CHAMPAIGN COUNTY MENTAL HEALTH BOARD

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

Champaign County Developmental Disabilities Board (CCDDB) AGENDA
Wednesday, November 20, 2013
Brookens Administrative Building
Lyle Shields Room
1776 E. Washington St., Urbana, IL 61802
8:00AM

1. Call to Order – Ms. Elaine Palencia, President
2. Roll Call – Stephanie Howard-Gallo
3. Additions to Agenda
4. Citizen Input
5. CCMHB Input
6. Approval of CCDDB Minutes
   A. 10/23/13 Board Meeting*
      Minutes are included in the packet. Board action is requested.
7. President's Comments – Ms. Elaine Palencia
8. Executive Director's Comments – Peter Tracy
9. Staff Report – Lynn Canfield
   Included in the Board packet.
10. Agency Information
11. Financial Report
    A. Approval of Claims*
       Included in the Board packet. Action is requested.
12. New Business
    A. Concept Paper for 1115 Waiver for Illinois Medicaid
       For information and comment.
13. Old Business
    A. CCDDB Retreat January 25, 2014
    B. Draft Three Year Plan 2013-2015 with FY 2014 Objectives*
       A copy of the draft Plan is included in the packet, with suggestions incorporated. A Decision Memorandum is included in the packet. Action is requested.
    C. CCDDB FY15 Allocation Criteria*
       A Decision Memo is included in the packet. Action is requested.
    D. CCMHB FY15 Allocation Criteria

A Decision Memo is included in the packet for information only. This is to be presented to the CCMHB later today for action.

E. Disability Resource Expo

A report from Ms. Bressner is included in the packet.

F. Ligas Update

Documents include a flyer for this evening's presentation by Tony Records, The First Annual Report of the Monitor, Ed McManus' November 3rd newsletter, and Peter Tracy's March 20th letter to Mr. Records.

14. Board Announcements
15. Adjournment

**Board action requested*

6.A.

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY (CCDDB) BOARD MEETING

Minutes –October 23, 2013

Brookens Administrative Center
Lyle Shields Room
1776 E. Washington St.
Urbana, IL

8:00 a.m.

MEMBERS PRESENT:	Joyce Dill, Phil Krein, Elaine Palencia, Mike Smith, Sue Suter
STAFF PRESENT:	Peter Tracy, Lynn Canfield, Nancy Crawford, Mark Driscoll, Stephanie Howard-Gallo
OTHERS PRESENT:	Patty Walters, Danielle Matthews, Dale Morrissey, Developmental Services Center (DSC); Linda Tortorelli, Vicki Niswander, Jennifer Knapp, Community Choices (CC); Kathy Kessler, Community Elements (CE); Glenna Tharp, PACE; Tracy Parsons, ACCESS Initiative (AI) Barb Bressner, Consultant; Dennis Carpenter, Charleston Transition Facility (CTF); Theresa O'Connor, Sally Mustered, David and Lisa Happ, C-U Autism Network (CUAN); Barb and Jeff Jewett, Parents; Tracy Parsons, ACCESS Initiative

CALL TO ORDER:

Ms. Elaine Palencia called the meeting to order at 8:00 a.m.

INTRODUCTION OF NEW BOARD MEMBER:

Philip Krein and Joyce Dill were introduced as new Board members.

ROLL CALL:

Roll call was taken and a quorum was present.

ADDITIONS TO AGENDA:

None.

CITIZEN INPUT:

Mr. David Happ from Philo, IL spoke regarding the lack of adult residential placement in the area for his daughter who is currently residing out of state. He encouraged the Board to encourage local providers to offer more jobs, day programs and residential programs.

Ms. Vicki Niswander informed the Board that the Governor's Office and Health and Family Services is in the process of writing a waiver and it will replace all eight Medicaid waivers in the state.

Ms. Barb Jewett from Mahomet spoke regarding the lack of residential placement in the area for her son. She encouraged the Board to increase residential capacity in the County and to encourage creative programming in the future.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD (CCMHB) INPUT:

The CCMHB will meet later today.

APPROVAL OF MINUTES:

Minutes from the July 17, 2013 Board meeting were included in the packet.

MOTION: Ms. Suter moved to approve the minutes from the July 17, 2013 Board meeting. Mr. Smith seconded and the motion passed unanimously.

PRESIDENT'S COMMENTS:

Ms. Palencia expressed her appreciation for the organization of the Disability Resource Expo and the Public Hearing on Intellectual Disabilities and Developmental Disabilities.

EXECUTIVE DIRECTOR'S REPORT:

Mr. Tracy requested input on allocation priorities for FY 2015. He also reviewed the allocation schedule for the coming year.

STAFF REPORT:

Ms. Canfield's staff report was deferred.

AGENCY INFORMATION:

None.

FINANCIAL INFORMATION:

Approval of Claims:
A copy of the claims report was included in the Board packet for action.

MOTION: Mr. Smith moved to accept the claims report as presented. Mr. Krein seconded the motion. The motion passed unanimously.

NEW BUSINESS:

Election of Officers:

MOTION: Ms. Dill moved for Mr. Smith to serve as Secretary for the CCDDB. Mr. Krein seconded the motion. A voice vote was taken and the motion passed unanimously.

Draft FY 13 Program Performance Outcomes:
A summary of all funded agency utilization data and performance measure outcome reports for FY 13 was included in the packet for information only.

Draft Three Year Plan 2013-2015 with FY 2014 Objectives:
A Briefing Memorandum and Draft Three-Year Plan with Objectives for FY 2014 are included in the packet. Comments are encouraged from stakeholders, families and the Board. The final draft will be presented for action at the November 20, 2013 meeting.

FY 15 Draft Allocation Criteria:
A Briefing Memorandum was included in the Board packet. The draft criteria described in this memorandum are to be used as guidance by the Board in assessing applications for CCDDB funding. However, they are not the sole consideration taken into account in finalizing funding decisions. Other considerations would include the judgment of the Board and its staff, opinion about the provider's ability to implement the program and services proposed, the soundness of the proposed methodology, and the administrative and fiscal capacity of the agency. Further, to be eligible to receive CCDDB funds, applications must reflect the Board's stated goals and objectives as well as the operating principles and public policy positions taken by the Board.

The final funding decisions rest with the CCDDB and their judgment concerning the most appropriate and efficacious use of available dollars based on assessment of community needs, equitable distribution across disability areas, and decision-support match up. The final document will be presented at the November 20, 2013 Board meeting for approval.

Ms. Dill expressed her belief that the needs of people should be the priority when considering funding CCDDB programs. Mr. Krein expressed there are significant limits on what the CCDDB will be able to fund this year.

Draft Meeting Schedule and FY 15 Allocation Schedule:
Drafts of a meeting schedule and a schedule with subjects and allocation timeline was included in the Board packet for review.

OLD BUSINESS:

Disability Resource Expo:
Ms. Bressner provided a verbal wrap –up of the Disability Resource Expo.

Public Hearing on Intellectual and Developmental Disabilities:
From the September 18 event, Stakeholder's Consolidated Statement, Melissa Picciola's PowerPoint Presentation, Court Reporter's Transcript, and additional submitted written testimony were included in the packet.

BOARD ANNOUNCEMENTS:

A CCDDB retreat will be tentatively scheduled for January 25, 2014.

ADJOURNMENT:

The meeting adjourned at 8:27 a.m.

Respectfully Submitted by: Stephanie Howard-Gallo

**Minutes are in draft form and subject to CCDDB approval.*

(9)

Lynn Canfield, Associate Director for Developmental Disabilities
Staff Report – November 20, 2013

Three Year Plan and FY2015 Funding Priorities: Final drafts of these documents are included in the packet. Input was sought from a wide variety of stakeholders, including advocates, board members, and all provider agencies with currently funded programs. I plan to meet with self-advocates affiliated with Community Choices, PACE, and Developmental Services Center prior to the November 20 meeting for their input; one contacted me privately regarding her preferences.

FY2014 Contracts and FY2013 Program Monitoring: Early in FY14, the amendment process was completed for several contracts, for various purposes: Community Choices' office address is now the permanent mailing address; some Developmental Services Center's contracts were renamed ("Care Management" is now "Service Coordination," "Non-Medicaid Employment Services" is "Community Employment," and "Non-Medicaid Developmental Training" is now "Integrated and Site-Based Day Services"); decreases to contract maximums of the agency's Clinical, Family Development Center, and Community Employment programs balanced an increase for ISB Day Services, as the population served includes a portion originally described until Non-Medicaid Employment Services. The two new fee-for-service contracts, Augmented Employment Services and Augmented Developmental Training, may still require amendments for similar adjustment, and billings to date are being studied to determine an accurate proportion. I was able to join Ms. Suter and Dr. Krein for meetings of the CU Autism Network and the Down Syndrome Network, a program visit at Community Elements, and a tour of Charleston Transitional Facility's Devonshire CILA (conducted by a resident), and Ms. Suter for tours and summaries of Developmental Services Center programs. These activities complemented the FY13 monitoring process, which Stephanie Howard-Gallo and I completed during summer.

FY2014 Quarterly Reports and FY2013 Annual Reports: FY13Annual Performance Outcome, Fourth Quarter Financial, and Personnel Reports were submitted and reviewed, with some clarifications requested and received. Several documents uploaded to the system were in file formats incompatible with our own and had to be emailed or hand-delivered separately, an issue later discussed with the website consultant (below). My summary of performance outcomes for all Intellectual Disability/Developmental Disability related programs appeared in the October board packet; feedback on this document led me to consider the impact of reporting requirements on individuals served as I began entering data from the FY14 First Quarter reports, with newly required information on persons served and volume of direct support hours. The parent networks may consider changing their utilization targets for FY15, to align more closely with the purposes of their meetings, events, and outreach efforts where demographic data collection has proved challenging. Some FY14 First Quarter reports required clarification or were missing required data; agency reporters are working with me to complete these.

Online Application and Reporting System: Mark Driscoll and I met with the application/reporting site's consultant for discussion of changes to application and report forms and for possible system

enhancements which would improve fee-for-service reporting and tracking. We continue to provide technical support to agency users as needed and to consider modifications based on their experiences with the site.

Anti-Stigma Alliance and Disability Resource Expo: As the 2013 Expo wrapped up, I resumed discussion of ideas offered by the Anti-Stigma Alliance planning group and the Ebertfest Coordinator for next year's festival, scheduled for April 23 through 27. With the Illinois Marathon on the 26th and Community Elements no longer across from the Virginia, our art show, which is becoming a tradition, will be very different; under consideration are an outdoor market-styled exhibit and sale and installations of Anti-Stigma artists' work in Ebertfest spaces. Relatedly, I've engaged stakeholders who value these events as opportunities for entrepreneurship to discuss other ways to support the artists, including in more integrated spaces.

Other Activity: In addition to researching person-centered planning models (e.g., Essential Lifestyles Planning), I have continued to read about Employment First in states with existing legislation, strategic plans, and executive orders and to engage in discussion with providers and stakeholders about direction, including the features of ID/DD service delivery outside of Illinois. In addition to activities noted above, I have attended: DSC's 2013 Recognition Event & Tree of Hope Campaign Kick-Off, The Chancellor's 28th Annual Celebration of Diversity, planning meetings for Parkland's November 15th PTSD event, ACHMAI Membership Meeting and ID/DD Subcommittee teleconferences, Metropolitan Intergovernmental Council quarterly meeting, Champaign-Urbana Cradle to Career meeting, Birth to Six Council meeting, Mental Health Agencies Council meeting, Quarter Center Admin Team Meeting, conversations with Detective Joel Sanders, Mark Driscoll, and Chief Patrick Connolly on ongoing work of the Crisis Intervention Team to improve responses where mental health is a factor, and ACCESS' Community Forum.

Ligas, PUNS, and Unmet Need: Data sorted for Champaign County, from the DHS website's October 15 update, is added below.

2/1/11:	**194** with emergency need; of **269** in crisis, **116** recent or coming grads.
4/5/11:	**198** with emergency need; of **274** in crisis, **120** recent or coming grads.
5/12/11:	**195** with emergency need; of **272** in crisis, **121** recent or coming grads.
6/9/11:	**194** with emergency need; of **268** in crisis, **120** recent or coming grads
10/4/11:	**201** with emergency need; of **278** in crisis, **123** recent or coming grads.
12/5/11:	**196** with emergency need; of **274** in crisis, **122** recent or coming grads.
5/7/12:	**222** with emergency need; of **289** in crisis, **127** recent or coming grads.
9/10/12:	**224** with emergency need; of **288** in crisis, **131** recent or coming grads.
10/10/12:	**224** with emergency need; of **299** in crisis, **134** recent or coming grads.
1/7/13:	**225** with emergency need; of **304** in crisis, **140** recent or coming grads.
2/11/13:	**226** with emergency need; of **308** in crisis, **141** recent or coming grads.
6/10/13:	**238** with emergency need; of **345** in crisis, **156** recent or coming grads.
10/15/13:	**244** emergency; **378** in crisis, with **160** exiting school in the past 10 or the next 3 years.

County: Champaign

Reason for PUNS or PUNS Update	
New	166
Annual Update	90
Change of category (Emergency, Planning, or Critical)	15
Change of service needs (more or less) - unchanged category (Emergency, Planning, or Critical)	16
Person is fully served or is not requesting any supports within the next five (5) years	132
Moved to another state, close PUNS	5
Person withdraws, close PUNS	16
Deceased	3
Other, supports still needed	1
Other, close PUNS	75

EMERGENCY NEED(Person needs in-home or day supports immediately)	
1. Individual needs immediate support to stay in their own home/family home (short term - 90 days or less); e.g., hospitalization of care giver or temporary illness of an individual living in their own home.	8
2. Individual needs immediate support to stay in their own home/family home or maintain their employment situation (long term); e.g., due to the person's serious health or behavioral issues.	26
3. Care giver needs immediate support to keep their family member at home (short term - 90 days or less); e.g., family member recuperating from illness and needs short term enhanced supports.	6
4. Care giver needs immediate support to keep their family member at home (long term); e.g., care giver is permanently disabled or is terminally ill and needs long term enhanced supports immediately to keep their family member at home.	15

EMERGENCY NEED(Person needs out-of-home supports immediately)	
1. Care giver is unable or unwilling to continue providing care (e.g., person has been abandoned).	31
2. Death of the care giver with no other supports available.	4
3. Person has been commited by the court or is at risk of incarceration.	2
4. Person is living in a setting where there is suspicion of abuse or neglect.	5
5. Person is in an exceedingly expensive or inappropriate placement and immediately needs a new plaec to live (for example, an acute care hospital, a mental health placement, a homeless shelter, etc.).	10
6. Other crisis, Specify:	137

CRITICAL NEED(Person needs supports within one year)	
1. Individual or care giver will need support within the next year in order for the individual to continue living in their current situation.	40
2. Person has a care giver (age 60+) and will need supports within the next year.	24
3. Person has an ill care giver who will be unable to continue providing care within the next year.	6
4. Person has behavior(s) that warrant additional supports to live in their own home or family home.	39
5. Individual personal care needs cannot be met by current care givers or the person's health has deteriorated.	7
6. There has been a death or other family crisis, requiring additional supports.	3
7. Person has a care giver who would be unable to work if services are not provided.	27
8. Person or care giver needs an alternative living arrangement.	14
9. Person has graduated or left school in the past 10 years, or will be graduating in the next 3 years.	160
10. Person is living in an inappropriate place, awaiting a proper place (can manage for the short term; e.g., persons aging out of children's residential services).	2
11. Person moved from another state where they were receiving residential, day and/or in-home supports.	8
12. The state has plans to assist the person in moving within the next year (from a state-operated or private Intermediate Care Facility for People with Developmental Disabilites, nursing home or state hospital).	1
13. Person is losing eligibilty for Department of Children and Family Services supports in the next year.	5
14. Person is losing eligibility for Early Periodic Screening, Diagnosis and Treatment supports in the next year.	3
15. Person is losing eligibility for Intermediate Care Facility for People with Developmental Disabilities supports in the next year.	1
16. Person is losing eligibility for Medically Fragile/Technology Dependant Children's Waiver supports in the next year.	1
17. Person is residing in an out-of-home residential setting and is losing funding from the public school system.	1

20. Person wants to leave current setting within the next year.	5
21. Person needs services within the next year for some other reason, specify:	31

PLANNING FOR NEED(Person's needs for service is more than a year away but less than 5 years away, or the care giver is older than 60 years)

1. Person is not currently in need of services, but will need service if something happens to the care giver.	75
2. Person lives in a large setting, and person/family has expressed a desire to move (or the state plans to move the person).	1
3. Person is disatisfied with current residential services and wishes to move to a different residential setting.	1
4. Person wishes to move to a different geographic location in Illinois.	2
5. Person currently lives in out-of-home residential setting and wishes to live in own home.	1
6. Person currently lives in out-of-home residential setting and wishes to return to parents' home and parents concur.	2
8. Person or care giver needs increased supports.	68
9. Person is losing eligibility for Department of Children and Family Services supports within 1-5 years.	1
14. Other, Explain:	12

EXISTING SUPPORTS AND SERVICES

Respite Supports (24 Hour)	18
Respite Supports (<24 hour)	29
Behavioral Supports (includes behavioral intervention, therapy and counseling)	101
Physical Therapy	75
Occupational Therapy	130
Speech Therapy	157
Education	206
Assistive Technology	42
Homemaker/Chore Services	4
Adaptions to Home or Vehicle	6
Personal Support under a Home-Based Program, Which Could Be Funded By Developmental Disabilites, Division of Rehabilitation Services or Department on Aging (can include habilitation, personal care, respite, retirement supports, budgeting, etc.)	8
Medical Equipment/Supplies	14
Nursing Services in the Home, Provided Intermittently	4
Other Individual Supports	23

TRANPORTATION

Transportation (include trip/mileage reimbursement)	125
Other Transportation Service	64
Senior Adult Day Services	2
Developmental Training	79
"Regular Work"/Sheltered Employment	78
Supported Employment	40
Vocational and Educational Programs Funded By the Division of Rehabilitation Services	14
Other Day Supports (e.g. volunteering, community experience)	13

RESIDENTIAL SUPPORTS

Community Integrated Living Arrangement (CILA)/Family	5
Community Integrated Living Arrangement (CILA)/Intermittent	5
Community Integrated Living Arrangement (CILA)/Host Family	1
Community Integrated Living Arrangement (CILA)/24 Hour	33
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 16 or Fewer People	9
Intermediate Care Facilities for People with Developmental Disabilities (ICF/DD) 17 or More People	1
Skilled Nursing Facility/Pediatrics (SNF/PED)	4
Supported Living Arrangement	3
Shelter Care/Board Home	1
Children's Residential Services	6

Child Care Institutions (Including Residential Schools)	5
Other Residential Support (including homeless shelters)	8
SUPPORTS NEEDED	
Personal Support (includes habilitation, personal care and intermittent respite services)	249
Respite Supports (24 hours or greater)	81
Behavioral Supports (includes behavioral intervention, therapy and counseling)	145
Physical Therapy	96
Occupational Therapy	169
Speech Therapy	152
Assistive Technology	83
Adaptations to Home or Vehicle	30
Nursing Services in the Home, Provided Intermittently	7
Other Individual Supports	52
TRANSPORTATION NEEDED	
Transportation (include trip/mileage reimbursement)	254
Other Transportation Service	116
VOCATIONAL OR OTHER STRUCTURED ACTIVITIES	
Support to work at home (e.g., self employment or earning at home)	6
Support to work in the community	171
Support to engage in work/activities in a disability setting	177
RESIDENTIAL SUPPORTS NEEDED	
Out-of-home residential services with less than 24-hour supports	95
Out-of-home residential services with 24-hour supports	123

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 108 DEVLPMNTL DISABILITY FUND												
*** DEPT NO. 050 DEVLMNTL DISABILITY BOARD												
90	CHAMPAIGN COUNTY TREASURER MENT HLTH BD FND 090											
		10/09/13	05	VR	108- 89		494718	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OCT ADMIN FEE	26,460.00
											VENDOR TOTAL	26,460.00 *
5352	AUTISM SOCIETY OF ILLINOIS GRANTS											
		10/09/13	02	VR	108- 82		494737	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	AUTISM OCT	1,000.00
											VENDOR TOTAL	1,000.00 *
16011	CHARLESTON TRANSITIONAL FACILITY											
		10/09/13	02	VR	108- 84		494754	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	NURSING SVCS OCT	1,430.00
		10/09/13	02	VR	108- 84		494754	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	RESIDENTIAL OCT	3,042.00
											VENDOR TOTAL	4,472.00 *
18203	COMMUNITY CHOICE, INC											
		10/09/13	02	VR	108- 85		494760	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	CUSTOM EMPLOY OCT	4,167.00
		10/09/13	02	VR	108- 85		494760	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	COMMUNITY LIVNG OCT	4,583.00
											VENDOR TOTAL	8,750.00 *
18209	COMMUNITY ELEMENTS											
		10/09/13	02	VR	108- 86		494761	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	COORD OF SVCS OCT	2,922.00
											VENDOR TOTAL	2,922.00 *
22300	DEVELOPMENTAL SERVICES CENTER OF CHAMPAIGN COUNTY INC											
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	APARTMENT SVCS OCT	34,371.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	AUGMENTED DT OCT	14,850.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	AUGMENTED EMPLOY OC	12,150.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	CARE MANAGEMENT OCT	33,109.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	CLINICAL SVCS OCT	14,871.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	CONNECTNS TRANSI OC	7,083.00
		10/09/13	02	VR	108- 87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	FAM DEV CENTER OCT	8,547.00

VENDOR NO	VENDOR NAME	TRN DTE	B N	TR CD	TRANS NO	PO NO	CHECK NUMBER	CHECK DATE	ACCOUNT NUMBER	ACCOUNT DESCRIPTION	ITEM DESCRIPTION	EXPENDITURE AMOUNT
*** FUND NO. 108 DEVLPMNTL DISABILITY FUND												
		10/09/13	02	VR 108-	87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	INDIV/FAM SUPRT OCT	29,500.00
		10/09/13	02	VR 108-	87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	NON MEDICAL DT OCT	40,098.00
		10/09/13	02	VR 108-	87		494769	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	NON MEDICAID EMP OC	32,807.00
											VENDOR TOTAL	227,386.00 *
22816	DOWN SYNDROME NETWORK						C/O WENDY BARKER					
		10/09/13	02	VR 108-	83		494773	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	DOWN SYNDROME OCT	1,250.00
											VENDOR TOTAL	1,250.00 *
54930	PERSONS ASSUMING CONTROL OF THEIR						ENVIROMENT, INC					
		10/09/13	02	VR 108-	88		494823	10/10/13	108-050-533.92-00	CONTRIBUTIONS & GRANTS	OPPORT FOR INDEP OC	4,885.00
											VENDOR TOTAL	4,885.00 *
										DEVLMNTL DISABILITY BOARD	DEPARTMENT TOTAL	277,125.00 *
										DEVLPMNTL DISABILITY FUND	FUND TOTAL	277,125.00 *

12.A.

The Path to Transformation:

Concept Paper for an 1115 Waiver for Illinois Medicaid

EXECUTIVE SUMMARY

The Illinois Medicaid Program is applying to the Centers for Medicare and Medicaid Services (CMS) for a comprehensive waiver granted under authority of Section 1115 of the Social Security Act. The *Path to Transformation* waiver will include all spending in the Illinois Medicaid Program and will cover all populations who are currently eligible for Medicaid and who may become eligible after ACA implementation. The proposal will result in tangible savings for both the state and federal governments, which will be used to reinvest in an integrated, rational and efficient healthcare delivery system. The waiver will demonstrate that by spending Medicaid dollars differently, we will have better health outcomes for our Medicaid clients at or below the same costs.

The *Path to Transformation* waiver will accomplish this goal through four important "pathways":

- *HCBS infrastructure, choice and coordination.* Illinois will rebuild and expand its home and community-based infrastructure, especially for those with complex health and behavioral health needs. We will expand access to and choice of HCBS services for our beneficiaries and ensure that services are based on individual needs and preferences rather than disability.
- *Delivery system transformation.* Illinois' healthcare delivery system will be built off of integrated delivery systems (IDS) -- centered around patient-centered health homes -- that are built based on the needs of the patient population. Integrated delivery systems have the ability to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices. IDSs will be held accountable for the health outcomes of individual patients within their networks as well as for their overall patient population. The goal is for IDSs to reduce costs and improve quality through management of care and care transitions and aligned incentives to ensure the right care at the right time in the most appropriate setting.
- *Population health.* Illinois will expand the capacity of the healthcare delivery system to take responsibility for the health of a population, with a focus on prevention, primary care and wellness. Population health can also be addressed by helping delivery systems focus on the health of their individual patients as well as on the health of the panel of patients they serve.

- *Workforce.* Illinois will build a 21st century health care workforce that that is ready to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand, including the ability to utilize community health workers and ensure all health professions are able to assume responsibility to the full extent of their education and training.

As a key component of the waiver application process, and then in management of the waiver itself, there will be numerous opportunities for input and collaboration by and among community stakeholders, providers, local government and state agency partners to design and then implement an improved Medicaid delivery system that reflects the priorities set forth in the waiver. This collaborative design process, which was begun under the state's Health Reform Implementation Council and continued and expanded under the State Health Care Innovation Plan process, will itself play a significant role in the transformation of the Illinois Medicaid Program.

BACKGROUND

The Illinois Medicaid Program is undergoing significant healthcare transformation. Illinois is among the last of the major states with an unsustainable fee-for-service Medicaid system. Consequently, service delivery is often fragmented and uncoordinated. This is rapidly changing, however. Pursuant to P.A. 96-1501 ("Medicaid Reform"), signed into law in January 2011, Illinois must enroll at least 50% of its Medicaid clients into some form of risk-based coordinated care by January 1, 2015. Under Medicaid Reform, care coordination is defined broadly to include both traditional managed care organizations as well as alternative payment methodologies such as risk- based direct provider payments from HFS.

HFS currently manages two capitated Medicaid managed care programs and an early expansion waiver program for individuals residing in Cook County. The first is a voluntary program for children and parents (with enrollment of approximately 247,000) in 18 counties.[1] The second program, known as the "Integrated Care Program" (ICP), is a mandatory program for non-dual seniors and persons with disabilities (SPDs). The program began in 2010 for individuals residing in the Chicago suburbs and collar counties surrounding Chicago and has an enrollment of approximately 39,500.[2] Four additional regions were recently added to the ICP and are not reflected in this enrollment figure. Long-term services and supports (LTSS) were also recently added to the ICP, making Illinois one of just a handful of states with an integrated managed acute and long-term care program. In early 2013, the State, in collaboration

[1] Illinois Department of Healthcare and Family Services, enrollment as of August 2013 (http://www2.illinois.gov/hfs/ManagedCare/Pages/Enrollment.aspx)
[2] Illinois Department of Healthcare and Family Services, enrollment as of August 2013 (http://www2.illinois.gov/hfs/ManagedCare/Pages/Enrollment.aspx)

with the Cook County Board and the Cook County Health and Hospital System (CCHHS) received an 1115 waiver to early-enroll approximately 115,000 individuals who will become eligible for Medicaid services in 2014. Under the "CountyCare" program, "newly eligible" are served by a provider network that includes both CCHHS and contracted network providers.

In order to provide options for care coordination services, Illinois has recently implemented innovative, alternate models of care in addition to the traditional managed care organizations. The alternative models of care – "care coordination entities" (CCEs) and "accountable care entities" (ACEs) – are organized and managed by hospitals, physician groups, Federally Qualified Health Centers, or social service organizations and are required to provide a full continuum of services, including behavioral health. CCEs were created under Medicaid Reform to provide an organized system of care for the most complex and vulnerable individuals, including the severely mentally ill, homeless, complex children and other high-cost, high-need groups. As of October 1, 2013, client enrollment has started in one of the CCEs and the State is in the process of finalizing implementation for the remaining CCEs.

ACEs were created by statute in the spring of 2013 and were informed by the early experience of preparing CCEs to become operational, the lack of progress toward developing integrated delivery systems under the State's existing managed care programs, as well as the findings and recommendations from the Alliance planning process on the structure and components of integrated delivery systems. Whereas CCEs are primarily focused on highly targeted sub-populations (e.g., homeless) and, therefore, will have fairly small enrollment, ACEs are focused on the full Family Health Plan and newly eligible populations. Both CCEs and ACEs are paid a PMPM care coordination fee, with fee-for-service reimbursement and shared savings potential initially; ACEs are required (and CCEs are encouraged) to begin moving to a risk-based arrangement after 18 months.

As the state moves ahead rapidly with expansion of coordinated care models, we – like many states -- continue to face an extremely challenging budget environment. Only one year ago, in 2012, the Medicaid Program was in crisis, on the brink of collapse, with a $2.7 billion budget hole for FY2013 and $1.9 billion in unpaid Medicaid-related bills. Through a combination of spending reductions, utilization controls and new revenues, Illinois addressed the urgent budget shortfall, primarily through the SMART Act ("Save Medicaid Access and Resources Together"). Similarly, the state was forced to make significant reductions in its mental health budget in recent years, cutting $114 million in general revenue funding for mental health services between 2009 and 2011. These cuts were necessary to ensure that services were scaled to existing appropriations, but they have also left the state and many of our

providers unable to invest in the kinds of systemic change needed to drive long-term cost savings, improved outcomes and improved patient care.

This waiver represents the culmination of multiple coordinated efforts by the State of Illinois to plan for full implementation of the Affordable Care Act and reform our health care delivery system around the vision of the Triple Aim. These efforts include:

- *Illinois Health Care Reform Implementation Council* On July 29, 2010 Governor Pat Quinn signed Executive Order #10-12 to create the Illinois Health Care Reform Implementation Council, an inter-agency subcabinet that has been charting Illinois' multi-dimensional path toward ACA implementation.
- *Illinois Health Insurance Marketplace.* For the first year after ACA implementation, the Marketplace will be operated in partnership with the federal government. Federal grant dollars are helping the State to build an integrated eligibility system for Medicaid, SNAP and TANF initially (and for other public programs later), and for an Illinois-based Marketplace.
- *The Alliance for Health.* In early 2013, Illinois was awarded a Model Design grant from the Center for Medicare & Medicaid Innovations (CMMI) for the development of a State Health Care Innovation Plan (SHCIP). The State convened a broad group of payers, providers, state agencies, consumers and other stakeholders -- collectively known as the Alliance for Health -- to design new service delivery models and multi-payer strategies for payment reforms, as well as population health and workforce measures designed to achieve improved health, more effective health care delivery, and lower costs. The Alliance completed the SHCIP in late October, and many of the SHCIP components and innovations are included in this concept paper. The State has committed to continuing the Alliance through an Executive Order to ensure that the reforms outlined in the SHCIP move forward.

PROPOSED 1115 REFORM WAIVER: *THE PATH TO TRANSFORMATION*

The Illinois Medicaid Program is poised for transformation, and the ability to secure federal investments for new priorities will support our next steps toward Medicaid reform and full ACA implementation. Our proposed approach identifies new priorities that are essential to a highly functioning Medicaid Program, with the flexibility in service design afforded by an 1115 waiver.

The *Path to Transformation* waiver will accomplish this goal through four important "pathways":

- *HCBS infrastructure, choice and coordination.* Illinois will rebuild and expand its home and community-based service infrastructure, especially for those with complex health and behavioral health needs. We will expand access to and choice of HCBS services for our beneficiaries.
- *Delivery system transformation.* Illinois' healthcare delivery system will be built off of integrated delivery systems -- centered around patient-centered health homes -- that are built based on the needs of the patient population. Integrated delivery systems will have the ability to employ team-based care practices, accept and disburse payments and financial incentives to providers within their system, and provide performance reports and counseling to individual doctors and practices.
- *Population management.* Illinois will expand the capacity of the healthcare delivery system to take responsibility for the health of a population, with a focus on prevention, primary care and wellness.
- *Workforce.* Illinois will build a 21st century health care workforce that that is ready to practice in integrated, team-based settings in geographies and disciplines that are in the greatest demand. Illinois will ensure all health professions are able to assume responsibility to the full extent of their education and training.

Pathway #1: ***Home and Community Based Infrastructure, Coordination and Choice*** -- It is not possible to deliver on the promise of the right care in the right setting, at the right time, without ensuring that supportive services exist in the home and community to assist clients with achieving their highest level of independent functioning and quality of life. Illinois is in the midst of implementing consent decrees related to three Olmstead-related class action lawsuits, by helping residents of nursing homes and other institutions to transition to the community. We have learned through the early implementation of these consent decrees, as well as implementation of the "Money Follows the Person Program", that our existing community infrastructure needs to be strengthened through the addition of community-based services that will enable individuals to remain in their own community post-transition and avoid re-institutionalization.

We also want to emphasize that for our clients who live in poverty, it is the social, cultural, environmental, economic and other factors that are the major causes of rates of illness and the magnitude of health disparities. Illinois Medicaid needs to reposition itself to directly tackle these multiple, challenging causes of ill health associated with poverty, with a renewed emphasis on the social determinants of health throughout all of our programs, services, policies and reform initiatives.

1A. COMBINE AND MODERNIZE HCBS WAIVERS. HCBS "waiver providers" provide an important Medicaid service to Seniors and Persons with Disabilities (SPD) by helping them to remain in their own home or to live in a community setting.

In Illinois, home and community-based services in Home and Community Based Services (HCBS) waivers, currently approved under Section 1915 (c) of the Social Security Act, are compartmentalized under nine separate waivers, three departments and numerous divisions within departments. The current waivers are for adults with developmental disabilities; children and young adults with developmental disabilities; elderly; medically fragile/technology dependent children; persons with brain injury; persons with disabilities; persons with HIV or AIDS; supportive living facilities; and a support waiver for children and young adults with developmental disabilities.

These separate waivers provide services based on an individual's primary disability rather than identification of service needs across disability. However, Illinois is in the process of incentivizing the coordination of care for the SPD population, intended to break through the silos which do not effectively address the holistic needs of clients with multiple disabilities and conditions. The current waiver structure makes it difficult for healthcare providers and community organizations as they face steep challenges in their efforts to work together and coordinate care. This structure, with nine HCBS waivers, is not consistent with the State's approach, moving forward.

The *Path to Transformation* waiver will assist the State in developing and implementing, across disabilities and across agencies, a uniform assessment instrument and a consolidated waiver structure. In addition, the State recently received funding under the Balancing Incentive Program (BIP) and plans to use the enhanced matching funds through that program to achieve additional expansion of capacity in the community. The waiver will provide the flexibility needed to deliver appropriate and essential HCBS waiver services, also referred to as "long-term supports and services" (LTSS), in a coordinated fashion through managed care entities and their provider networks. In addition, the state is in the process of developing a universal assessment tool (UAT) for SPD populations that will support efforts to tie services to the needs of the beneficiary. Specifically, Illinois seeks to accomplish the following through the *Path to Transformation:*

- Rationalize service arrays and choices so that they are based on beneficiary needs and preferences to remain as independent as possible, rather than disability or condition;
- Increase flexibility and choice for beneficiaries;
- Support development and expansion of community based options;

- Reduce waiting lists for waiver services;
- Develop outcome-based reimbursement strategies that emphasize quality of care and align payments with the goals of the program;
- Reduce administrative complexity and cost inherent in managing nine separate waivers.

The state also requests CMS feedback on the feasibility of implementing a provider assessment on waiver providers to support access to HCBS services and counteract the additional incentive toward institutionalization that is inherent in the state's current nursing facility assessment.

1B. BEHAVIORAL HEALTH EXPANSION AND INTEGRATION -- As home- and community-based services have experienced continuous budget cuts, it has become nearly impossible in Illinois to provide the depth and breadth of long-term supports and services that are needed by the Medicaid population with co-morbidities, including mental illness, substance use disorders and chronic health conditions. We believe that we cannot produce the desired health outcomes – while bending the cost curve for these most expensive clients – without enhancing these community-based services.

The *Path to Transformation waiver* will invest in the transition to an integrated system, including behavioral healthcare, with the following:

- Development, implementation and training on evidence-based recovery models, community crisis supports, step-down and transitional living programs, patient-centered behavioral health homes, and systems of care;
- Development, implementation of and training on discharge planning policies to create seamless care transitions between psychiatric or detoxification services in acute or sub-acute care settings, to community-based services for persons with mental illness and substance use disorders;
- Training for staff of state agencies and community providers to assess and assist clients, across disabilities, with co-morbidities and multiple conditions;
- Development and use of health information technology (HIT) for behavioral health programs, to make necessary seamless exchange of clinical data possible with primary care and hospital providers.

1C. STABLE LIVING THROUGH SUPPORTIVE HOUSING -- The ACA offers a paradigm shift to assist low-income adults with complex health and behavioral health needs who will have access to health coverage under

Medicaid, for the first time, by reason of income -- even if they do not qualify for Medicaid as a permanently disabled person. It is possible to aid in recovery of these adults by offering the essential healthcare services and supports.

A recovery-oriented model must consider the healthcare value of providing supportive housing and employment for these vulnerable populations in Illinois. Not only can supportive housing prevent individuals from unnecessarily living in costlier institutional settings, but a growing body of research suggests that stable and affordable housing may help individuals living with chronic diseases and behavioral health conditions maintain their treatment regimens and achieve better health outcomes at a lower cost.[3] Supported employment likewise promotes stability, dignity and self-respect to further the recovery process and achieve independence in the community.

Through the *Path to Transformation* waiver Illinois seeks to expand access to supportive housing through capital funding for supportive housing projects and by expanding supportive housing services. In lieu of direct funding for these programs, the State may also explore the creation of a DSRIP program for behavioral health providers that incentivizes the creation of more supportive housing and supportive housing services.

Pathway #2: ***Delivery System Transformation***

2A. IMPLEMENT AND EXPAND INNOVATIVE MANAGED CARE MODELS – As described above, Illinois is in the midst of a rapid and significant shift from a largely fee-for-service model to a risk-based managed care model that includes both traditional MCOs as well as new, provider-driven models (i.e., Coordinated Care Entities and Accountable Care Entities). CCEs and ACEs will establish integrated delivery systems centered around Patient-Centered Health Homes. They will develop multi-disciplinary teams, robust care coordination capabilities, and a high level of integration among primary care, hospital and behavioral health providers. They will be linked by connective technology for tracking of clients and timely transmission of patient clinical data between provider partners. The providers within the network will agree to manage care transitions and deliver care in the most appropriate settings.

These new models of integrated service delivery will also demonstrate how Medicaid can reduce the rate of growth to sustainable levels by piloting payment reforms, including financial incentives that reflect value-based purchasing policies and Illinois requirements for risk-based payments in care

[3] See, for example, Culhane, et al., *Public Service Reductions Associated with Supportive Housing,* Housing Policy Debates, Volume 13, Issue 1, 2002, pages 107-163; and Craig C, Eby D, Whittington J. *Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs.* IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011.

coordination systems. These payment reforms will incorporate multi-payer strategies being developed through the Illinois State Innovation Model Design grant. While CCEs and ACEs will contract directly with the state, they will also have the ability to contract with traditional MCOs, driving higher levels of integration and accountability throughout the Medicaid program. These new models will enable people covered by Medicaid to remain with their providers if they shift from Medicaid to premium subsidy. With tens of thousands of people newly eligible for Medicaid likely to shift between Medicaid and premium subsidy as wages and hours change it becomes even more important for the state's providers to care for people in their community regardless of the payer. Given the importance of these new models to system redesign efforts, the *Path to Transformation* waiver will invest in their design, start-up, and implementation, including:

- Project management, network organization and governance structure support;
- Assistance with design of tracking and reporting systems, including the use of EHR technology for all providers within a network;
- Assistance with data collection, reporting, claims analysis and data analytics to track outcomes, performance and cost savings;
- Support for training programs for staff involved in care coordination, client record monitoring, reporting and technology use.

2B. TRANSFORM PUBLIC PROVIDERS – Illinois is home to two large public health and hospital systems – the University of Illinois Hospital and Health System and Cook County Health and Hospitals System. These systems play a vital role in the state's health care delivery system, including the provision of trauma and burn services, transplant services, and sub-specialty care. CCHHS is a major safety net provider for the underserved of Cook County and is one of the largest and most comprehensive public health and hospital systems in the country. The U of I system includes a 495-bed tertiary hospital with nationally recognized transplant programs, an outpatient facility, and 19 neighborhood clinics serving communities throughout the near west, south and southwest sides of Chicago. Both of these systems were active participants in the Illinois Alliance for Health and are committed to the transformation outlined in the State Health Care Innovation Plan.

Illinois will continue to rely on its public providers throughout the implementation of the ACA and beyond. However, we also recognize that large public providers face numerous unique barriers to transformation that extend beyond those faced by other providers. These include cost-based reimbursement methodologies that haven't incentivized efficiency, legal and political barriers that can inhibit integration with other providers, and multiple layers of oversight that can slow the pace of

change. For these reasons, and consistent with the goals of the Alliance for Health, Illinois proposes a Delivery System Reform Incentive Program (DSRIP) to create strong incentives for transformation within these vital providers. DSRIP funds will be contingent on public systems meeting aggressive milestones with respect to integrated care delivery and improved patient outcomes.

2C. HOSPITAL/HEALTH SYSTEM TRANSFORMATION – Much of healthcare reform is focused on reducing hospital admissions/readmissions and the use of emergency rooms for primary care, which will positively impact health outcomes and the quality of care but may also negatively impact hospitals' bottom lines. The *Path to Transformation* waiver will invest in hospitals that are committed to transitioning to a modern service delivery model through:

- Development and implementation of one or more incentive-based pools to drive transformation of systems, including, but not limited to:
    - Primary care development, quality care improvements, and regional collaborations on state public health initiatives and community needs;
    - Development of integrated delivery systems, including HIT/HIE infrastructure, governance and care models;
    - Development, implementation and training on effective transitions of care models;
- Technical assistance to support the development of integrated delivery systems that are capable of assuming responsibility for the health care of a defined population;
- An access assurance pool for hospitals and health systems to cover uninsured and unreimbursed Medicaid costs to assure access and preserve the "safety net";Development and implementation of a pool to support debt relief or capital investments for hospitals that commit to redesigning, downsizing or closing some or all of their facilities, including transformation of rural systems to potentially create rural "hubs" that are not built around inpatient care.

2C. NURSING FACILITY TRANSFORMATION – Illinois has approximately 1,200 long-term care facilities serving more than 100,000 residents, from the young to the elderly.[4] The state ranks in the top quintile nationally on the number of licensed nursing home beds per thousand persons aged 65 years and older.[5] Illinois has made substantial progress in recent years toward rebalancing its long-term services and supports and offering community-based alternatives. Specifically, Illinois has implemented the Pathways/Money Follows the Person (MFP) Demonstration Program, which has assisted hundreds of

[4] Illinois Department of Public Health

[5] Center for Medicare and Medicaid Services, Nursing Home Data Compendium 2012 Edition

individuals with transitioning to the community. Earlier this year Illinois received federal approval for its Balancing Incentive Program (BIP) application, which commits the state to balancing its spending on home and community based services with its spending on institutional services. As Illinois works to rebalance its long-term care system while looking ahead to the health needs of the advancing baby-boomer generation, the State is working with the nursing home providers and community advocates. The *Path to Transformation* waiver will invest in nursing facilities transitioning to the modern service delivery system through:

- Development and implementation of an incentive-based pool for nursing facilities to drive transformation, including, but not limited to:
    - Quality of care improvements;
    - Participation in integrated delivery systems with capacity to assume responsibility for patient care across the full continuum of preventive, acute and long-term care services;
    - Development, implementation and training on effective transitions of care models between nursing facilities, home and community-based care and hospitals;
- Debt relief or capital investments for nursing facilities that commit to redesigning, downsizing or closing some or all of their facilities, including technical assistance in developing new business models to retool facilities to meet the needs of emerging populations;
- Flexibility to develop and fund additional supportive housing and employment options for those populations in need of long term care, at the appropriate levels.

Pathway #3: ***Build Capacity of the Health Care System for Population Health Management*** -- By 2017, Illinois expects that an additional 500,000 Medicaid clients will be enrolled under the Affordable Care Act, a combination of "newly eligible" adults and "already eligible" clients under current Medicaid rules. In addition, another 500,000+ people will shop for private health insurance in the Health Insurance Marketplace. The health status of these currently uninsured populations is varied — many of the formerly uninsured will be young, relatively healthy adults, but there is evidence to suggest that many will have pent-up demand for health care. With this influx of enrollees into healthcare systems, the Healthcare Reform Implementation Council and the Alliance for Health have focused substantial attention on the need to build linkages between public health and health care delivery systems and to expand the capacity of the system and the skills it will need to manage the health of a defined population.

The new community needs assessment mandate offers opportunities for the state and local health departments to collaborate with local hospitals and community health centers to share data and

analyses and assure that as much attention as possible is directed to fulfilling the identified needs. Establishing and certifying a new category of worker, community health workers, will also help bridge the gap between personal and public health. These workers, who originate in and serve their local communities in linguistic and culturally sensitive ways, are essential to team with providers to educate and motivate consumers to actively participate in improving their own health.

3A. WELLNESS STRATEGIES – Providing health coverage to more people also requires a focus on front-end strategies to deflect individuals from costlier back-end care. The *Path to Transformation* waiver will leverage health and other public health dollars by investing in evidence-based prevention and wellness-focused strategies for Medicaid clients, such as tobacco cessation, obesity prevention, diabetes self management, nutrition counseling, fall prevention, physical fitness, and other non-traditional services that assist in improving the health of our clients. We will test payment reforms for wellness programs and integration of public health services that may provide direct incentives for clients or address socioeconomic circumstances of families, with the goal to lower costs of traditional medical services. We also will seek to bring in additional Medicaid funds to fund the public health system, including enhancing the funding pool for local government provided services to improve the ability of these local systems to support the health of their communities in a cost effective manner.

Pathway #4: ***21st Century Health Care Workforce*** -- Illinois ranks near the middle among states on the total number of active physicians and active primary care physicians per 100,000 population. However, the supply of providers does not necessarily match the demand in certain areas of the state and for some populations. For example, only 64.9% of Illinois physicians reported that they were accepting new Medicaid patients in 2011, compared to a national median of 76.4%.[6] Similarly, 28.5% of Illinois residents live in an area that has been designated as a primary care Health Professional Shortage Area (HPSA), compared to a national median of 18.6%.[7] Even in areas where supply is currently sufficient, concerns exist about capacity for an expanded insured population when Marketplace and expanded Medicaid coverage begin in 2014. In addition, Illinois falls well below the national median in its use of non-physician providers. Illinois has 20.2 physician assistants and 35.3 nurse practitioners per 100,000 people, compared the national median of 33.5 and 62.1, respectively.

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[6] NCHS analysis of NAMCS Electronic Medical Records Supplement from Decker, S. "In 2011 Nearly 1/3 of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help." *Health Affairs,* 31, no. 8, 2012. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

[7] HPSA information from the Health Resources and Services Administration (HRSA); population data from ACS. Accessed through the *Benchmark State Profile Report for Illinois* provided by CMMI.

While it is not possible to rapidly increase the pipeline of physicians, the State must invest in training and retraining the types of providers that are needed within the Medicaid program. Similarly, we must invest in a workforce that includes healthcare professionals who can provide and/or assist with primary and preventative healthcare for our clients.

4A. GRADUATE MEDICAL EDUCATION – Illinois is currently one of a handful of states that does not have a Medicaid Graduate Medical Education program. In order to align the provider workforce with the needs and goals of the state, we propose to develop a Graduate Medical Education (GME) pilot program with the following goals:

- Increase the number of primary care providers in Illinois.
- Increase the number of primary care providers working in medically underserved areas, including rural areas.
- Increase the number of providers who are trained to practice in a, team-based, patient-centered medical home setting within an integrated delivery system.

The program would incentivize primary care GME programs in Illinois to address state workforce goals through payments for performance on specific GME program metrics. We propose that the GME pilot be a five-year graduated program design with the details and parameters to be developed during the waiver planning process.

4B. LOAN REPAYMENT -- Consistent with the recommendations of the Illinois Alliance for Health, Illinois will expand primary care capacity by reinstating a State Loan Repayment program across a broad range of professionals (including physicians, advanced practice nurses, psychologists, and other health care professionals) in underserved areas.

4C. OTHER WORKFORCE TRAINING -- The *Path to Transformation* waiver will invest in training and preparing healthcare providers, such as community health care workers, in-home specialized personal attendants, care coordinators, nurses of all specialties, physician assistants/nurse practitioners and physicians to work on primary care provider teams to assure that overall health improvement goals are achieved in addition to providing appropriate clinical care. Education in healthcare across the lifespan and disabilities is essential for our workforce to be prepared for the rapid growth of aging adults and people with disabilities. This workforce training will be implemented in cooperation with community colleges and other certification programs.

Financing/Budget Neutrality

By implementing the *Path to Transformation*, Illinois expects to achieve significant savings, including the following:

Future managed care savings. Our with-waiver baseline will include projected savings under the state's planned managed care expansions, including the following:

- *Family Health Plan mandatory managed care* – Beginning on July 1, 2014, Illinois will begin mandatory managed care enrollment (ACEs, MCOs or MCCNs) for the Family Health Plan population in five regions of the state (Greater Chicago, Rockford, Quad Cities, Central Illinois, Metro East).

- *Newly eligible mandatory managed care* – Beginning on July 1, 2014, Illinois will begin mandatory managed care enrollment (ACEs, MCOs or MCCNs) for the Newly Eligible Medicaid adult population in the same five regions of the state.

Savings resulting from waiver innovations. Many of the innovations outlined in this concept paper are investments that will help to "bend the cost curve" by eliminating unnecessary costs, reducing rates of institutionalization, and focusing on health and wellness, which will yield a return within the five-year budget window. We will be working with our actuaries to identify and quantify these anticipated savings.

Previous managed care savings. Illinois requests "credit" for the savings achieved under our existing managed care programs (implemented under state plan authority), that would have not been achieved in the absence of these programs. These include our voluntary Healthy Families program as well as the mandatory Integrated Care Program (ICP) for the SPD population.

As described above, Illinois has taken significant action to address a looming Medicaid budget crisis. These actions were necessary to prevent collapse of the Medicaid program, but they are not sustainable. Illinois recognizes that it must invest now to ensure access for the uninsured population that will gain Medicaid or Exchange coverage beginning in 2014. We must also invest now to build a modern, integrated delivery system that can achieve better outcomes at less cost. Failing to make these investments now may result in short-term savings but longer-term costs in the form of high emergency department and inpatient admissions and poorer health outcomes and population health. To ensure that Illinois is able to make these investments, we are requesting to use a without-waiver trend that is reflective of the national rate of cost growth.

Illinois proposes to reinvest a portion of these savings into reforming its health care infrastructure, including the programs outlined above and a number of state-only funded programs that may qualify as "Designated State Health Programs" for purposes of federal matching payments. Below is a preliminary list of DSHPs. We are in the process of identifying a complete list of programs that would be eligible for federal matching funds as Designated State Health Programs (DSHPs).

- Department of Public Health targeted prevention and screening programs
- Department of Children and Family Services assessment services
- Illinois State Board of Education early intervention and treatment services for children with mental health/behavior disorders
- Department of Human Services substance abuse prevention services, health education/promotion services

Illinois will maintain budget neutrality over the five-year life of the *Path to Transformation* Wavier, with total spending under the waiver not exceeding what the federal government would have spent without the waiver. We are not, however, proposing to establish a global cap on federal Medicaid expenditures for Illinois. In partnership with the federal government, and with the flexibility afforded by the *Path to Transformation* waiver, Illinois Medicaid will be transformed to a high quality healthcare delivery system, producing positive health outcomes for our Medicaid populations while reducing costs and creating a significant return on investment.

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

13.B

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

DECISION MEMORANDUM

DATE: November 20, 2013
TO: Members, Champaign County Developmental Disabilities Board (CCDDB)
FROM: Lynn Canfield, Associate Director
SUBJECT: Draft Three Year Plan 2013-2015 with FY2014 Objectives

The Three Year Plan for fiscal years 2013-2015 with objectives for FY2014 has been finalized and is attached for the Board's consideration and action. An initial draft was presented at the October 23rd meeting and subsequently distributed to a diverse set of stakeholders including agencies, family networks, and other interested parties. A brief report and opportunity for discussion occurred during the October board meeting. In the weeks that followed, CCDDB staff received, discussed, and incorporated several suggestions. Those are indicated with strikethroughs, underlines, and italics.

A final draft of the Three Year Plan is attached. Action is requested.

Decision Section
Motion: Approve the Three-Year Plan (2013 – 2015) with Fiscal Year 2014 Objectives as presented.

_____ Approved

_____ Denied

_____ Modified

_____ Additional Information Needed

DRAFT

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

THREE-YEAR PLAN

FOR

FISCAL YEARS 2013 - 2015
(12/1/12 – 12/31/15)

WITH

ONE YEAR OBJECTIVES

FOR

FISCAL YEAR 2014
(12/1/13 – 12/31/14)

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY
(CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD)

WHEREAS, the Champaign County Developmental Disabilities Board has been established under the Illinois County Care for Persons with Developmental Disabilities Act (IL Compiled Statutes, Chapter 55, Sections 105/0.01 to 105/13 inclusive) in order to "provide facilities or services for the benefit of its residents who are mentally retarded or under a developmental disability and who are not eligible to participate in any such program conducted under Article 14 of the School Code, or may contract therefore with any privately or publicly operated entity which provides facilities or services either in or out of such county."

MISSION STATEMENT

The mission of the Champaign County Board for Care and Treatment of Persons with a Developmental Disability (CCDDB) is the *advancement* ~~promotion~~ of a local system of programs and services for the treatment of *people with* intellectual disabilities and/or developmental disabilities in accordance with the assessed priorities of the citizens of Champaign County.

STATEMENT OF PURPOSES

1. Planning for the intellectual disability and developmental disability service *and support* system to assure accomplishment of the CCDDB goals.

2. Allocation of local funds to assure the provision of a comprehensive system of community based intellectual disability and developmental disability services and supports *anchored in high-quality person-centered planning.*

3. Coordination of affiliated providers of intellectual disability and developmental disability services and supports to assure an interrelated accessible system of care.

4. Evaluation of the system of care to assure that services and supports are provided as planned and that services are effective in meeting the needs and values of the community.

In order to accomplish these purposes, the Champaign County Developmental Disabilities Board must collaborate with the public and private sectors in providing the resources necessary for the effective functioning of the intellectual disability and developmental disability service and support system. The CCDDB shall perform those duties and responsibilities as specified in Sections 105/01 to 105/13 inclusive of The County Care for Persons with Developmental Disabilities Act.

CHILDREN AND FAMILY FOCUSED PROGRAMS AND SERVICES

Goal #1: Identify children at-risk of developmental delay and intellectual disability or developmental disability and support early intervention services and family supports.

Objective #1: Support use of evidence based/informed models for provider programs serving families with *young* children ~~age birth to five~~ *not eligible for Early Intervention or under the School Code*, and require collaboration and coordination by providers to limit duplication of effort.

Objective #2: Participate in collaborative bodies such as the Champaign County Birth to Six Council whose mission focuses on serving families with young children.

Objective #3: Collaborate with the Champaign County Mental Health Board on issues of mutual interest associated with early intervention services and programs.

Objective #4: Prioritize children and families involved with the ACCESS Initiative to facilitate access to supportive or early intervention services, if appropriate.

Objective #5: In consultation with the Champaign County Mental Health Board, continue realignment of funding to support early intervention services for children with an intellectual disability or developmental disability or delay.

Goal #2: Support adults' and families' access to services and programs, including evidence based practices, to increase positive outcomes.

Objective #1: Support a continuum of evidence-based, quality services for persons with an intellectual disability or developmental disability ~~in response to reduced state supported services~~.

Objective #2: Promote wellness for people with intellectual disabilities and developmental disabilities, to prevent and reduce early mortality, as embodied in the "10x10 Wellness Campaign."

Objective #3: Encourage training of interested persons across the service spectrum on the use of evidence based/informed practice and associated outcome measurement.

COMMUNITY ENGAGEMENT & ADVOCACY

Goal #3: ~~Address~~*Reduce* the stigma associated with intellectual disabilities and developmental disabilities through broad based community education efforts/events designed to challenge discrimination and to promote ~~acceptance~~ *respect*, dignity, and social inclusion.

Objective #1: Continue support for and involvement in the signature anti-stigma and community education events, disAbility Resource Expo: Reaching Out for Answers and Roger Ebert's Film Festival.

Objective #2: ~~Encourage~~ *Support* ~~consumer and~~ *self advocacy and family* advocacy groups' community education efforts to reduce stigma and promote inclusion.

Objective #3: Participate in *and promote* other community based activities such as walks, forums, and presentations to raise awareness.

Goal #4: Stay abreast of emerging issues affecting the local systems of care and consumer access to services and be proactive through concerted advocacy efforts.

Objective #1: Monitor implementation of the Affordable Care Act and the expansion of Medicaid by the State of Illinois and advocate for increased service capacity sufficient to meet consumer demand through active participation in the Association of Community Mental Health Authorities of Illinois (ACMHAI) and other state and national associations.

Objective #2: Track state implementation of class action suit settlements involving persons with intellectual disabilities and developmental disabilities, including the Ligas Consent Decree and closure of state facilities, and advocate for the allocation of state resources sufficient to meet the needs of clients returning to home communities.

Objective #3: Monitor implementation of the Illinois Employment First Act including any associated rulemaking.

Objective #4: Through our association with *the National Association of County Behavioral Health and Developmental Disabilities Directors* (NACBHDDD), follow developments at the state and federal levels of ~~other Olmstead and~~ Olmstead-related cases.

Objective #5: Continue broad based advocacy efforts at the state and local levels to respond to continued reductions in state funding and increasing delays in payment for local community-based intellectual disability and developmental disability services and supports and to the broader human services network under contract with the State of Illinois.

Objective #6: Continue to promote effective methods of engaging consumer and family groups in advocacy, including parent groups currently funded, and coordinate with ACCESS Initiative as feasible.

Objective #7: Statewide and locally, explore and promote service system redesign efforts consistent with recommendations of the Blueprint for System Redesign in Illinois, including appropriate state funding for development of community-based services and infrastructure.

Objective #8: Assess impact, on local systems of care for persons with intellectual disabilities and developmental disabilities, of the State of Illinois' and provider networks' movement to a regional service/managed care delivery model.

Objective #9: In collaboration with the United Way of Champaign County, monitor implementation of the regional 211 information and referral system and its impact on local utilization of funded information and referral services.

Goal #5: Maintain an active needs assessment process, relying heavily on key informants and public testimony from stakeholders, to identify current issues affecting consumer access and treatment.

Objective #1: Continue to assess the impact of state funding ~~reductions~~ on consumer access to care and provider capacity.

Objective #2: Participate in other county-wide assessment activities to ensure CCDDB target populations are represented. *Investigate an online survey instrument for broader stakeholder/resident input.*

Objective #3: Track Illinois Department of Human Services Division of Developmental Disabilities' Prioritization of Urgency of Need for Services (PUNS) database for state and local trends and to ensure full representation of the service preferences of Champaign County residents.

Objective #4: Using Child and Family Connections data for Champaign County, track the identification of intellectual disabilities and developmental disabilities or delays among children, Birth to 6, and engagement in Early Intervention and Prevention services.

RESOURCE DEVELOPMENT & COLLABORATION

Goal #6: Increase investment in programs and services through promotion of collaborative and innovative approaches.

Objective #1: Through participation in the Association of Community Mental Health Authorities of Illinois (ACMHAI), seek input and feedback on innovative approaches for resource development or cost containment.

Objective #2: Partner with other local entities for a coordinated response to needs of at-risk populations.

Objective #3: Consider non-financial support to agencies ~~to offset state funding reductions and control costs~~.

Objective #4: Support and assist with affiliations and mergers of providers as a means to streamline the delivery of services and enable administrative cost savings through economies of scale.

Objective #5: Encourage development of collaborative agreements between providers to increase or maintain access and coordination of services for consumers residing ~~in Rantoul and rural Champaign County~~ *outside of Champaign and Urbana.*

Objective #6: Continue participation and support for Champaign County Specialty Courts serving persons with substance use disorders and/or mental health disorders, sharing information on services for those who also have intellectual disabilities or developmental disabilities in order to maintain adequate support for those with dual diagnoses.

Goal #7: Sustain the collaborative working relationship with the Champaign County Mental Health Board (CCMHB).

Objective #1: Implement the Intergovernmental Agreement between CCDDB and CCMHB.

Objective #2: Coordinate integration, alignment, and allocation of resources with the CCMHB to ensure the efficacious use of resources within the intellectual disability and developmental disability service and support continuum.

Objective #3: Assess alternative service strategies that empower consumers and increase access to needed but underutilized services.

ORGANIZATIONAL DEVELOPMENT, ADMINISTRATION, AND ACCOUNTABILITY

Goal #8: Implement policies and procedures to assure financial accountability for CCDDB dollars tied to co-funded programs. The primary focus is related to programs which are also funded by revenue from the State of Illinois. Utilize the online application and reporting system to track all objectives pertaining to this goal.

Objective #1: Identify each CCDDB funded contract that budgets state revenue as part of program revenue and develop mechanisms to track the level of state payments during the term of the contract.

Objective #2: Clarify how CCDDB dollars are used in each co-funded contract. Enforce policies to assure that reductions in state contract maximums are not supplanted by CCDDB dollars without prior notice or negotiation.

Objective #3: All CCDDB grant contracts that receive State of Illinois funding as part of the total program revenue shall be required to report all staffing changes to the CCDDB. At the discretion of the CCDDB, agencies shall provide a full listing of all full, part-time, and contractual employees on a quarterly basis.

Objective #4: Require all CCDDB funded agencies to notify the CCDDB of the termination or lay off of employees funded in full or in part with CCDDB funds accompanied by an explanation of the projected impact on consumers' access to or utilization of services.

Objective #5: Evaluate risk for loss of co-supported services resulting from state funding reductions.

Goal #9: Set priorities for funding through an annual review and allocation process to ensure access to core intellectual disability and developmental disability services and supports by consumers.

Objective #1: Draft priorities based on current service needs and operating conditions ~~including consideration of changes in state funding and payment practices~~ and obligations established through Memoranda of Understanding and Intergovernmental Agreements.

Objective #2: Solicit input from *individuals with disabilities, family members, the community at large, and* the service network ~~and community at large~~ on proposed funding priorities prior to adoption.

Objective #3: Utilize a competitive application process to evaluate proposals in relation to annual priorities.

Goal #10: Maintain program and financial accountability of service providers and programs under contract with the Board.

Objective #1: Evaluate program performance on a quarterly and annual basis.

Objective #2: ~~Implement~~ *Maintain and investigate modifications to* the Audit and Financial Accountability policy.

Objective #3: Investigate the possible options for developing a web based billing system to support fee-for-service contracts and improvement of accountability.

Objective #4: Evaluate provider administrative expenses and cost allocation plans to ensure maximum investment in consumer services.

Goal #11: Encourage high-quality person-centered planning and follow-through for individuals served by agencies receiving funding from the CCDDB and, through the Intergovernmental Agreement, from the CCMHB.

Objective #1: Continue to include person-centered planning as an important component of the funding priorities.

Objective #2: Develop guidelines for structuring and assessing the quality of person-centered planning processes and outcomes.

Objective #3: Require that reports of program performance include examples of outcomes and measures of person-centered planning.

Goal #12: Respond to State funding reductions for intellectual disability and developmental disability services and supports through administrative efficiencies at the Board level enabling maximum investment in community service grants and contracts.

Objective #1: Continue the administrative services agreement as defined in the Intergovernmental Agreement the Board and the Champaign County Mental Health Board.

DECISION MEMORANDUM

DATE: November 20, 2013

TO: Members, Champaign County Developmental Disabilities Board

FROM: Peter Tracy, Executive Director

SUBJECT: FY15 Allocation Priorities and Decision Support Criteria

Overview:

In Illinois, we are currently in the midst of major changes in the delivery of supports and services for people with intellectual disabilities and developmental disabilities. The changes are being brought about by the State's rebalancing efforts (i.e., state operated facility closures), lawsuits and consent decrees, national trends and paradigm shifts, new statutes (e.g., Employment First), implementation of the Affordable Care Act, Medicaid expansion, and various managed care pilot projects being implemented by the Illinois Department of Healthcare and Family Services. Community based providers are faced with the challenge of positioning to adapt to change in the continued climate of fiscal austerity, payment delays, and antiquated state policy.

Of concern to community mental health authorities (708 Boards) and county developmental disabilities boards (377 Boards) is how the myriad of changes will affect established and traditional funding patterns and exactly where we fit in this new fiscal and policy environment. The State's shift away from General Revenue Funding (GRF) to Federal Financial Participation (FFP) will continue to redefine our funding parameters and will create additional stress on an already stressed system because of the inadequacy of Medicaid rates.

On the positive side (for 708 and 377 Boards), the changes cited above will actually open up tremendous opportunities for rethinking how we prioritize local dollars. Specifically, we can anticipate the State will control costs by making adjustments in clinical and service eligibility requirements. It is reasonable to predict that a significant cohort of people will be in need of services and supports but will not meet the intellectual disability or developmental disability threshold necessary to receive an award. We have seen this pattern play out with the Early Intervention program.

Lastly, even though we know radical changes are coming, we still don't know the details of how the State systems (e.g., Department of Human Services, Department of Healthcare and Family Services, and the Department of Children and Family Services) will be organized and how services and supports will be operationalized. As they say, "the devil's in the details." So to the extent possible we will try to influence change, but I anticipate we will mostly be watching and positioning ourselves to respond to change in a way which best meets the needs of the people of Champaign County.

While the structural changes, system uncertainty, and resource challenges described above might suggest a strategy of attempting to do 'more-of-the-same with less', these conditions might also be seen as presenting a unique opportunity to utilize discretionary funds selectively and systematically to identify and support creative approaches that are effective in:

- engaging, mobilizing, and leveraging partnerships with generic community resources (civic and cultural associations, workplaces, learning places, etc.)
- developing and mobilizing citizen-based personal support networks
- moving from sheltered, custodial, and 'activity-based' programming to a systematic focus on connection, companionship, and contribution.

Statutory Authority

Funding policies of the Champaign County Developmental Disabilities Board (CCDDB) are predicated on the requirements of the County Care for Persons with Developmental Disabilities Act (55 ILCS 105/ Section 0.01 et. seq.). All funds shall be allocated within the intent of the controlling act as codified in the laws of the State of Illinois. The purpose of this memorandum is to recommend and confirm service and program priorities for the FY15 (July 1, 2014 through June 30, 2015) funding cycle. CCDDB Funding Guidelines require annual review and update of decision support criteria and priorities in advance of the funding cycle application process.

Upon approval by the Board, this memorandum shall become an addendum to the CCDDB funding guidelines incorporated in standard operating procedures.

Expectations for Minimal Responsiveness

Applications that do not meet these thresholds are "non-responsive" and will be returned to the applicant. All agencies must be registered using the on-line system. The application(s) must be completed using the on-line system.

1. Eligible applicant – based on the Organization Eligibility Questionnaire.
2. Compliance with the application deadline. Late applications will not be accepted.
3. Application must relate directly to intellectual disabilities and developmental disabilities programs, services, and supports.
4. Application must be appropriate to this funding source and shall provide evidence that other funding sources are not available to support this program/service.

FY15 Priorities and Decision Support Criteria

Upon approval by the CCDDB, the items included in this section will be heavily weighted in the decision of which applications should receive funding during the FY15 contract year (July 1, 2014 through June 30, 2015). These items are closely aligned with CCDDB planning and needs assessment processes, State and federal statute changes, intergovernmental agreements, memoranda of understanding, recommendations of consultants hired by the Board, the Board's stated goals and objectives, and the operating principles and public policy positions taken by the Board. The weighting of innovation grants will include the following principles:

- Individuals with disabilities should have the opportunity to live like those without disabilities. They should have control over their day and over where and how they live.
- Supports for individuals with disabilities should focus on building connection, companionship, and contribution in the broader community, and on supporting presence and participation in community settings where their individual contributions will be recognized and valued.
- Supports for individuals with disabilities should focus on developing and strengthening personal support networks that include friends, family members, and community partners.
- Supports for individuals with disabilities should systematically identify and mobilize individual gifts and capacities and create access to community associations, workplaces, and learning spaces in which network members have influence and standing.

The FY15 allocation process is intended to respond to a wide range of stakeholder/resident input, including that learned through the September 18, 2013 Public Hearing on Intellectual Disabilities and Developmental Disabilities and concerns brought to our attention throughout the cycle.

Priority #1 – Person Centered Planning (PCP)

Applications shall provide detailed information about the PCP process used by the applicant to develop a cogent service and support plan predicated on and specific to CCDDB funding and which identifies and mobilizes community partnerships and resources that exist beyond the service system. To the extent possible, CCDDB dollars will follow individuals rather than programs and will focus on PCP-driven services and supports tied to the individual. In addition, the PCP process shall promote self-directed and culturally appropriate individualized service plans which include measurable desired outcomes that strike a balance between what is 'important-to' and what is 'important-for' the individual.

PCP processes must include the presence and participation of the person with a disability, including whatever supports the person needs to express his or her intentions and wishes. These supports may include participation and representation by one or more family members, friends, or community partners in whom the person with a disability has indicated trust, especially in cases where the individual may have significant difficulty expressing their intentions and wishes.

Individuals should have the opportunity to make informed choices, based on access to complete information about services and financial supports available in integrated settings, exposure to integrated settings and individuals who work and live in them, and exploration of any concerns they may have about integrated settings.

Priority #2 – Employment Services and Supports

Applications which focus on vocational services and supports which are predicated on efficacious PCP processes and which incorporate Employment First Act principles shall be prioritized, with an emphasis on full or part time work in integrated, community settings, consistent with industry standards, based on a person's interests and abilities, and, when indicated and chosen, supported by individually designed services. Further, all employment/vocational related applications must warrant that CCDDB funding shall not supplement services funded by Medicaid. The following are examples of ES services and supports:

- assessment, exploration, and enhancement of vocational interests and abilities;
- support for the acquisition of job tasks and problem-solving skills;
- assistance in establishing a vocational direction/objective consistent with preferences;
- engagement of friends, family members, and community partners in identifying and creating access to workplaces in which those members have influence and standing;
- access to supported and/or customized employment opportunities;
- promotion of competitive employment outcomes;
- blended and/or transitional programs incorporating increased community integration.

Priority #3 – Comprehensive Services and Supports for Young Children

Applications with a focus on services and supports for young children with developmental delays not covered by the State's Early Intervention program(s) or under the School Code shall be prioritized. Examples of services and supports include:

- an array of Early Intervention services addressing all areas of development;
- coordinated, home-based, and taking into consideration the needs of the entire family;
- early identification of developmental delays through consultation with child care providers, pre-school educators, and medical professionals;
- supports (including education, coaching, and facilitation) that focus on developing and strengthening personal and family support networks that include friends, family members, and community partners;
- supports that systematically identify and mobilize individual gifts and capacities and create access to community associations, workplaces, and learning spaces in which network members have influence and standing.

Priority #4 – Flexible Family Support

Applications which focus on flexible, PCP-driven, family support for people with ID/DD and their families, which are designed to enhance stability and their ability to live together, shall be prioritized. Examples of flexible family support include:

- family respite, recreational activities, mutual support options, transportation assistance;
- assistive technology, home modification/accessibility supports, information, and education;
- other diverse supports which allow individuals and their families to determine care and treatment;
- assistance to the family to develop and maintain active, engaged personal support networks for themselves and their son or daughter.

Priority #5 – Adult Day Programming and Social and Community Integration

Applications for PCP-driven adult day programming for people with ID/DD who may also have behavioral support needs and/or significant physical limitations shall be prioritized. Examples of services include:

- speech therapy, occupational therapy, fitness training, personal care support;
- support for the development of independent living skills, social skills, communication skills, and functional academics skills;
- community integration and vocational training, per consumer preferences
- facilitation of social, friendship, and volunteering opportunities;

- access to community education programs, fitness and health promotion activities, mentoring opportunities, and by other creative means.

Priority #6 – Self Advocacy and Family Support Organizations
Applications highlighting an improved understanding of ID/DD through support of sustainable self-advocacy and family support organizations, especially those comprising persons who have ID/DD, their parents, and others in their networks of support, shall be prioritized.

Priority #7 – Inclusion and Anti-Stigma Programs and Supports
Applications that support efforts to reduce stigma associated with ID/DD may describe creative approaches which share the goals of increasing community awareness and challenging negative attitudes and discriminatory practices.

Priority #8 – Individualized Residential Service Options
Applications which focus on residential service and support options predicated on efficacious PCP processes and not funded by the Department of Human Services shall be prioritized. CCDDB funding for residential (and other) services and supports can potentially disqualify people from Medicaid and other State funding options.

Overarching Decision Support Considerations

The FY15 CCDDB allocation process will require all applications to address the overarching criteria listed below. Assessment of all FY15 applications will focus on alignment with these overarching criteria.

1. Underserved Populations - Programs and services that promote access for underserved populations identified in the Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity and the consultation with Carl Bell, M.D.
2. Countywide Access - Programs and services that promote county-wide access for all people in Champaign County. Zip code data is mandated.
3. Medicaid Anti-Supplementation - Programs and services eligible for Medicaid reimbursement for eligible people with intellectual disabilities and developmental disabilities shall not receive CCDDB funding.
4. Budget and Program Connectedness - Applications must clearly explain the relationship between budgeted costs and program components and must demonstrate how individuals and their preferences are driving the services. "What is the Board buying and for whom?" is the salient question to be answered in the proposal, and clarity is required.

Secondary Decision Support and Priority Criteria
The process items included in this section will be used as important discriminating factors which influence final allocation decision recommendations.

1. Approach/Methods/Innovation: Applications proposing evidence-based or research-based approaches and addressing fidelity to the model cited. Applications demonstrating creative and/or innovative approaches to meet defined community need.

2. Evidence of Collaboration: Applications identifying collaborative efforts with other organizations serving or directed by individuals with ID/DD and members of their support networks, toward a more efficient, effective, inclusive system of care.
3. Staff Credentials: Applications highlighting staff credentials and specialized training.
4. Records Systems Reflecting CCDB Values and Priorities: Applications proposing to develop and utilize records systems for individual supports, programs, and projects that clearly reflect CCDB values and priorities. Such records systems can be used to provide rapid feedback to CCDB on the impact and efficacy of innovative projects and provide project managers and direct support staff with direction and feedback that can be utilized in day-to-day management, supervision, and mentoring / coaching.

Process Considerations

The criteria described in this memorandum are to be used as guidance by the Board in assessing applications for CCDDB funding. However, they are not the sole consideration taken into account in finalizing funding decisions. Other considerations would include the judgment of the Board and its staff, opinion about the provider's ability to implement the program and services proposed, the soundness of the proposed methodology, and the administrative and fiscal capacity of the agency. Further, to be eligible to receive CCDDB funds, applications must reflect the Board's stated goals and objectives as well as the operating principles and public policy positions taken by the Board. The final funding decisions rest with the CCDDB and their judgment concerning the most appropriate and efficacious use of available dollars based on assessment of community needs, equitable distribution across disability areas, and decision-support match up.

The CCDDB allocation of funding is a complex task predicated on multiple variables. It is important to remember that this allocation process is not a request for proposals (RFP). Applicants for funding are not responding to a common set of specifications but rather are seeking funding to address a wide variety of developmental disability service and support needs in our community. In many respects our job is significantly more difficult than simply conducting an RFP. Based on past experience, we can anticipate that the nature and scope of applications will vary significantly and will include treatment, early intervention, and prevention models. For these reasons, a numerical rating/selection methodology is not applicable or relevant to our particular circumstances. Our focus is on what constitutes a best value to our community, based on a combination of cost and non-cost factors, and will reflect an integrated assessment of the relative merits of applications using criteria and priorities approved by the CCDDB.

Caveats and Application Process Requirements:

- Submission of an application does not commit the CCDDB to award a contract or to pay any costs incurred in the preparation of an application or to pay for any other costs incurred prior to the execution of a formal contract.
- Technical assistance available to applicants will be limited to process questions concerning the use of the online registration and application system, application forms, budget forms, application instructions, and CCDDB Funding Guidelines.
- Applications which include excessive information beyond the scope of the application format will not be reviewed and, at the discretion of staff, may be disqualified from

consideration. Letters of support for applications are discouraged and, if submitted, will not be considered as part of the allocation and selection process.

- The CCDDB retains the right to accept or reject any or all applications and reserves the right to refrain from making an award when that is deemed to be in the best interest of the county.
- The CCDDB reserves the right to vary the provisions set forth herein at any time prior to the execution of a contract where the CCDDB deems such variances to be in the best interest of Champaign County.
- Applications and submissions become the property of the CCDDB and, as such, are public documents that may be copied and made available upon request after allocation decisions have been made. Materials submitted will not be returned or deleted from the online system.
- The CCDDB reserves the right, but is under no obligation, to negotiate an extension of any contract funded under this allocation process for up to a period not to exceed two years with or without additional procurement.
- If selected for contract negotiations, the applicant may be required to prepare and submit additional information prior to final contract execution, in order to reach terms for the provision of services that are agreeable to both parties. Failure to submit required information may result in cancellation of the award of a contract.
- The execution of financial contracts resultant of this application process is dependent upon the availability of adequate funds and the needs of Champaign County.
- The CCDDB reserves the right to further define and add application components as needed. Applicants selected as responsive to the intent of this online application process will be given equal opportunity to update proposals for the newly identified components.
- All proposals considered must be received on time and must be responsive to the application instructions. The CCDDB is not responsible for lateness or non-delivery of mail or messenger. Late applications shall be rejected.
- The contents of a successful application will be developed into a formal contract, if selected for funding. Failure of the applicant to accept these obligations can result in cancellation of the award for contract. The CCDDB reserves the right to withdraw or reduce the amount of an award if there is misrepresentation of the applicant's ability to perform as stated in the application.
- The CCDDB reserves the right to negotiate the final terms (i.e., best and final offer) of any or all contracts with the applicant selected, and any such terms negotiated as a result of this application process may be renegotiated and/or amended in order to meet the needs of Champaign County. The CCDDB also reserves the right to require the submission of any revision to the application which results from negotiations conducted.
- The CCDDB reserves the right to contact any individual, agency, or employee listed in the application or to contact others who may have experience and/or knowledge of the applicant's relevant performance and/or qualifications.

Final Decision Authority – The CCDDB will make the final decision concerning all applications for funding, taking into consideration staff recommendations, defined decision support criteria, best value, and availability of funds.

Decision Section:

Motion to approve the FY15 Allocation Decision Support Criteria as described in this memorandum.

_____ Approved

_____ Denied

_____ Modified

_____ Additional Information Needed

CHAMPAIGN COUNTY MENTAL HEALTH BOARD

13.D.

CHAMPAIGN COUNTY BOARD FOR CARE AND TREATMENT OF PERSONS WITH A DEVELOPMENTAL DISABILITY

DECISION MEMORANDUM

DATE: November 20, 2013
TO: Members, Champaign County Mental Health Board (CCMHB)
FROM: Peter Tracy, Executive Director
SUBJECT: FY15 Allocation Priorities and Decision Support Criteria

In Illinois, we are currently in the midst of major changes in the delivery of supports and services for people with mental illnesses, substance use disorders, and intellectual disabilities and developmental disabilities. The changes are being brought about by the State's rebalancing efforts, lawsuits and consent decrees, national trends and paradigm shifts, new statutes, implementation of the Affordable Care Act, Medicaid expansion, and various managed care pilot projects including the Choices project in Champaign Vermilion, Ford and Iroquois Counties.

Of concern to community mental health authorities and county developmental disabilities boards is how the myriad of changes will effect established funding patterns, and exactly where do we fit in this brave new world? The State's shift away from General Revenue Funding (GRF) to Federal Financial Participation (FFP) will continue to redefine our funding parameters, and will also create additional stress on an already stressed system because of the inadequacy of Medicaid rates.

On the positive side (i.e., for 708 and 377 Boards), the changes cited above will actually open up tremendous opportunities for rethinking how we prioritize local dollars. Specifically, we can anticipate the State (and their managed care entities) will control costs by making adjustments in clinical eligibility requirements. It is reasonable to predict that a significant cohort of people will be in need of services, but will not meet the clinical threshold necessary to receive services.

Lastly, even though we know radical changes are coming, we still don't know the details of how the State systems (e.g., Department of Human Services, Department of Healthcare and Family Services, and the Department of Children and Family Services) will be organized and how services will be operationalized. As they say, "the devil's in the details." So to the extent possible we will try to influence change, but I anticipate we will mostly be watching and positioning ourselves to respond to change in a way which best meets the needs of the people of Champaign County.

Statutory Authority

Funding policies of the Champaign County Mental Health Board (CCMHB) are predicated on the requirements of the Illinois Community Mental Health Act (405 ILCS 20 / Section 0.1 et.seq.). All funds shall be allocated within the intent of the controlling act as codified in the laws of the State of Illinois. The purpose of this memorandum is to recommend and confirm service and program priorities for the FY15 (July 1, 2014 through June 30, 2015) funding cycle. CCMHB Funding Guidelines require annual review and update of decision support criteria and priorities in advance of the funding cycle application process.

Expectations for Minimal Responsiveness

Applications that do not meet these thresholds are "non-responsive" and will be returned to the applicant. All agencies must be registered using the on-line system. The application(s) must be completed using the on-line system.

1. Eligible applicant – based on the Organization Eligibility Questionnaire.
2. Compliance with the application deadline. Late applications will not be accepted.
3. Application must relate directly to mental health, substance abuse or developmental disabilities programs and services.
4. Application must be appropriate to this funding source and shall provide evidence that other funding sources are not available to support this program/service.

FY15 Decision Priorities and Decision Support Criteria

Priority #1 – Collaboration with the Champaign County Developmental Disabilities Board

Full compliance with the terms and conditions of the Intergovernmental Agreement between the CCMHB and the Champaign County Developmental Disabilities Board (CCDDB). This agreement defines the FY15 allocation for developmental disabilities programs and services, as well as the expectation for integrated planning by the Boards.

Priortiy #2 – ACCESS Initiative Sustainability

The CCMHB has committed to sustaining our system-of-care after the term of the cooperative agreement with IDHS expires on September 30, 2015. A major component of this effort will be to continue our support and sponsorship of the Community Coalition with the City of Champaign and other units of local government. We envision the Community Coalition as the system-integrating and planning level of the system of care. In addition, the CCMHB plans to work with the Community Coalition, the Illinois Department of Healthcare and Family services, and Choices (the managed care company contracted for the pilot project in Champaign, Vermilion, Ford and Iroquois Counties to plan the "service level" for the system-of care and organize our resources to coordinate with other funders to enhance service capacity and efficacy. Full integration of these collaborations and programs will facilitate and improve system level policy and coordination, police-community relations, seamless service delivery, expansion of available matching funds, and sustainability of the system-of-care infrastructure (e.g., family and youth involvement, cultural competence, trauma informed, strength based, etc.).

Priority #3 – Behavioral Health Programs for Youth with Serious Emotional Disturbance.

Alignment between Quarter Cent for Public Safety funding, CCMHB funding, and other federal, state and/or local funding streams to efficaciously address the needs of youth with SED by supporting the following services and supports:

(a) **Parenting with Love and Limits (PLL)** – Maintenance of Parenting with Love and Limits (PLL) as a means of assuring clinical efficacy and attainment of desired outcomes for ACCESS Initiative youth and families, as well as other youth involved in the juvenile justice system.

(b) **ACCESS Initiative** – In partnership with the Illinois Department of Human Services (IDHS), implementation of the Substance Abuse and Mental Health Services Administration (SAMHSA) Children's Initiative (by subcontract from the IDHS). During FY15, the project will be entering its transition phase as it moves away from the funding provided through the Cooperative Agreement to the sustainability phase.

(c) **Quarter Cent for Public Safety** – Full compliance with the MOU and support of development of a system of care which includes integrated planning with PLL and ACCESS Initiative. For FY15, it is recommended that this funding be used exclusively to support the Youth Assessment Center operated by the Regional Planning Commission (CCRPC).

Priority #4 – Behavioral Health Services and Supports for Adults with a Behavioral Health and Criminal Justice Interface.

Continuation during FY15 of the reconfigured behavioral health system which was designed to assure appropriate linkage to behavioral health services following incarceration, deflection of people with serious behavioral health problems prior to incarceration, and improved coordination between community based service providers and the Champaign County Jail's behavioral health service provider for people during their incarceration.

Included as a component of this priority is our continued support of the specialty courts, related services, and supports. Full compliance with memoranda of understandings pertaining to specialty courts will be continued during FY15.

Priority #5 – Local Funder Collaboration on Special Initiatives

It is recommended we support local funder collaborations intended to expand the availability of psychiatric services in Champaign County and/or development of an emergency shelter for families facing homelessness. Expansion of psychiatric services

could include supporting a partnership between community based behavioral health providers and the Federally Qualified Health Center (FQHC) in Champaign County. The only caveat to this item pertains to how the ACA and Medicaid expansion addresses this deficiency. The implementation of Medicaid managed care could conceivably address this issue. An emergency shelter for families was piloted in the community last winter and spring. The prospect exists for those involved with the pilot to lead an effort to establish a permanent facility. As part of any collaboration with other local funders on an emergency shelter for families, consideration would be given to providing support services at the shelter.

Priority #6 – Support and Compliance with all Memoranda of Understanding and Intergovernmental Agreements

It is recommended we support and comply with expectations associated with MOUs and IGAs (e.g., commitment to funding 2-1-1 services).

Overarching Decision Support Considerations

The FY15 CCMHB allocation process will require all applications to address the overarching criteria listed below. Assessment of all FY15 applications will focus on alignment with these overarching criteria.

1. **Underserved Populations** - Programs and services that promote access for underserved populations identified in the Surgeon General's Report on Mental Health: Culture, Race, and Ethnicity and the consultation with Carl Bell, M.D.
2. **Countywide Access** - Programs and services that promote county-wide access for all people in Champaign County. Zip code data is mandated.
3. **Budget and Program Connectedness** - Applications that clearly explain the relationship between budgeted costs and program components receive additional consideration. "What is the Board buying?" is the salient question that must be answered in the proposal, and clarity is required.
4. **Realignment of Existing FY14 Contracts to Address Priorities** – The CCMHB reserves the right to reduce or eliminate incumbent programs and services in order to support the six FY15 priorities listed in this memorandum.

5. Anti-Stigma Efforts – Activities that support efforts to reduce stigma associated with mental health, substance use disorders, and intellectual disabilities/developmental disabilities by increasing community awareness and challenging negative attitudes and discriminatory practices.

Secondary Decision Support and Priority Criteria

The process items included in this section will be used as discriminating factors which influence final allocation decision recommendations. The CCMHB uses an on-line system for agencies interested in applying for funding. An agency must complete the one-time registration process including the Organization Eligibility Questionnaire before receiving access to the on-line application forms.

Approach/Methods/Innovation: Applications proposing evidence based or research based approaches, and in addition address fidelity to the specific model cited. Applications demonstrating creative and/or innovative approaches to meet defined community need will receive additional consideration.

Staff Credentials: Applications that address and highlight staff credentials and specialized training will receive additional consideration.

Process Considerations

The criteria described in this memorandum are to be used as guidance by the Board in assessing applications for CCMHB funding, however, it is not the sole consideration taken into account in finalizing funding decisions. Other considerations would include the judgment of the Board and its staff, opinion about the provider's ability to implement the program and services proposed, the soundness of the proposed methodology, and the administrative and fiscal capacity of the agency. Further, to be eligible to receive CCMHB funds, applications must reflect the goals and objectives stated in the Three Year Plan as well as the operating principles and public policy positions taken by the Board. The final funding decisions rest with the CCMHB and their judgment concerning the most appropriate and efficacious use of available dollars based on assessment of

community needs, equitable distribution across disability areas, and decision-support match up.

The CCMHB allocation of funding is a complex task predicated on multiple variables. It is important to remember that this allocation process is not a request for proposals (RFP). Applicants for funding are not responding to a common set of specifications, but rather are applying for funding to address a wide variety of mental health, developmental disability and substance abuse treatment needs in our community. In many respects our job is significantly more difficult than simply conducting an RFP. Based on past experience we can anticipate the nature and scope of applications will vary significantly and will include treatment, early intervention and prevention models. For these reasons, a numerical rating/selection methodology is not applicable and relevant to our particular circumstances. Our focus is on what constitutes a best value to our community based on a combination of cost and non-cost factors, and will reflect an integrated assessment of the relative merits of applications using criteria and priorities approved by the CCMHB.

Caveats and Application Process Requirements:

- Submission of an application does not commit the CCMHB to award a contract or to pay any costs incurred in the preparation of an application or to pay for any other costs incurred prior to the execution of a formal contract.
- Technical assistance available to applicants will be limited to process questions concerning the use of the on-line registration and application system, application forms, budget forms, application instructions and CCMHB Funding Guidelines.
- Applications which include excessive information beyond the scope of the application format will not be reviewed and at the discretion of staff may be disqualified from consideration. Letters of support for applications are discouraged and if submitted will not be considered as part of the allocation and selection process.

- The CCMHB and CCDDB retains the right to accept or reject any or all applications, and reserves the right to refrain from making an award when it is deemed to be in the best interests of the county.
- The CCMHB reserves the right to vary the provisions set forth herein at any time prior to the execution of a contract where the CCMHB deems such variances to be in the best interest of Champaign County.
- Applications and submissions become the property of the CCMHB and as such, are public documents that may be copied and made available upon request after allocation decisions have been made. Materials submitted will not be returned or deleted from the on-line system.
- The CCMHB reserves the right, but is under no obligation, to negotiate an extension of any contract funded under this allocation process for up to a period not to exceed two years with or without additional procurement.
- If selected for contract negotiations, the applicant may be required to prepare and submit additional information prior to final contract execution, in order to reach terms for the provision of services that are agreeable to both parties. Failure to submit required information may result in cancellation of the award of a contract.
- The execution of financial contracts resultant of this application process is dependent upon the availability of adequate funds and the needs of Champaign County.
- The CCMHB reserves the right to further define and add additional application components as needed. Applicants selected as responsive to the intent of this on-line application process will be given equal opportunity to update proposals for the newly identified components.
- All proposals considered must be received on time and must be responsive to the application instructions. The CCMHB is not responsible for lateness or non-delivery of mail or messenger. Late applications shall be rejected.
- The contents of a successful application will be developed into a formal contract, if selected for funding. Failure of the applicant to accept these obligations can result in cancellation of the award for contract. The CCMHB reserves the right to

withdraw or reduce the amount of an award if there is misrepresentation of the applicant's ability to perform as stated in the application.

- The CCMHB reserves the right to negotiate the final terms (i.e., best and final offer) of any or all contracts with the applicant selected and any such terms negotiated as a result of this application process may be renegotiated and/or amended in order to meet the needs of Champaign County. The CCMHB also reserves the right to require the submission of any revision to the application, which results from negotiations conducted.
- The CCMHB reserves the right to contact any individual, agency or employer listed in the application or to contact others who may have experience and/or knowledge of the applicant's relevant performance and/or qualifications.
- Final Decision Authority – The CCMHB will make the final decision concerning all applications for funding, taking into consideration staff recommendations, defined decision support criteria, best value, availability of funds, and equitable distribution of funds between disability areas.

Decision Section:

Motion: Move to approve the FY15 Allocation Decision Support Criteria as described in this memorandum.

_____Approved

_____Denied

_____Modified

_____Additional Information Needed

n/a

13. E.

7th Annual disABILITY Resource Expo
Board Report
November, 2013

The 7th annual "disABILITY Resource Expo: Reaching Out For Answers" was held on Saturday, October 12, 2013 at Lincoln Square Village in Urbana. We were very fortunate to have been able to change the venue of the 2013 Expo just less than two weeks prior, due to the new Fluid Event Center not being quite complete at that point. The Urbana Business Association happily aided us in transitioning back to our previous location at Lincoln Square Village. Fluid Event staff were very gracious in providing staff and support, both during set-up on Friday, and during the event on Saturday. A total of 92 exhibitors were on hand to share information and resources to the large number of attendees. Of these 92 exhibitors, 26 were new to the Expo this year. Being able to accommodate this large increase in exhibitors in space we had outgrown last year was no small task. Hats off to Jim Mayer, who did an admirable job making it all fit well within the space constraints we were faced with.

Some remarkably talented folks provided entertainment at this years' Expo. We were pleased to have representatives from the U.S. Power Soccer Association put on a demonstration of the fastest growing wheelchair sport in the country. A wheelchair dance team from Momenta, a performing arts company out of the Chicago area, performed beautiful dance routines for us. Phyllis Mueller with Drumming For Health engaged participants in therapeutic drumming sessions throughout the day. Leaders For Life Martial Arts students gave an amazing demonstration, and even invited several children from the audience to join in and learn some special moves. Champaign's own talented jazz pianist, Donnie Heitler, entertained folks with his wonderful music. There were mini therapy horses to pet, transportation surveys to gather information about accessible transportation needs in our community, and so much more.

As always, the Expo was very in tune with accessibility needs of our participants. Interpreters, personal assistants, and a Spanish translator were available upon request, as were alternative formatted materials. The Disability 101 Bookmark was distributed, and was available in large print. The 2013 Resource Book was distributed to all participants, and was available on CD. Thanks to Lynn Canfield for all her work in developing the Resoource Book, as well as the Expo's new website, where folks can find this years' Resource Book and lots of other great information. The website is: www.disabilityresourceexpo.com or www.disabilityresourceexpo.org.

As always, Jen Knapp did a phenomenal job pulling together a very large group of volunteers for set-up on Friday, and to assist on Saturday during the event. The volunteers were amazing and really helped make everything run smoothly. We were pleased this year to utilize the resources of Court Services community service volunteers, who proved to be invaluable in the tear-down process.

Exhibitor and participant evaluations were gathered during the event. Both of these surveys were very positive, and will be an important aide in planning for the 2014 Expo. The Steering Committee met on November 8 to debrief and begin to discuss ideas for the 8th Annual Expo. This was definitely a year not without challenges, but in light of all of them, I have to say that the Expo Steering Committee is the best group of hard-working, dedicated individuals I have ever had the pleasure to work with.

Respectfully submitted
Barb Bressner, Consultant

13.F.

Update on Ligas Consent Decree

Including:

Informational Flyer for Tonight's Presentation

First Annual Report of the Monitor

Ed McManus' November 3, 2013 Newsletter

March 20th Letter from Peter Tracy

The Ligas Consent Decree Update

Tony Records, Court Monitor

The Ligas Consent Decree was ordered by the U.S. Federal court on June 15, 2011. This Decree will provide choice and opportunities for thousands of adults with developmental disabilities. Tony Records will give updates on the state of Illinois's progress over the last year.

Sponsored by:

Transition Planning Committee

THE AUTISM PROGRAM of Illinois TAP
VISIT WWW.THEAUTISMPROGRAM.ORG

COMMUNITY CHOICES
A COOPERATIVE APPROACH TO HUMAN SERVICES

CHAMPAIGN COUNTY DEVELOPMENTAL DISABILITIES BOARD
CHAMPAIGN COUNTY MENTAL HEALTH BOARD

C-U Autism Network

The Pavilion
BEHAVIORAL HEALTH SYSTEM

November 20, 2013

Free

7:00 p.m. -8:30 p.m.

Christopher Hall

904 W. Nevada, Urbana, IL

For more information contact:

Linda Tortorelli—ltortore@illinois.edu, 217.244.0928

For more information about the Ligas Consent Decree go to

http://www.thearcofil.org/arc-and-ligas-court-monitors-first-annual-report

Down Syndrome Network
DSN

UCP

STANLEY LIGAS, et al. v. JULIE HAMOS, et al.

First Annual Report of the Monitor

September 27, 2012

Submitted by: Tony Records, Monitor
7109 Exeter Road
Bethesda, MD 20814
301-529-9510
traconsult@mindspring.com

Section 1 – Introduction

This report is respectfully submitted to the Court, the Parties and the Intervenors in accordance with the Consent Decree (Decree) approved and filed by the Court on June 15, 2011. Specifically, the Decree requires that:

> The Monitor shall file annual reports to the Court, which shall be served on all Parties and Intervenors and be made publicly available. Such reports shall include the information necessary, in the Monitor's professional judgment, for the Court, Plaintiffs and Intervenors to evaluate Defendants' compliance or non-compliance with the terms of the Decree.[1]

The Monitor has engaged in numerous activities consistent with Section XIV (Monitoring and Compliance) of the Decree. There have been seven parties' meetings since the approval of the Decree. During each of these meetings, the Monitor has given a verbal report of progress and concerns regarding compliance as well as a review of activities. The Monitor has also met with and talked to counsel and representatives of the parties and intervenors separately on an ongoing basis. No prior drafts of this report or any part of this report have been submitted

[1] Consent Decree, Section XIV, ¶34, at Page 19.

to the parties, intervenors or anyone else. This report was served by hand to the Parties and Intervenors at the scheduled Parties' meeting of September 27, 2012.

This report is organized in five sections. Following the introduction is a section describing the activities of the Monitor during the past year and anticipated activities for the next year. This is followed by a brief and general description of actions taken by the Defendants during this period. The next section is the primary section, which includes a sequential description of activities and findings listed in order of requirements of the Decree and as listed in the established Compliance Standards developed by the Monitor in accordance with the Decree.[2] Finally, the Monitor has included some overall comments designed to communicate a broad description of progress and successes thus far, as well as anticipated possible roadblocks to compliance in the future.

There has been one instance, on May 1, 2012 when the Monitor notified the Defendants and Plaintiffs' counsel of non-compliance with ¶21. (c) of the Decree (Crisis Services). In accordance with the Compliance provisions of the Decree,[3] the Monitor met and conferred with the parties to discuss the necessary actions to achieve compliance. The defendants are now implementing the action steps that were developed as the result of this process. (See section on Crisis Services on page 22-23 for further details). Other than this one instance, there have been no other notices or written findings of non-compliance.

[2] Consent Decree, Section XIV, ¶32, at pages 17 and 18.
[3] Consent Decree, Section XIV, ¶35, at page 19

Section 2 - Activities of the Monitor

The Monitor was appointed by the Court on July 19, 2011 and started monitoring activities on August 3, 2011. During the past year, the Monitor has engaged in numerous activities designed to initiate and encourage necessary compliance-related actions, assist the Defendants in the implementation of the Consent Decree requirements, facilitate communication between the parties, engage in activities to inform the public about the requirements of the Decree and evaluate overall compliance.

At the outset, it is important to state clearly that the Monitor has received full cooperation and support from the Defendants, including the Departments of Human Services and Home and Family Services, the Governor's office, the Attorney General's office and, in particular, the management team and staff at the Division of Developmental Disabilities (DDD). DDD has provided the Monitor with unfettered access to program staff, class members, class member records and requested information and documents. Plaintiffs' counsel and representatives as well as counsel for the Intervenors have also been readily available and responsive to the Monitor whenever called upon. In all of the parties' meetings, discussions have been productive and on point toward the goal of compliance with the Decree.

The Monitor has also experienced full cooperation and support from the community service providers, ICF/DD facility staff, advocacy organizations and family associations throughout the state of Illinois through the provision of information, facilitation of meetings and direct input on issues relating to compliance activities.

Class members, as well as their guardians and families have also been forthcoming and responsive to the Monitor and continuously expressed a willingness to

participate in activities and share their experiences in order to assist the Monitor in evaluating compliance.

Activities of the Monitor over the past year include the following:

- ✓ The Monitor held initial separate meetings with all counsel to discuss expectations and obtain various perspectives on challenges pertaining to compliance activities.

- ✓ The Monitor has facilitated each of the parties' meetings. These meetings were held on 8/22/11, 9/19/11, 10/24/11, 12/5/11, 1/23/12, 3/29/12 and 6/21/12. These parties meetings are now being scheduled routinely each quarter in order to maintain regular line of communication among the parties and to document progress and concerns on a timely basis. To increase efficiency and productivity, these meetings have now been bifurcated to include full participation of the parties and Intervenors for discussion and input relating to paragraphs 4-10, 25 and 45 of the Decree and only class counsel and defendants' participation with regard to the remaining provisions of the Decree.

- ✓ Initial and continuous meetings have been conducted with key staff at DDD and DHS who have specific responsibilities relating to implementation of compliance related activities. The Associate Director of DDD has been the key liaison with the Monitor in facilitating meetings, document production and development and coordination of compliance activities.

- ✓ The Monitor has devoted a significant amount of time and effort to provide information sessions across the state to class members, potential class members, families, guardians, community service providers, advocacy organizations, ICF/DD providers, PAS agencies and other stakeholders. These information sessions provided an overview of the Decree and Implementation Plan as well as an update of compliance activities and ways stakeholders can play a vital role in providing information and feedback on *Ligas* related issues. Audiences of more than twenty of these information sessions have included more than 1,800 individuals.

- ✓ Monthly meetings are held with the DDD Director to review progress and challenges related to implementation activities designed to develop strategies to address current issues. The Monitor has also had several meetings with the DHS Secretary to provide an update of activities and any concerns about overall compliance.

- ✓ The Monitor has also met on several occasions with the Governor's office to provide an overview of activities and discuss any overall compliance concerns.

- ✓ The Monitor has reviewed hundreds of documents provided by the defendants, class counsel, service providers, PAS agencies, advocacy organizations and families that have provided significant information, insight and perspective to compliance activities and challenges.

- ✓ The Monitor has reviewed all information on the defendants' various websites relevant to compliance activities and policies that relate to the Decree. The Monitor has worked directly with DDD staff to review and modify information on the *Ligas* page or the DDD website.

- ✓ The Monitor has provided his telephone and email contact information widely across the state in order to hear directly from class members, families, guardians, service providers and PAS agencies about questions and concerns relative to implementation of compliance related activities. As a result, there have been numerous inquiries and concerns received which require specific follow-up and clarification with the defendants. This process has helped clarify many policy questions that have emanated as result of new compliance activities.

- ✓ In accordance with the Decree, the Monitor developed, with input from the parties and intervenors, Compliance Evaluation Standards.[4] These Standards were completed on July 17, 2012. These Standards include agreed-upon standards as well as the specific methodology the Monitor will utilize in measuring compliance.

[4] ¶32 of June 15, 2011 Consent Decree at page 17

Section 3 - Overall Activities of the Defendants and Parties

Implementation of activities to foster compliance with the Decree has required the infusion of significant resources and personnel efforts by the defendants. It is important to state at the outset that the developmental disabilities system in Illinois has, through the past years, been fraught with inadequate funding, slow growth of capacity, shortages of staff and a weak infrastructure. Within two months after the approval of the Decree, a new Director of DDD was hired. During the same period, the defendants entered into two other major consent decrees and announced the closures of two state-operated developmental centers.

Including those individuals in crisis, individuals on the waiting list and those in ICFs/DD who have requested home community based services, there are currently approximately 12,000 *Ligas* class members. This overall scenario presented the defendants with a seemingly Sisyphean task of entering into a new way of responding to the needs of people with intellectual and developmental disabilities.

The defendants, however, through planning and coordination, have undertaken a systematic approach toward compliance with the Decree. A team within DDD was assigned to specific tasks related to various requirements of the Decree. A *Ligas* budget was developed. New resources were created or identified to support development of community-based supports. A *Ligas* website was established. The *Ligas Implementation Plan* was drafted and negotiated with the parties and intervenors. Policies were developed and/or modified to address *Ligas* requirements. Communications about *Ligas*-related activities were sent to families, class members, community services providers and PAS agencies. This report, in the section immediately below, provides specific information about these activities. In many instances, these activities have resulted or will result in compliance within the timeframes established in the Decree. In some instances, as specified below, compliance with the timeframes of the Decree has been slow or

will be difficult to achieve within the timeframes prescribed unless additional steps are taken. These strong efforts of the defendants, however, have established a foundation upon which substantial compliance can be obtained and sustained over time. It is important for the parties to appreciate that this is the end of the first year of at least a nine year period of implementation of compliance activities.

During this first year of implementation, the parties and intervenors have also collectively contributed toward resolution of issues as they arise. Through the parties' meetings as well as informal communication methods, the parties and intervenors have effectively negotiated timeframes, compliance documents (to include the Implementation Plan and Outreach RFP) and have worked well together to clarify compliance issues.

The Monitor has served as a facilitator with the parties toward productive resolution of issues. With regard to the defendants, the Monitor has assumed a more hands-on role as compliance activities have evolved. This means at times advising the defendants through the offering of suggestions, and, when necessary, the Monitor will goad the defendants toward the direction needed to achieve sustained compliance. This method of mentoring and consultation will continue as long as there is continued priority on compliance with the Decree and measurable progress.

Section 4 – Compliance Requirements and Activities

This section provides a specific review of the compliance requirements in each of the nine major areas of compliance, which include the following:

1. Resources and Capacity
2. Class Member List(s)
3. Transition Service Plans
4. Transition for Class Members in ICFs/DD
5. Crisis Services
6. Transition for Class Members on Waiting List
7. Outreach
8. Implementation Plan
9. Data Reports

Each area of compliance is listed below in a separate section that includes: a description of the requirements in the Consent Decree; timeframes or deadlines for compliance; related activities described in the Implementation Plan and; the status of implementation of compliance activities by the defendants. In accordance with this provision, this section is considered by the Monitor as the primary measure of compliance with the Decree. For some of the requirements, the timeframes for implementation of the specific timeframes have not yet transpired. In these instances, the Monitor will report on activities that have occurred so far and, where appropriate, the likelihood that these actions will lead to timely compliance.

There are also findings in two other distinct areas of the Decree including services to named plaintiffs and dispute resolution.

Resources and Capacity

The Decree requires that resources for community services to be provided consistent with the choice of a class member and the requirements of paragraphs 17 through 19 and 21 through 23 of the Decree. Resources necessary to meet the needs of individuals with developmental disabilities who choose to receive services in ICFs/DD shall be made available and such resources will not be affected by Defendants' fulfillment of their obligations under the Decree. Funding for services for individuals with developmental disabilities will be based on the individual's needs using federally approved objective criteria regardless of whether the individual chooses to receive services in an ICF/DD or in a community-based setting. Amendments to the state Medicaid plan will continue to include ICF/DD services as an alternative choice for long term services.[5] Annual budgets will be sufficient to fund the services necessary to comply with the Decree consistent with the choices of individuals with developmental disabilities, including class members.[6]

The Implementation Plan calls for a continuation of activities to develop new community services providers and the voluntary conversion of ICFs/DD to community-based services.[7] The Implementation Plan also calls for the development of annual budget proposals to incorporate the necessary resources to carry out the provisions of the Decree. The Plan also includes resources for a listing of specific contractual agreements necessary to address the anticipated increase in demand for services, additional DDD staff to be hired in order to manage compliance and prepare compliance-related reports and funding for direct services for class members as they are identified to receive community services.[8]

[5] ¶ 4 of June 15, 2011 Consent Decree at page 7
[6] ¶ 5 of June 15, 2011 Consent Decree at pages 7and 8.
[7] Ligas Implementation Plan, 12/15/11, Section IV, Page 13.
[8] Ligas Implementation Plan, 12/15/11, Section X, Page 20-22.

In order to comply with the provisions of the Decree regarding resources, the defendants engaged in numerous activities. These activities include the following:

- A *Ligas* budget was developed for Fiscal Year 2013 and beyond. The DDD Director presented a six-year budget to the parties and intervenors at the December 5, 2011 parties' meeting. The projected budget information presented reflected the needed growth in community capacity called for in the Decree. The budget planning assumptions were also included in the presentation. There were no changes projected in the budget levels for people living in ICF/DD settings. The *Ligas* budget totals $38.9 million in FY13. The anticipated *Ligas* expenditures for the six-year period from FY12-FY17 is $456.4 million. Six months later, it was announced that the legislature reduced the overall budget by 4%. The DHS Secretary assured the parties that there will be no specific cuts to services. It is expected that these reductions will be absorbed through delayed start-up and reduced annualization of new services.
- Since then, Department of Human Services (DHS) has recently announced instituted changes in the reimbursements as well methods and standards for establishing payments for home and community-based services, particularly targeting small (1-4 person) Community Integrated Living Arrangements (CILA). Many of these changes are designed to realign the prior disincentives in the reimbursement rate structure for smaller community homes. These changes include the following:
    - An increase in the staff fringe benefit percentage for all CILAs from 20% to 25%.
    - Modification of direct care staffing funding formulas for 1, 2, 3 and 4 person homes;
    - Increase minimum direct care staff coverage by two hours per day;
    - Update housing allowances for CILA sites with a capacity of four persons or fewer;
    - Adjust funding for vehicle purchases and vehicle operation for CILA sites with a capacity of four persons or fewer; and
    - Implement funding formula changes in nursing services reimbursement for medication administration and nurse monitoring.

These changes will be effective October 1, 2012. It is estimated that these combined changes will result in an increase of $19.30 million in new annualized state expenditures.

- A new *Ligas Implementation Team* was funded and is being assembled. Positions for this team includes the following:
    - Compliance Coordinator – This position is currently vacant and the work is being shared by the DDD Associate Director and a senior staff within BTS.
    - Program and Data Support Staff – This position has not yet been established.
    - Bureau of Quality Management Staff (7) - Three positions were filled in FY12. One position was posted and qualifications have been approved. Two positions are being filled through the state attrition process.
    - Bureau of Transition Services Staff (4) – Two positions were filled in FY12. Two positions have not yet been posted.
    - Appeals Unit Staff – Position was filled in FY12
    - Rates Section Staff – Position was filled in FY12
    - Medicaid Waiver Staff (3) - Two positions were posted and candidates were identified and are pending final approval.
- Budget allocations were identified for contract services and service enhancements for PAS agencies.
- Grants for PAS agencies were enhanced to facilitate *Ligas*-related activities.
    - Effective July 1, 2012 grants to PAS agencies for intake and screening have been increased across the board by 10%. This increase is to allow for the expected increase in work demand.
    - Reimbursement funds for PAS agencies work in PUNS-related activities will be structured to allow for expedited payments.
- Proposed amendments were submitted to the Center for Medicare and Medicaid (CMS) for the expansion of the Medicaid Home and Community Based Services (HCBS) Waiver. On June 13, 2012 the defendants submitted application to increase the adult waiver capacity from 15,920 individuals to 18,200 individuals. This increase was designed to allow for sufficient increase in capacity to serve the number of new class members called for to comply with the Decree. These requested amendments were approved by CMS on September 20, 2012. The defendants and the Monitor will track capacity growth closely and, if necessary, the defendants will submit additional amendments in the future.

- The DDD Director has pledged to re-assemble a workgroup of stakeholders to evaluate the rates and rate structure for funding of home and community-based services.

The Monitor commends the defendants for the many steps taken as described above in order to identify resources to support expanded community-based capacity to comply with the Decree. While each one of these efforts are of consequence and will play a significant role in moving implementation forward, still more needs to be done. The Monitor has the following specific concerns with regard to resources:

- It is important that the full *Ligas Implementation Team* needs to be hired and functioning in order to meet the many challenging demands of the Decree and Implementation Plan. As listed above, only 8 of the 18 new staff positions have been filled. It is absolutely necessary for the defendants to expeditiously move forward and hire and train these new staff. Overall, DDD is already seriously understaffed to implement all of its responsibilities along with the added responsibilities that the implementation of the Decree presents.
- Although reassembling a community rates workgroup is an important step toward rebalancing the funding and rate structure of home and community-based services, this issue must be given top priority and move forward with vivacity. Even with the recent rates enhancements listed above, the overall rates for home and community-based services in Illinois remain to be among the lowest in the country. With the demand for new services statewide as called for in *Ligas* implementation, it will be quite difficult to expect providers to continue expansion or to attract new community providers with such low rates.
- The *Ligas* budget also includes $446 thousand in FY12 and $1.9 million in FY13 for contractual agreements called for in the Implementation Plan. To date, other than agreements with PAS agencies, there have not been any specific contracts executed or implemented for *Ligas* implementation. Contracts are called for in the areas of Outreach, Transition Planning and a Family Support liaison. Over the next six months, the Monitor will work closely with DDD to make sure these contracts are in place and fully operational.
- An extraordinarily long reimbursement cycle for reimbursement only compounds the challenge of operating with low rates and, at the same time,

asking the provider community to step forward and borrow even more in order to serve more people. The Monitor has received reports from many providers that reimbursement payments typically can take from seven to nine months. Even those who qualify for the "expedited payment" often report as much as 60 days or more for reimbursement payment. Over the next year, the Monitor will review this issue carefully to determine its degree of impact with compliance with the Decree.

Class Member List(s)

The Decree requires the defendants to maintain a statewide database in which all Class Members are enrolled.[9] Defendants are also required to promptly revise the class member database and waiting list data.[10]

The Implementation Plan describes the process for the development and maintenance of a class member list that will be accessible to the Monitor and Class Counsel. Intervenors' counsel will have access to the class list as provided in the Implementation Plan. DDD will use its PUNS database to maintain a list of Waiting List class members. The Plan also calls for DDD to review the adequacy of the PUNS database.

Upon recommendation by the Monitor and agreement of the parties and intervenors, the defendants have developed and maintained two class member lists.

First, there is now a list of class members pursuant to ¶2 (a) of the Decree, who: qualify for Medicaid Waiver services; live in an ICF/DD with nine or more residents and; have affirmatively requested community-based services or placement in a community-based setting. As of September 12, 2012 there were 697 class members in this category. The defendants maintain a list that contains, at a minimum: the names of individuals; the documentation to verify their written affirmative request; date of birth; social security number and; the name of the facility in which they live. Development of this list has been challenging and has required numerous modifications. Due to many various factors, including data entry errors, difficult transcription, interpretations of hand-written forms, undated or unsigned applications as well as numerous name discrepancies, initial lists contained many inaccuracies. The most recent list has been reviewed and re-

[9] ¶8 June 15, 2011 Consent Decree at Page 8.
[10] ¶9 June 15, 2011 Consent Decree at Page 9.

reviewed and appears to be consistent with the requirements. Of particular concern has been ensuring that none of those listed as Objectors are not included on the list, unless there is a more current affirmative written statement that the individual and/or guardian has changed their mind and has since requested services in a community-based setting. A senior staff member within the DDD has been assigned to maintain this list and inform the Monitor of any particular updates and concerns. As a result of the events above, the quality and veracity of this list has continued to improve.

Second, there is a list of class members pursuant to ¶2 (b) of the Decree who: qualify for Medicaid Waiver services; live in a family home and; are in need of and have affirmatively requested home and community-based services or services in a community-based setting. These individuals are known as Waiting List Class Members. As of September 12, 2012, there were 10,894 class members in this category. This list is also maintained as a subset of the overall waiting list (Commonly known as the PUNS list) for services.

Development and refinement of this list has also proven to be quite challenging. Utilization of this initial list revealed that much of the class member information was outdated and/or inaccurate. A large number of addresses were incorrect and some individuals had moved out of state. Contact information was often inaccurate or outdated. Out of the initial 1330 individuals selected from this list to be funded for services, more than 350 individuals could not even be located. Some individuals on the initial list are now deceased. In more than 100 other instances, after individuals were contacted, it was determined that they no longer needed or wanted home and community-based services or services in a community-based setting.

As soon as these inaccuracies were discovered, DDD took immediate action to address these problems. The PAS agencies have the primary responsibility to update the information on the waiting list. Communications were sent to each

PAS agency with clear instructions on updating data on the waiting list and reminding them of their responsibility regarding individual updates. DDD assigned a key staff member as well as an additional professional staff member to work on this list as a high priority. These two staff are now in constant communications with PAS agency representatives to correct inaccurate data and update waiting list information. Budget allocation adjustments have also been made to ensure that payments to PAS agencies are reimbursed for PUNS entry and update activities on an expedited basis. These efforts thus far have been quite effective.

The Monitor is concerned about the often outdated and inaccurate data on the PUNS waiting list. This problem has already had a negative impact on compliance with another primary requirement of serving Waiting List class members. (See section on Transition for Class Members on Waiting List).

Over the next six months, the Monitor will continue to work closely with the DDD staff responsible for maintenance of the class member lists. As called for in the *Compliance Evaluation Standards*, the Monitor will then conduct a review of class member records using a random selection method of class members on both class member lists. Results of this review will be provided to the parties and intervenors.

As an overall note, the problems identified in the class member lists issue are also symptomatic of a more endemic issue within DDD – the lack of a comprehensive integrated data system. It will be important for DHS over the next several years to address this issue and develop a plan to address the overall need for a data system that is responsive and consistent with the ever-growing challenges within DDD and DHS. The Monitor recognizes that development of a comprehensive data system will require a significant initial investment of resources. The outcome of such an endeavor, however, would help ensure effectively coordinated services for class members and others.

Transition Service Plans

The Decree requires the defendants to develop transition plans for all class members who are selected to be served pursuant to the Decree. Transition plans shall describe all services required, how they will be developed and obtained and a timetable for transition.[11] Transition plans will be developed by a Qualified Professional in conjunction with the class member and guardian and others, as appropriate.[12]

The process for transition planning will include the class member's personal vision, preferences, strengths, and needs in home, community and work and shall reflect the value of supporting relationships, productive work, participation in community life and personal decision making.[13] Services and supports will be integrated into the community and consistent with choices of class members and guardians. Transition plans shall not be limited by the current availability of services but be within the confines of the waiver and State Plan.[14] Transition plans for class members who are determined to be in crisis will be developed.[15]

The Implementation Plan calls for a phase-in process for the completion of a transition service plan for each class member seeking services in a community-based setting. The Plan outlines an 18-month long process that includes a pilot trial period, re-evaluation and state-wide implementation by July 1, 2013. This process ensures coordination required between PAS/ISC agencies and class members.[16]

[11] ¶11 June 15, 2011 Consent Decree at Page 9.
[12] ¶12 June 15, 2011 Consent Decree at Page 9.
[13] ¶13 June 15, 2011 Consent Decree at Page 9 & 10.
[14] ¶14 June 15, 2011 Consent Decree at Page 10.
[15] ¶21.(b) June 15, 2011 Consent Decree at Page 12.
[16] Ligas Implementation Plan, 12/15/11, Section VI, Page 15

The defendants have begun to implement the transition planning process consistent with what is described in the Implementation Plan. These activities include the following:

- DDD developed Transition Service Plan documents through a process of receiving broad input from the parties, class members and families, PAS agencies and other key stakeholders. These documents include a Transition Plan format and accompanying instructions for class members moving from their homes or ICFs/DD to CILA and a more abbreviated form for class members seeking community-based services in crisis situations. On June 26, 2012, DDD facilitated a conference call of all PAS agencies, who will be responsible for completion of the Transition Service Plans, to discuss the proposed plan and receive final input. Once input was received, documented and modifications were made, the forms and instructional guidelines were finalized in July 2012.
- The finalized guidelines for the Transition Service Plans were also posted on the DDD Website. (*Ligas* website page)
- Two of the PAS of agencies who had volunteered to participate in the pilot evaluation process were selected. These PAS agencies selected to participate in the pilot are Developmental Disability Services of Metro East and Suburban Access, Inc.
- Following an initial conference call, both of the selected pilot PAS agencies and their program staff participated in a half–day training on August 23, 2012. The Monitor participated in this training activity.
- Each of the pilot agencies then selected a sampling of class members living at home and living in ICFs/DD who would participate in the sample. The total sampling size is 141 individuals. The period for completing the pilot and evaluating its results will continue through December 2012. Monthly conference calls with the two pilot PAS agencies will be conducted by DDD with the Monitor's participation to review progress and implementation challenges throughout the pilot period.
- After reviewing the results of the pilot activities, DDD will make necessary changes to the forms and processes in the beginning of 2013.
- By May 31, 2013, DDD will provide training to all 18 PAS agencies and begin statewide implementation of the new Transition Service Plan by July 1, 2013.

With regard to the transition planning process for class members in crisis, the defendants took a slightly different approach. DDD drafted modifications to the existing Crisis Funding Request and developed the *Crisis Transition Plan and Funding Request.* (Final Draft 7/25/12) This form and format, along with detailed instructions, were posted on the DDD website and disseminated to all PAS agencies for input. These documents were finalized and were required to be utilized by all PAS agencies statewide beginning September 14, 2012. Since this crisis transition planning form is a relatively minor adaptation to an existing form, a pilot process was not considered necessary.

The Monitor is generally pleased with the progress the defendants have made toward the development of a Transition Service Plan. Converting a system from virtually no transition service planning to a person-centered approach as required in the Decree necessitates a carefully planned and deliberate process that takes time to evolve. As these Transition Service Plans are evaluated, needed modifications will be completed and training and retraining will be implemented.

Another component of this process will be the training of PAS agencies and others on effective person-centered planning. The *Ligas Implementation Plan* calls for a consultant to be identified to work with the DDD Bureau of Transition Services during the first two years of the Decree to review transition plans and train PAS agencies and providers on their development.[17] To date, this consultant has not been identified or hired. This consultant should be hired as soon as possible to begin work in coordination with the transition planning development schedule.

Over the next year, the Monitor will carefully review the further transition planning process and report to the parties on the progress and challenges identified.

[17] *Ligas Implementation Plan,* Section X, at page 21

Transition for Class Members in ICFs/DD

The Decree requires all class members in ICFs/DD to transition to community services or community-based settings consistent with their transition plans if, at the time of transition, the class members request placement in a Community-Based Setting as confirmed and documented in accordance with the Decree.[18]

- One third of class members in this category will transition by 12/15/2013. The number of class members to transition during this period will be determined by June 15, 2013.
- Two thirds of class members in this category will transition by 12/15/2015. The number of class members to transition during this period will be determined by June 15, 2015.
- All class members in this category will transition by 6/15/2017. The total number of class members to transition from ICFs/DD will be determined by June 15, 2017.

The Implementation Plan calls for the identification and referral of these class members to PAS/ISC agencies for assistance in transition to community-based settings. The number of people identified for transition from ICFs/DD is expected to change, pursuant to the results of the outreach process described below. PAS/ISC agencies will monitor the adjustment and resolve issues as they are identified. [19]

It is unknown exactly how many class members in this category will be identified on June 15, 2013. Of the number of class members identified on that date, one-third are required to be served by December 15, 2013. As reported in the Class Member List section, there were 697 class members in ICFs/DD as of September 12, 2012. As of that same date, 153 class members in this category have received

[18] ¶17 June 15, 2011 Consent Decree at Page 10.
[19] Ligas Implementation Plan, 12/15/11, Section V, Page 14 -15

funding for community-based services or services in a community-based setting. Of the 153 who have received funding, at least 113 of these class members have actually started community-based services and billing for these services has been verified. On September 7, 2012, DDD sent requests to PAS agencies for monthly updates for 528 class members to determine the status of choice and selection of community services providers and projected transition dates. The overwhelming majority (97%) of class members who have transitioned have requested and received funding for Community Integrating Living Arrangements, (CILA) and the remainder of the class members (3%) have requested and received funding for home-based services (HBS) and have returned to their family home.

It should be noted that, to date, 19 individuals living in ICFs/DD who were contacted to receive transition supports to community services have since changed their minds and chosen to stay living in the ICF/DD. In each of these instances the individual's choices were respected and they were removed from the class member list.

A large number of class members who were living in ICFs/DD (61) who have moved services in a community-based setting did so as a result of a voluntary downsizing or closure agreement. There are expected to be at least 200 additional individuals who will be identified over the next year who are living in ICFs/DD now and will need to move due to voluntary downsizing or closure agreements. It will be imperative for the defendants to ensure that these individuals are provided with the opportunity to review an array of options so they can make an informed decision about where and how they want to receive services and supports. The Monitor has discussed this with the parties and DDD staff and will be working closely with the defendants in tracking how choices are being facilitated for individuals who are affected by implementation of voluntary downsizing and closure plans.

Crisis Services

The Decree requires the defendants to serve Class members who meet the crisis criteria described in ¶21 (a) of the Decree and who request community services or placement in a community-based setting expeditiously.[20] Services and/or placement will be provided in a manner consistent with the transition plan.

The Implementation Plan calls for the PAS/ISC agencies to continue to submit requests for services from individuals in crisis situations. DDD will ensure that class members are served expeditiously.[21] The Monitor established the standard, with the agreement of the parties, that the timeframe to receive services for class members in crisis will be 24-72 hours, although this timeframe may vary, depending on individual circumstances, or if temporary services are in place to address the immediate crisis.[22]

As mentioned in the introductory section, on May 1, 2012, the Monitor notified the defendants and class counsel of non-compliance in that crisis services were not being provided expeditiously as called for in paragraph 21(c) of the Decree. After a sampling review of the crisis services for class members from June 2011 to April 2012, the Monitor found a large percentage of class members who were not served for weeks and, in some instances, months, who needed services immediately. The Monitor recommended that the defendants develop a plan to address these issues. The defendants acknowledged the problem and immediately developed a draft corrective action plan and reviewed the plan with the Monitor. This draft plan was then presented to the parties and discussed at the June 21, 2012 parties' meeting. Following the meeting, class counsel provided written comments to the defendants on June 28, 2012 on the corrective action for crisis services. The defendants, in conjunction with the Monitor have since modified this plan and have moved forward with many of the action steps. The DDD Deputy Director for Community

[20] ¶21.(C) June 15, 2011 Consent Decree at Page 12.
[21] Ligas Implementation Plan, 12/15/11, Section VIII, at Page 19
[22] Compliance Evaluation Standards, July 17, 2012 at Page 14

Services has been assigned the lead responsibility for overseeing implementation of the crisis corrective action plan.

Some of the key action steps in the Crisis Service Request Action Plan include the following:

- DDD has developed an internal quality assurance process and checklist for management staff and Network Coordinators to individually evaluate each crisis request packet to ensure timeliness and completion.
- The internal database has been modified to ensure accuracy of entities.
- Network staff have been provided additional training in the areas of crisis data entry and processing crisis requests.
- Network Coordinators have now been assigned authorization to issue Pre-Award Letters in order to expedite processing of these letters.
- Training will be conducted in October 2012 for DDD Network staff and PAS agencies about submitting complete and accurate crisis funding requests, and being fully prepared when presenting requests to the Review Committee.
- The frequency for internal DDD informal review committee meetings has been increased to reduce the lag time in approval.
- Rate setting unit staff have been instructed to give high priority to crisis requests which will be specifically labeled as high priority. Distribution of award letters will also be streamlined and conveyed electronically.
- A management report will be designed for improved overall internal monitoring of crisis requests. The first management report will be produced in the first week of January 2013.

Since the Crisis Corrective Action Plan has been implemented, the Monitor has reviewed the crisis requests from June 15, 2012 through September 7, 2012. There have been 70 crisis service requests during that period. The defendants provided a status report to the Monitor showing the activities and outcomes of each one of these requests. The results of this review show significant progress, even for those requests processed prior to implementation of the corrective action plan. In most instances, protective and/or emergency services were in place in a

matter of days and not weeks, although some of the requests have taken longer than the 24-72 hour established standard.

The defendants should be commended for acknowledging the extent and seriousness of the problem and responding with the requisite level of urgency which, to date, has demonstrated early positive outcomes.

As mentioned in the Transition Service Plan section above, the defendants have developed and are now implementing the *Crisis Transition Plan and Funding Request* form. Utilization of this form as prescribed should result in a more effective and uniform manner in processing crisis request.

Historically, the defendants process approximately 300 to 350 crisis requests per year. Hopefully, as more individuals on the waiting list are served, this large demand for crisis requests will decrease. In the meantime, the Monitor will continue to closely evaluate the implementation of the corrective action plan and communicate the results to the parties. As called for in the *Compliance Evaluation Standards,* the Monitor will conduct a 100% document review of all class members served in crisis and 5% random sampling of direct communication with class members or their families to evaluate the response of the defendants and outcomes.

Transition for Class Members on Waiting List

The Decree requires Class members described in ¶2.b of the Decree will transition to community-based services. These class members are referred to in the Decree as "Waiting List Class Members.[23] Class members described in ¶2.b and ¶22 (a) and ¶22 (b) will transition in accordance with the following schedule:

- Community-based services or placement in a community-based setting for 1,000 Waiting List class members will begin by June 15, 2013.
- Community-based services or placement in a community-based setting for an additional 500 Waiting List class members will begin by June 15, 2014.
- Community-based services or placement in a community-based setting for an additional 500 Waiting List class members will begin by June 15, 2015.
- Community-based services or placement in a community-based setting for an additional 500 Waiting List class members will begin by June 15, 2016.
- Community-based services or placement in a community-based setting for an additional 500 Waiting List class members will begin by June 15, 2017.
- Following June 15, 2017, Waiting List class members will receive community-based services or placement in a community-based setting at a reasonable pace.[24]

The Implementation Plan incorporates the criteria for prioritization for selection of class members who are on the waiting list to receive funding for community-based services or services in a community-based setting. Within each category, selections will be made based on the length of time on the waiting list database.[25]

As reported in the Class Member List section above, the PUNS list shows 10,894 individuals who qualify as Waiting List class members. In order to implement a

[23] ¶22.(c) June 15, 2011 Consent Decree at Page 13.
[24] ¶23.(c) June 15, 2011 Consent Decree at Page 13.
[25] Ligas Implementation Plan, 12/15/11, Section VII, Page 17-19

systematic process for selections of class members to effectuate services for the initial 1,000 individuals by June 15, 2013, the defendants engaged in several selection events. (Commonly referred to as "PUNS pulls") The first selection event identified 800 individuals believed to be class members occurred in February 2012. After an initial screening process, 65 individuals were removed from this list and 735 letters were sent to the class member and/or guardian and their respective PAS agencies indicating that funding for community-based services or services in a community-based setting would be available upon application. The second selection event occurred in June 2012, which identified an additional 626 individuals and, after initial screening 22 individuals were removed from the list, resulting in 604 application letters being sent to the class members and respective PAS agencies. A third selection event is occurring presently and 1,500 individuals believed to be class members are being selected. Each of the selection events have chosen people in accordance within the criteria for prioritization as listed in the *Ligas Implementation Plan.*

As reported in the Class Member List section above, this selection process exposed significant shortfalls in the reliability of the PUNS list data. For example, from the initial selection of 800 individuals, 120 individuals were determined as unable to locate, 109 individuals have since refused services, 24 individuals have moved out of state, 17 individuals were found to be ineligible for HCBS services, 17 individuals were located in settings rendering them ineligible to be class members and 10 individuals are now deceased. These calculations alone result in nearly 300 individuals out of 800 (or 37%) who, if PUNS data were accurate would not have been considered class members. It should be noted that the initial selection of class members, generally, include many of those who have been waiting for services the longest. Thus some of the data for these individuals is more than six years old, contributing, in part, to the high level of inaccuracy.

DDD recognized the degree of inaccuracies and took immediate action to address the problem. Additional staff have been assigned to assist PAS agencies in updating PUNS data and, in a number of instances, have helped the PAS agencies directly in locating individuals or information about individuals through research and various database inquiries. This process has been successful but is arduous and produces results slowly.

Despite the gross inaccuracies of the PUNS list for the initial selections, there has been significant movement over the past six months in an effort to comply with the requirements. Movement toward the provision of services for those found eligible is as follows:

- As of September 1, 2012, services have been initiated for 135 class members.
- An additional 30 class members have received finding awards and services are about to begin soon.
- Packets for another 73 individuals have been completed to DHS for funding approval.
- 348 individuals are in the process of receiving Level II and Level III screening by PAS agencies and requests are being processed.
- Initial contact has been made with an additional 114 individuals who have confirmed that they have requested services.

In summary, if all of the above individuals who are being processed for services actually begin services by June 15, 2013, (An extraordinarily optimistic scenario) this comes to a total of only 700 class members, well short of the 1,000 class members as required in the Decree.

Meeting this requirement can only be possible if at least 300 more class members are served who are being selected for the current selection event involving 1,500 names from the PUNS list. Even if the letters to the class members from this selection event are sent as early as mid October 2012, it would be unrealistic to expect actual services to begin for many of these individuals by June 15, 2013.

The Monitor is gravely concerned about the likelihood of full compliance with this requirement in the Decree. To address this area of possible non-compliance, the Monitor suggests that the defendants take some additional steps toward further progress.

- First, some additional staffing assistance should be assigned to provide the necessary support to manage and conduct follow-up activities for the next large selection event. Reviewing PUNS data, working with the PAS agencies and identifying barriers during this process is an individually-driven and labor intensive process that requires an "all hands on deck" approach.
- Secondly, DDD should develop its own technical assistance arm for PAS agencies to teach, train and monitor the updating and entry of PUNS list information and processing of applications for services. The responsiveness of the PAS agencies throughout this process has varied greatly. Effort will be needed to ensure consistency and uniformity statewide.
- Third, DDD should identify areas where processing of service applications has moved slowly and develop administrative remedies where necessary. For example, it has been reported that processing the applications for Medicaid eligibility for some class members has taken several months, even where individuals already qualify for Supplemental Security Income (SSI) which indicates a strong likelihood for Medicaid eligibility. DDD or DHS could assist in the process of expediting the application process, thus moving applications forward more quickly.
- Finally, DDD could poll community service providers in every region to determine existing service options and opportunities that could be shared with PAS agencies to make individual choices more effective.

To assist in compliance with this requirement of the Decree, the Monitor suggests a special dedicated meeting in early January 2013 with the defendants and class counsel to provide a comprehensive update on progress at that point and identify and address any barriers to compliance.

Outreach

The Decree requires the defendants to maintain a fair and accessible process by which individuals or their guardians can affirmatively request services and maintain records of those requests.[26]

The Implementation Plan outlines numerous activities designed to identify individuals throughout the state who are or will be in need of home and community based services and services in a community based setting. These activities include training and information sessions as well as the development and distribution of written materials to broad based audiences.

For potential class members living in ICFs/DD, the Plan provides a detailed description and requirements for the development of a Request for Proposals (RFP) to secure the services of an outside contractor(s) to contact all potential class members and determine and document an informed decision on whether they are requesting services in a community-based setting.

The defendants engaged in numerous activities to comply with the Outreach requirements of the Decree and activities described in the *Ligas Implementation Plan*. At the initial parties' meeting, it was agreed by the parties and memorialized by the Monitor that for those individuals who live in ICF/DD settings, they are considered a class member if they have completed a PASS Form 1238 or its predecessor, DHMDD Form1243, or DD PAS 10 form, or the Request form disseminated through plaintiffs' counsel, and checked the box that they choose Home and Community Based Services.

The Defendants, and in many instances, in conjunction with the Monitor, engaged in activities to inform stakeholders as well as the community at large about the

[26] ¶25 June 15, 2011 Consent Decree at Page 14

requirements of the Decree and how services can be sought and received by qualified class members. Some of these activities include the following:

- DDD and the Monitor has have been conducting training activities for each of the 18 PAS agencies on the requirements of the Decree and Implementation Plan and, in particular, their role in facilitating choice for class members.
- DDD has developed a *Ligas* website[27] that includes a full and downloadable description of the requirements of the Decree, updates on documents and activities related to the Decree and contact information for parties interested in more information. This website is updated on a regular basis.
- DDD maintains a consumer-friendly PAS agency locator function on the DDD website whereby families can locate their PAS agency by simply entering their county or zip code.
- DDD has also structured the 1-888-DDPLANS toll free number so that families can be directed to the *Ligas* inquiry staff support.

With regard to outreach to persons living in ICFs/DD, the defendants, with input from representatives from class counsel, intervenors counsel and the Monitor, developed a Ligas Outreach Request for Proposals (RFP) (Reference #22028606). The RFP was released to the public for solicitation on September 13, 2012 and proposals are due to DHS no later than October 9, 2012. This RFP is designed to secure the services of an independent contractor to maintain a fair and accessible process by which individuals with developmental disabilities or their legal guardians can affirmatively request in writing to receive community-based services or services in a community-based setting or continue to receive services in an ICF/DD.

The Monitor is pleased that the outreach RFP has been released and looks forward to the selection of a contractor so work on this important endeavor can begin. At this juncture, the timetable for work by the contractor is six months behind schedule.

[27] http://www.dhs.state.il.us/page.aspx?item=40989

Implementation Plan

The Decree requires that the defendants finalize the Implementation Plan, with input from the parties and intervenors.[28] The Implementation Plan must be filed with the Court by December 15, 2011. The Implementation Plan shall be updated and amended at least annually.[29]

The *Ligas Implementation Plan* was negotiated by the parties and intervenors and filed with the Court by the defendants on December 15, 2011. There was joint agreement by all parties, the Intervenors and the Monitor on the initial Implementation Plan. The Plan was ordered as a supplement to the Decree on February 15, 2012.

The defendants have utilized the *Ligas Implementation Plan* as their blueprint for activities designed to comply with the decree. At each scheduled parties' meeting, the defendants provide a verbal update of Plan activities and respond to questions from class counsel and counsel for the intervenors. There have also been significant inquiries from key stakeholders and members of the public at large about implementation activities.

December 15, 2012 marks the one year point since the *Ligas Implementation Plan* was filed with the Court. The Monitor recommends that the defendants resubmit a proposed amended Ligas Implementation Plan with necessary revisions at the next scheduled parties meeting for review and input. Following the input from the parties, intervenors and the Monitor, the defendants should file the updated plan to the Court, as required in the Decree.

[28] ¶27 June 15, 2011 Consent Decree at Page 15.
[29] ¶28 June 15, 2011 Consent Decree at Page 15

Data Reports

The Decree requires the defendants to provide the Monitor, Plaintiffs, Class counsel, Intervenors and Intervenors' Counsel and make publicly available, a detailed report containing data and information sufficient to evaluate Defendants' compliance with the Decree and Defendants' progress towards achieving compliance.[30] Not less than every six months, defendants shall provide data reports to the Monitor, class counsel and intervenors.

Implementation Plan Activities – The Implementation Plan calls for the submission of data reports.

The defendants provided a draft data report format to the parties, intervenors and Monitor and have received their input. Since then, the data reports have been resubmitted to the parties and intervenors with additional input and feedback. Most recently, on August 20, 2012 the defendants submitted the Data Reports to the parties, intervenors and Monitor with data included from the first six months and second six months.

The Data Reports include class member data regarding the class member list(s), services to class members in ICFs/DD, services to class members from the Waiting List, ICF/DD resident outreach, transition service plans, crisis services, voluntary ICF/DD closure and downsizing agreements, eligibility appeals and the *Ligas* budget. The Monitor finds the form and format for class member data to be acceptable. It will be increasingly important, however, to ensure that data with regarding budget expenditures and shortfalls, if any, are updated on a regular basis.

[30] ¶ 33 of June 15, 2011 Consent Decree at page 18.

Services for Named Plaintiffs

The Decree requires the defendants within sixty days to offer each of the Named Plaintiffs the opportunity to receive appropriate community-based services or services in a community-based setting.[31]

The defendants have complied with this requirement of the Decree. All five named plaintiffs were offered services in community based settings and have successfully transitioned to their new homes or received home-based services funded through the Illinois home and community-based waiver.

Dispute Resolution

The Decree clarifies the rights of class members to appeal or seek administrative or judicial review pursuant to governing law through the existing fair hearing process. Class members may also avail themselves of any informal appeal process that currently exists.[32]

The Monitor reviewed the appeal data with the defendants in April 2012 and identified a number of problems with the appeal process. Scheduling of appeals hearings and obtaining written hearing determinations were taking an inordinately long time, in some instances as much as six months to a year. The appeals application process was often confusing to individuals and families and some families reported that they were not aware of their appeal rights.

[31] ¶37 June 15, 2011 Consent Decree at Page 21
[32] ¶24 June 15, 2011 Consent Decree at Page 14

As a result of these problems, the defendants, with input from class counsel, developed and are implementing an appeals corrective action plan that includes the following activities and tasks:

- HFS has hired an additional three new Administrative Law Judges as hearing officers and one additional attorney to support the hearing process.
- The newly hired ALJ's, at the request of HFS, conducted site visits to several CILA settings to better understand community-based services for people with developmental disabilities.
- The application process was streamlined so that appeals come directly to DDD rather than the additional pass through with HFS.
- A draft to include modifications of the appeals rights form is being finalized.
- Appeals unit staff have been instructed in writing to give top priority to crisis appeals.
- Appeals unit staff are being trained to expedite informal appeals.
- An internal checklist has been drafted to provide effective and ongoing tracking of appeals.
- PAS agencies are being re-trained on preparing complete appeal requests.
- Weekly internal management reports will be generated to ensure internal reviews are scheduled on a timely basis.
- Management reports will be incorporated into the *Ligas* data reports.

The Monitor is confident that the above action steps will greatly alleviate many of the procedural problems with the appeals process. Over the next year, the Monitor will review appeals data with the defendants and provide the parties with findings and recommendations for improvement.

Section 5 – Overall Comments

As shown throughout this report, compliance with the Decree requires a systematic and comprehensive approach by the defendants, coupled with an infusion of significant resources now and over the next nine years. The report also illustrates the complexity of the various requirements and how each requirement is inextricably intertwined with many of the other requirements. In drafting this report and in conducting monitoring activities, the Monitor found it somewhat challenging to maintain focus not only on the details of compliance, but also on the fundamental principles of the Decree – That class members will be afforded the opportunity for real choices about where and how services will be provided and - Resources will be made available to respect these choices. Keeping those principles in mind, the parties and intervenors can be pleased that at least 323 class members have received funding approval for community-based services who, in the opinion of the Monitor, would not have received this funding without the impetus of the Decree.[33] This "bottom line" should not be overlooked.

In addition to this measure of success, there are numerous structural, procedural and cultural changes that have taken place over the past 15 months. In many ways, implementation of compliance related activities has exposed significant flaws in the service delivery system for people with intellectual and developmental disabilities. Some of these flaws have been addressed and many, if not most, still linger. Some of the compliance concerns articulated in this report are not because of lack of effort of the defendants but rather due to longstanding systemic and resources problems, that have yet to be resolved.

[33] This number includes 153 class members transitioning from ICFs/DD, 165 Waiting List class members and five named plaintiffs.

The Monitor will continue to work diligently with the parties and intervenors to address these problems until substantial compliance with all of the requirements becomes a reality.

ED's NEWSLETTER

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HAS LIGAS TURNED OUT TO BE A DISAPPOINTMENT? . . .

For all the people who were seeking the Home-Based Services program and got it, the answer is certainly no. There is no question that the Ligas Consent Decree has opened the door to in-home services for hundreds of adults with intellectual and developmental disabilities who have been sitting on Illinois' Waiting List for years.

But for many, many families who want to move their sons or daughters into CILAs, it has been a different story. I have heard from a lot of those families. They are disappointed, disillusioned, frustrated. They got the letter last year, announcing that their name had been selected from PUNS and offering them CILA funding. But they simply can't find a group home, or at least not the right one, for their family member.

The Division of Developmental Disabilities' statistics tell the story: 50% of those selected from PUNS in the past year and a half were offered CILA (most of them had told their PAS agencies that they wanted and needed CILA) and 50% were offered Home-Based. Yet 88% of the new enrollments are for Home-Based and only 12% are for CILA. (The figures are as of June 30: 917 new people in HBS and 130 in CILA.)

There are many reasons for this. Two key reasons are that many providers are unable, economically, to expand to meet the need, and that many families are dissatisfied with what they are being offered.

I conducted an informal survey of a number of PAS agencies during the past couple of weeks to get a feel for what is happening--what their experience has been in assisting people to find CILAs. The conclusion I reached after talking to them and talking to families is that it's systemic. To put it another way, it's great that the State entered into a federal court consent decree to provide services to 3,000 new people (over a six-year period), and it's great that they are offering CILA to 50% of them. But if the CILA system is not really equipped to respond to the need, what's the point?

Court Monitor Tony Records expressed concern about the issue in the report he submitted to U.S. District Judge James Holderman Sept. 30. He said the disparity between CILA and Home-Based "is statistically significant enough to warrant close and careful examination. It is not clear what has led to this irregularity with regard to expectations and results." Records recommended that the State conduct a review "to determine the reasons for the number of class members who were selected for CILA who did not accept CILA supports and services."

WHAT THE PAS AGENCIES SAY . . .

In talking to PAS agencies, I got a whole host of reasons why more families are not seizing the opportunity for residential services. "These are the lucky ones," one PAS program director told me. "It's ironic. These are the

people who finally got the letter they have been waiting for, and they were so excited, but there's nothing there."

It's not really that there is nothing. But most families don't want their sons or daughters very far away, and often there is no availability at a nearby agency. (Some families are not being reasonable. "One family didn't want the CILA to be more than 20 minutes away--that's unrealistic!") Meanwhile, most providers are not expanding; they are concerned about the economy, not to mention that they are not paid enough by the State and historically have not been paid on time. Who could blame them?

The PAS agencies say a lot of those families who got the letters just are not ready for their sons or daughters to move. "But they want something, so they enroll in Home-Based." And many families are very undecided; they are still looking; they have not made up their minds yet. The division has been willing to be patient with such families, as long as they can demonstrate that they are actively looking.

Individuals with challenging behaviors or medical issues are finding it difficult to identify providers willing to serve them. It has become harder and harder for providers to obtain funding for 1-1 staffing, which discourages them from taking on such cases. "Many providers are just very selective about whom they will take."

Then there are the families who just aren't satisfied with what they are finding. Eight-person CILAs continue to be the norm in Illinois; there are twice as many 8-person homes as any other size home. Illinois is way out of step with the rest of the country in this regard. "Most people do not want their sons or daughters to have to share a bedroom." The division last year improved the rates for 4-person homes, and some providers have responded, but many feel the rate is still inadequate for that size home. Many states encourage the Shared Living model of CILA, in which a caregiver lives in the home and cares for two individuals, but very few Illinois providers have embraced that model.

Another complaint of families is that the CILA program is too restrictive, especially concerning day services. Most people in CILA have no choice but to attend a traditional Developmental Training program. Families that have fashioned a good array of day services through Home-Based do not want to switch to CILA. "People with a routine, with community involvement--working, volunteering, having flexibility to use a variety of programs--they don't want to give that up," one director said.

Another agency mentioned that some low-income parents are paying themselves to be the personal support worker for their daughter or son through Home-Based, and they don't want to give up that income.

Meanwhile, the PAS agencies report being pressured by division staff to get people enrolled in services. "They are telling us to push the providers to accept people, but we have no authority to do that."

DRAWING SOME CONCLUSIONS . . .

It's my impression that when the plaintiffs' lawyers in Ligas negotiated the Consent Decree with the State, it was with the assumption that the State could realistically carry out its provisions, one of which was that 3,000 persons with IDD living in the community would be offered residential or in-home services over a six-year period. The implementation plan for the decree, drafted by the State and approved by Judge Holderman, provides that 50% of those selected be offered CILA, and that those names be taken from a pool that includes people who told their PAS agency that they needed CILA right away (the "emergency" classification); people

who said they needed it within a year (referred to as "critical";); and people whose primary caregiver was 75 or older.

But the information obtained from the PAS agencies demonstrates that there are numerous barriers to the achievement of those CILA goals.

If the plaintiffs' lawyers feel the State is failing to comply with the decree, they can petition the judge to crack down. The lawyers have already indicated that they have concerns about the lack of Person-Centered Planning in the Illinois DD system and the lack of employment opportunities, as well as the size of CILAs. Tony Records, while praising the state for meeting its June 30 target for enrollments, has called the system "deeply flawed." CEOs I have talked to call it "broken".

Clearly, the State needs to spend a great deal more money to comply with the decree and to make the system work. Even more importantly, the current Medicaid Waiver for the IDD population needs a major rewrite to provide more meaningful and flexible services--in line with what other states are doing.

Governor Quinn has already demonstrated a great commitment to people with IDD in his efforts to close state-operated institutions. But he and the General Assembly need to take significant steps to reform the community system as well. If they don't, it may be up to the judge to do it.

GOVERNOR'S OFFICE SEEKING OK FOR MASSIVE NEW WAIVER . . .

Out of the blue on Oct. 18, the governor's office announced that it is going to ask the federal government for authority to create a huge new Medicaid Waiver program that will supplant the nine waivers currently operating in Illinois. They call it the Path to Transformation Waiver, to be administered under Section 1115 of the Social Security Act.

I say out of the blue because no one I have talked to had a clue that this was coming. To be frank, a lot of us are very skeptical about the plan. The governor's office describes it in glowing terms--how wonderful it will be for Illinois. We would be more comfortable if this had been discussed openly with providers, families, trade associations, etc., but it appears to have been put together behind closed doors, with the assistance of a large Florida-based consulting company, Health Management Associates, and is now about to be carried out on a very short timeline. The formal proposal is to be made to the U.S. Centers for Medicare and Medicaid Services by Feb. 15. Then it will be up to CMS to approve or deny it.

Illinois now has nine Waiver programs, which involve obtaining funding from the feds. Three of them are in the Division of DD--the adult waiver (for CILA and Adult Home-Based), the children's support waiver

(for Kids' Home-Based) and the children's residential waiver (for children's group homes). The other Illinois waivers are for the elderly; for medically fragile/technology dependent children; for persons with brain injury; for persons with physical disabilities (the Div. of Rehab Services' Home Services program); for persons with HIV and AIDS; and the Supportive Living Facilities waiver which provides housing and services to persons with physical disabilities and the elderly.

The proposal is to scrap all of these and create this 1115 Waiver. The feds would continue to pay Illinois the same total amount of money they are currently paying for the nine waivers. One big advantage that the proponents see is that Illinois would be able to decide how to allocate those funds. But some of us fear that

the DD division could be shortchanged in the process (though it's a little hard to imagine that anyone could justify giving the division even less funding than we now have.

The governor's office has a page on its website, http://www2.illinois.gov/gov/healthcarereform/Pages/1115Waiver.aspx, which explains that Section 1115 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 such as supportive housing

--Using innovative service delivery systems that improve care, increase efficiency and reduce costs."

Waivers are generally approved for five years. A number of states have small 1115 waivers, but Illinois is believed to be the first state proposing to collapse all of its waivers into an 1115.

A "stakeholder meeting," open to the public, is to be held Nov. 14 from 1-3 p.m. at the Thompson Center in the Loop, Room 9-040. More details will be divulged then.

THE MURRAY LAWSUIT: GIVE ME A BREAK! . . .

I have been poring through motions and briefs and opinions ad infinitum since February (I do it so you don't have to!) in the lawsuit brought by 11 guardians to stop the State from closing the Murray Developmental Center in Centralia. I have to tell you, it's so tiresome. Most of the people who read this newsletter get it--that people with disabilities belong in the community when possible, not locked up in huge institutions. Gov. Quinn has had the political courage and good sense to undertake to close some of these facilities, but these 11 guardians actually want their family members to stay there for the rest of their lives. They are of course backed up by the Murray employees, who don't want to lose their jobs, and the community of Centralia, whose economy is dependent on the facility.

The guardians' attorneys have succeeded in delaying the closure, which was supposed to have taken place by now. A hearing in federal court on their motion for an injunction against the State has been

repeatedly postponed; the latest date is Jan. 6. The guardians keep claiming that no resident of Murray ought to be forced to move to a CILA, yet the State points out that there is no force involved whatsoever--the only people who move to CILAs will be those whose guardians have consented to it. If the guardians do not consent, the person would move to another SODC or to an ICFDD.

I have been trying to give you a flavor of the litigation over the past eight months. Today I want to share with you some language from the attorney general's latest memorandum, dealing with what evidence will be admissible at the injunction hearing:

"The parties' conception of this litigation is, to put it mildly, quite divergent. The state's executive branch has the discretion to decide how best to allocate its scarce resources and how best to implement human services, subject of course to the requirements of federal law. This includes closing the facility. . . . We acknowledge the facility closure necessarily provokes fears and anxieties for family members who have had sons, daughters and siblings at Murray for many years. But (their) letters, and the emotions they convey, have no bearing whatever on the federal law issues to be decided in this case. . . . No institution for the developmentally

disabled would ever close if resident and guardian preference for a particular facility inevitably trumped the authority of the state government which funds and operates those facilities with taxpayer dollars."

Further, referring to persons who have already moved out and have been living in small CILAs for several months:

"They no longer live in an institutional, congregate setting with 50 or 60 others in their ward, often in a shared bedroom with two or three other people. Rather, these individuals now have their own home and their own bedroom. They no longer have to eat the institutional fare served to all, but have meals prepared in their own kitchen, with food they may have chosen after a trip to the grocery store. Furthermore, they have the comforts of home most people share--a quieter environment in a residential neighborhood, their own backyard, a living room with their own furniture, bedrooms largely decorated according to their own preferences and more opportunities to partake in community activities and outings. . . ."

That says a lot, doesn't it?

OTHER STUFF . . .

Calls and letters: Bill Choslovsky, an attorney for Misericordia, took issue with my report that a lot of people who wanted to move out of ICFDDs and into the community have been able to do so thanks to the Ligas consent decree. He points out, correctly, that of the 385 people who had moved out as of June 30, 250 were not people who chose to move; they had to move because their facilities closed. The remaining 135 people chose to move.

Why not streamline PUNS?: A dad who is a member of the Ligas Class Member/Family Advisory Committee reported that he registered his son in PUNS in 2005. Five years later, he went back to the PAS agency to make sure he was still on the list. "They had no record of him. It was as if they didn't know he existed. So they took our information again even though he was already on the list in Springfield. Clearly the left doesn't know what the right hand is doing. To me, it seems that in this day and age it should be very simple and this whole process should be streamlined. There should be one simple online

database that requires registration and then a secure login password. If I can track my airline miles why can't I track our son's PUNS status? It's appalling."

Congratulations to the athletes of Leeda Services of Chicago, organized as the Loyola Scorpion Kings softball team, for winning the bronze medal at the North American Invitational Special Olympics in Trenton, N.J. The competition featured teams from 10 states, Canada, Mexico, Puerto Rico and the Dominican Republic. The Scorpion Kings represented the City of Chicago. The team, led by Coach Jose Herrera and MVP Aaron Salle, pulled a big upset over the top-seeded Dominican Republic team.

Rep. Sara Feigenholtz has introduced House Bill 3694, which would restore Medicaid adult dental coverage. Dental coverage was severely limited in 2012 to emergency cases only. There's a similar bill in the Senate, SB2605, sponsored by Sen. Heather Steans.

The Social Security Administration has announced a cost-of-living increase in benefits of 1.5% for 2014. This will mean an increase in the allotments for both the adult and children's Home-Based programs, which are tied to the level of SSI.

THE CONSULTING PRACTICE . . .

I will be keeping you posted on my activity as a member of the Illinois Human Services Commission. The reconstituted commission met Sept. 25 and heard remarks from Jerry Stermer, acting director of the Governor's Office of Management & Budget. The co-chairs of the commission are Greg Wass of Management & Budget and Grace Hou, president of the Woods Fund and former assistant secretary of DHS. Among the members are DHS Secretary Michelle Saddler, DHFS Director Julie Hamos and Mark Doyle of the governor's office. I am participating in a workgroup on Increasing Options and Opportunity which is concerned with issues affecting people with disabilities.

Speaking dates:

--Meeting of Ups for DownS (United Parent Support for Down Syndrome) at Fox Run Golf Links, Elk Grove Village, Nov. 19, 7:30 p.m.

--Annual meeting of Assn. of Community Mental Health Authorities in Illinois, in Bloomington Dec. 5.

COMMENTS . . .

If you like the newsletter, let me know. If you hate it, fire away. If you have a correction or a suggestion or an opinion, I would like to hear it. And, of course, I won't use your name without an OK. My email is mcmanus06@comcast.net

Peter Tracy

From: Peter Tracy <peter@ccmhb.org>
Sent: Wednesday, March 20, 2013 10:48 AM
To: 'traconsult@mindsping.com'
Cc: troy.markert@illinois.gov; ccddbSmith (mike@mjsmithcpa.com); lynn@ccmhb.org
Subject: The Need for Incentives to Build Capacity

March 20, 2013

Mr. Tony Records
Ligas Consent Decree Monitor
traconsult@mindspring.com

Dear Mr. Records:

I am the executive director of the Champaign County (Illinois) Developmental Disabilities Board (CCDDB) and the Champaign County Mental Health Board (CCMHB). These Boards are part of local government and are responsible for planning, funding, monitoring, and evaluating local service systems for people with disabilities. Our combined annual funding is about $7.5M with property tax as the primary revenue source. Both Boards were created by public referenda.

We have been closely following the implementation of the Ligas Consent Decree and applaud your efforts. From our perspective in Champaign County, we are concerned about the absence of adequate placement capacity for Ligas Class Members in four-person homes. Based on review of PUNS data and conversations with Department of Human Services (DHS) staff, we understand that five individuals originally from Champaign County have been identified for movement out of ICFs/DD, approximately 25 have been selected from PUNS for either Home Based Support or CILA placement, although their eligibility status is under review, and another 125 County residents are represented on the PUNS list as in need of "Out-of-home residential services with 24-hour supports." While these numbers include persons who may not be determined eligible, we anticipate that the fluid nature of Ligas Class Membership under the Consent Decree may yet add to the number of individuals seeking, and entitled to, integrated community living options. In addition to Ligas Class Members, we are aware of others in emergency status seeking to return to Champaign County. Appropriate placements do not currently exist and may not be developed unless some effort is made to incentivize providers to create appropriate placement options. Clearly, the task of creating an environment which encourages and facilitates the creation of these new resources will fall on DHS.

In order to quickly develop the additional capacity needed, it is my opinion that the following problems will need to be addressed:

- Service providers do not have the financial resources to cover the preliminary (i.e., upfront) costs associated with planning and implementing increase residential capacity.
- The preliminary costs at issue include dollars to build or lease a four person group home, furnish and supply the home, and hire and train staff necessary to operate the home.
- There are no contractual provisions to cover the fixed costs of operating the four person or less group home during the start-up phase prior to reaching full capacity.
- There are no contractual provisions for bed-hold to cover fixed costs if there are vacancies in the four person or less group home.

- There are no provisions for expedited and timely payment to providers to assure the financial viability necessary to support quality services.

In our opinion, if these issues are not resolved, the process of creating the four person group home resources necessary to meet the needs of people in the Ligas Class will move very slowly. As a local funder, we desire to see these resources created and to the extent possible will do what we can to help.

Sincerely,

Peter Tracy
Executive Director
Champaign County Developmental Disabilities Board
Champaign County Mental Health Board
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