</td>
<td>• CCEs can focus on certain populations. Some target people with severe mental illness, older adults or people with disabilities.</td>
<td>• CCEs and ACEs give safety net providers opportunities to build integrated networks themselves</td>
</tr>
<tr>
<td>• Care Coordination Entities</td>
<td></td>
<td>• Preparing for the shift to risk-</td>
</tr>
<tr>
<td>• Accountable Care Entities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• CountyCare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


- Some LTSS users will have the option to enroll in a CCE and some may be auto-enrolled.
- CCEs will continue to be paid on a fee-for-service basis and receive a monthly care coordination fee.
- CCE members will provide additional assessment and coordination services.
- LTSS providers will have to choose whether to partner with CCEs.
- CountyCare in particular will affect the provision of mental health and substance use disorder treatment services, especially for detainees in Cook County Jail. As a managed care entity CountyCare aims to link individuals with mental illness or substance use disorder to community-based providers and coordinated that care with primary and acute care services.

| Governor’s Office of Health Innovation and Transformation | In concert with the structural reforms to the LTSS system through BIP, new CMS rules on HCBS setting and planning, and the strategies developed during the Olmstead consent decree implementation, the 1115 waiver will change the way individuals access HCBS.
- Common array of services available to all, including individuals with mental illness and substance use disorders, based on need instead of narrow menus of services based on disability-status
- The 1115 waiver would reduce or eliminate the PUNS waiting list for DD services. |
| The 1115 waiver protects hospital UPL payments under managed care and makes funds available specifically for safety nets to provide services to vulnerable populations and loan repayment for workforce. |
| The Alliance and the 1115 include strategies to drive the development of integrated delivery systems. Safety nets face distinct challenges in adapting to the expectations of IDS due to capital access, physician relationships, and leadership capacity |
- Quality-based payments for HCBS providers
- Health Homes for Adults with serious mental illness
- Incentive pool for MCOs to ensure stable housing for individuals with SMI/SUD
- The 1115 waiver and Alliance for Health Plan present a challenge to ensuring consumer protections in the newly forming integrated delivery systems
- They also present a new regulatory challenge for the Department of Insurance, as providers become risk-bearing entities carrying out some traditional insurer functions
## Appendix B

### Recent Illinois Health Workforce Initiative Recommendations

#### Summary Chart

This chart summarizes the recommendations from several recent State health workforce initiatives in Illinois. Where any initiative identifies a recommendation, it is indicated by an “X”. In many cases, more than one initiative identifies the same or similar recommendation and “Xs” are in each of the relevant columns. The first column includes recommendation categories, meant to show similar overlapping and complementary recommendations within the given category. This report will continue to be updated as taskforces meet and federal agreements are negotiated.

<table>
<thead>
<tr>
<th>Recommendation Categories</th>
<th>Workforce Recommendations</th>
<th>Planning Initiatives</th>
<th>Initiatives with Potential Implementation Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Career Pathways</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Encourage development, integration, and employment of CHWs</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td></td>
<td>Adopt or develop career pathway model for: Community Health Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Adopt or develop career pathway model for: Home Health Aides (including Enhanced Home Health Aides)</td>
<td><strong>X</strong></td>
<td><strong>X</strong></td>
</tr>
<tr>
<td></td>
<td>Adopt or develop career pathway model for: Medical Assistants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**HCRIC Workforce Report**

<table>
<thead>
<tr>
<th>Planning Initiatives</th>
<th>Initiatives with Potential Implementation Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Alliance for Health Planning Grant Report</em> ($2 million planning grant)</td>
<td><strong>Statewide Medicaid 1115 Waiver Application</strong> (Potential $5 billion over 5 years)</td>
</tr>
<tr>
<td><em>IWIB Health Care Task Force Report</em> (Draft Report - Final Report Pending)</td>
<td><strong>Alliance for Health Implementation Grant Application</strong> (Potential $100 Million)</td>
</tr>
</tbody>
</table>
### Curriculum and Training Recommendations

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Forthcoming</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthen bridge program within nursing profession.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bridge course curricula between military training and Illinois Practice Requirements</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Encourage interprofessional education within health professions schools</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Illinois should support adoption of Community Health Worker curricula – such as the 3-tiered curricula developed at South Suburban College and approved by the ICCB – at community colleges in all regions of the state.</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Interprofessional Education &amp; Collaboration (IPEC) Readiness Survey should be disseminated again through a state sponsored site in order to attempt to gain additional responses.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Adopt a Nurse Licensure Compact</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue statewide efforts to streamline licensing/credentialing process for Veterans</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facilitate use of telehealth</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Form methods for tracking emergence of new job niches and potential for control of practice standards</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Utilize Peer counselors as members of care team</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Consider extending increase in Medicaid reimbursement rates for PCPs to mid-level providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Category</td>
<td>Action</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Expand the roles of home care aides and integrate them into teams</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Explore use of community paramedics, who train to and provide treatment in the home when possible</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Expand access to and facilitate provision of specialty care</strong></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Careers Pipeline</strong></td>
<td><strong>Strengthen health careers pipeline</strong></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td></td>
<td>Develop coordinated exposure and enrichment programs aimed at K-12 students.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Continue development of pipeline models and experiences that emphasize interprofessional education and collaborative practice; provide professional development for educators and health care professionals to assist in expanded implementation of these models.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td><strong>Loan Repayment and Scholarships</strong></td>
<td>Funding for State's medical school scholarship program</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identify sustainable state or federal funding for student loan repayment</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Develop a Graduate Medical Education pilot program aimed at addressing the unmet primary care needs of the state</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong></td>
<td>Promote team-based care within integrated delivery systems</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ensure health care workers are paid a living wage</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Health and Medicine Policy Research Group
September 2, 2014
<table>
<thead>
<tr>
<th>Health and Medicine Policy Research Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2, 2014</td>
</tr>
</tbody>
</table>

| Implement a number of workforce supply and demand tracking, data sharing, and other changes to identify and respond to health workforce shortages and surpluses across different worker categories. |  |  | X |  |

| Policy, Legislation, and Regulation Changes | Explore regulation of medical assistants by professional board or IDFPR; research transfer of veterans' credentials, as happens with CNAs |  | X |  |
| Restructure behavioral health services for publicly funded consumers |  | X |  | X |

<p>| Scope of Practice Changes and Recommendations | Create a method/process to research and handle scope of practice change proposals and bills |  | X |  |
| Meet medication administration needs through workforce scope of practice changes |  | X |  |  |
| Research and clarify privileging process for advanced practice nurses |  |  |  | X |
| Consider reintroducing legislation to expand SOP of dental hygienists to provide preventive oral health services under collaborative agreement |  | X |  |  |
| Change scope of practice to allow practitioners to practice at the top of their education and training |  | X |  | X |</p>
<table>
<thead>
<tr>
<th>Task</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop evidence-based methods to measure both the movement of</td>
<td>X</td>
</tr>
<tr>
<td>healthcare delivery (particularly ambulatory care) toward team-</td>
<td></td>
</tr>
<tr>
<td>based care, and the results of that movement re: patient-health</td>
<td></td>
</tr>
<tr>
<td>outcomes and cost savings.</td>
<td></td>
</tr>
<tr>
<td>Examples of collaborative agreements under which scopes-of-</td>
<td>X</td>
</tr>
<tr>
<td>practice have been delineated to provide for more effective team-</td>
<td></td>
</tr>
<tr>
<td>based approaches should be made available.</td>
<td></td>
</tr>
<tr>
<td>A visual representation of the overlapping scope-of-practice areas</td>
<td>X</td>
</tr>
<tr>
<td>for licensed (and scope-of-work areas for non-licensed) staff</td>
<td></td>
</tr>
<tr>
<td>should be developed.</td>
<td></td>
</tr>
<tr>
<td>A coterie of Level 3 NCQA-recognized practices exist in the state;</td>
<td>X</td>
</tr>
<tr>
<td>these should be queried or surveyed to help develop a baseline of</td>
<td></td>
</tr>
<tr>
<td>best practices for staffing, staff functions, and collaboration &amp;</td>
<td></td>
</tr>
<tr>
<td>delegation procedures within team-based settings.</td>
<td></td>
</tr>
</tbody>
</table>