The Path to Transformation: Illinois 1115 Waiver Proposal

February 10, 2014

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I. Description of Proposed Program

Background and Overview

Illinois' Medicaid and All Kids programs have undergone tremendous change in recent years as the state implements improvements to enhance access and quality for beneficiaries while also controlling costs. As Illinois prepares to implement a major Medicaid expansion that will extend eligibility by 2017 to an estimated 500,000 individuals, through a combination of "newly eligible" adults and "already eligible" clients, the state is seeking additional flexibility in our Medicaid program to incentivize delivery system and payment innovation, increase access to community based options, and positively impact social determinants of health that are driving up health care costs.

The State of Illinois Department of Healthcare and Family Services, in cooperation with the Department of Children and Family Services, the Department on Aging, the Department of Human Services and the Department of Public Health, is seeking a five-year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses all services and eligible populations served under a single demonstration authority, with broad flexibility to manage the programs more efficiently and to align and coordinate programs around the triple aim rather than around traditional silos. We recognize that for our clients who live in poverty, social, cultural, environmental, economic and other factors are major causes of rates of illness and health disparities. Under this *Path to Transformation* waiver, Illinois Medicaid will 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.

Through the *Path to Transformation* waiver, Illinois seeks to become a national leader in Medicaid payment and delivery system innovation, transforming from a fee-for-service system to an advanced system of care where patient outcomes and provider payments are aligned. Illinois, like many states, needs investment from the federal government to make the fundamental changes that are needed now in order to achieve the triple aim of better health, improved care delivery systems and lower costs. In order to make the changes outlined in this proposed waiver, Illinois is seeking substantial flexibility and additional federal investment in innovative strategies designed to increase access to care and incentivize the development of comprehensive, integrated delivery systems capable of taking responsibility for the health of a defined population.

Illinois' *Path to Transformation* waiver represents the next critical step in reform efforts undertaken by the state in recent years, including the Governor's Health Care Reform Implementation Council; the development of a statewide, comprehensive State Health Care Innovation Plan; a large-scale expansion of managed care across Medicaid eligibility groups; multiple coordinated efforts to improve access to home and community based services; the development of a statewide, secure electronic transport network for sharing clinical and administrative data among health care providers in Illinois and bordering states (ILHIE); and a major public health initiative to implement activities throughout Illinois that focus on tobacco-free living, active living and healthy eating, and fostering healthy and safe physical environments. Each of these reform efforts directly informed the content of this Section 1115 waiver proposal.

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. The Council continues to meet regularly and has issued recommendations to help guide the state in: establishing a health insurance exchange (also known as a Marketplace) and other pro-consumer reforms; reforming Medicaid; assuring high quality care; identifying federal grants and other non-governmental funding sources; fostering the widespread adoption of electronic medical records; and strengthening Illinois' health care work force.

Expansion of managed care

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 provider-organized delivery systems that include risk-based payment methodologies.

HFS currently manages two capitated Medicaid managed care programs and an early expansion waiver program for individuals residing in Cook County, which was extended through March 31, 2014. 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 added to the ICP a year ago, 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 with the Cook County Board and the Cook County Health and Hospitals 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 through a unique public-private partnership.

A third capitated program is just starting through the Medicare-Medicaid Alignment Initiative for dually eligible beneficiaries. Joint capitation rates will be paid by the State and federal governments to eight plans in two large regions of the state starting in February 2014.

Illinois Medicaid Managed Care Programs

Program	Covered Population	Geography	Current/ Projected Enrollment	Launch Date
ICP	Non-Dual Eligible (Medicaid-only) Seniors and Persons with Disabilities	Greater Chicago; Rockford; Quad Cities; Central Illinois; Metro East	136,000	Varies by Region. Suburban Chicago in 2011, remaining non-Chicago regions in late 2013, City of Chicago in early 2014

[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)

County Care	New ACA Adults	Cook County	112,000	October 2013
MMAI	Dual Eligibles	Greater Chicago; Central Illinois	136,000	March 1, 2014 (voluntary; June 1, 2014 (opt-out)
CCEs	Complex Adults, Complex Children	CCE Specific	TBD	CCE Specific
ACEs	Healthy Families, New ACA Adults	ACE Specific	TBD	July 1, 2014
Voluntary TANF	Healthy Families	Adams, Brown, Cook, DeKalb, Henderson, Henry, Jackson, Kane, Knox, Lee, Livingston, Madison, McHenry, McLean, Mercer, Peoria, Perry, Pike, Randolph, Rock Island, Scott, St. Clair, Tazewell, Warren, Washington, Williamson, Winnebago, Woodford	254,000	1980s

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.

ACEs were created by statute in the spring of 2013 and were informed by the early experience of preparing CCEs to become operational, 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.

Development of a comprehensive State Health Care Innovation Plan

On February 21, 2013 Illinois was awarded a State Innovation Model grant from the federal Department of Health and Human Services Innovation Center. This funding supported an intensive six-month planning process designed to build upon the delivery and payment system reforms already underway in the state to develop a comprehensive, multi-payer State Health Care Innovation Plan (SHCIP). The planning process was led by a broad stakeholder group – the Alliance for Health ("Alliance") – comprised of representatives from providers, health plans, state agencies, social service organizations and other entities. Stakeholders participated in an intensive consensus building process toward the development of the SCHIP.

The SHCIP outlined a vision for health system transformation built upon the premise that the major contribution to better health and lower costs will be achieved when people live in healthy, safe communities with appropriate resources, including access to high-quality health care delivery systems in which provider teams help patients achieve physical, mental and emotional wellbeing.. To achieve this vision, the Alliance for Health Innovation Plan was organized around five major transformation objectives that support the Triple Aim:

1. Clinical integration and supporting payment reform innovations
2. Additional integration innovations for people with specific needs
3. Population health innovations
4. Workforce innovations
5. "Learning health care system" innovation

Collectively, these transformation drivers will support the establishment of an integrated care model standard for health care delivery; provide incentives and tools to assist both medical and non-medical providers in advancing along a continuum toward becoming comprehensive, community-based integrated delivery systems that provide patient-centered individual care; and improve the health status of populations. Many of the innovations of the Alliance Plan related to Medicaid are reflected in this *Path the Transformation* waiver. On January 16, 2014, Governor Quinn signed an executive order creating the Governor's Office of Health Innovation and Transformation (OHIT), to lead implementation of the recommendations of the Alliance Plan, including leadership on implementation of this proposed 1115 waiver.

Improving access to community-based long-term services and supports

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 managed by the Department of Healthcare and Family Services through agreements with two other 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. Illinois intends to create a new approach to these programs, building on projects already underway to coordinate care for Seniors and Persons with Disabilities (SPD), intended to break through the silos that do not effectively address the holistic needs of clients with multiple disabilities and conditions.

Under the *Path to Transformation* waiver, Illinois intends to continue this work by consolidating the existing 1915(c) waivers and introducing program changes to improve access, choice, and integration of services to individuals, incentivizing providers to partner with the state to innovate, coordinate and participate in new care models, and ensuring appropriate credentialing, certification/licensure of those who provide services to clients. In order to ensure that children, youth, and adults in community settings receive the effective behavioral health services and support, at the appropriate level of intensity, based

on their needs, Illinois will offer LTSS that follow the principles and values of systems of care to children with SED/youth and adults with serious mental illness.

Illinois is also currently 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 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. 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.

Implementation of Community Transformation Grant

In 2011, Illinois received a Community Transformation Grant (CTG) from the CDC for $24M over a five-year period. The CTG, named We Choose Health, focuses on four main areas: tobacco-free lifestyles, active living and healthy eating; high-impact quality clinical and other preventive services, and creation of healthy and safe physical environments. We Choose Health seeks to improve the level of health equity in communities through a combination of locally targeted and statewide initiatives. Statewide initiatives include healthy child care (an initiative to implement the Nutrition and Physical Activity Self Assessment for Child Care through the Child Resource and Referral Network) and Healthy Hearts (an initiative to support providers' prevention efforts by integrating data exchange and analysis tools).

Health Information Exchange

The Illinois Health Information Exchange (ILHIE) is a statewide, secure electronic transport network for sharing clinical and administrative data among health care providers in Illinois and bordering states. The exchange is designed as a secure environment to improve the health of the people of Illinois through better and more informed decision-making enabled by the quick exchange of, and access to patient information such as medical records, labs, immunizations and prescriptions at the point of care. The Illinois Health Information Exchange Authority (ILHIE Authority) was established to provide a governance structure for the network, which currently serves more than 3,500 health care providers throughout the state and connects more than 120 hospitals for electronic public health reporting.

Waiver Goals

The goals of the *Path to Transformation* waiver are to:

1 Support linkages between health care delivery systems and services that directly impact key social determinants of health, including housing and early intervention home visitation services.

2 Create incentives to drive development of integrated delivery systems that are built around patient-centered health homes; have a network of providers including primary care, specialists, hospitals, long-term, and behavioral health, as dictated by the populations they serve; and can incentivize a system of care that creates value and ensures that savings are shared with individual health care.

3 Promote efficient health care delivery through optimization of existing managed care models, including traditional risk-based managed care, ACEs and CCEs.

4 Enhance the ability of the health care system to engage in population management, by leveraging public health resources and encouraging linkages between public health and health care delivery systems.

5 Strengthen the state's health care workforce to ensure it is prepared to meet the needs of Medicaid beneficiaries.

6 Consolidate Illinois' nine existing 1915(c) waivers under a single 1115 waiver to rationalize service arrays and choices so that beneficiaries will remain as independent as possible, and based on needs defined by a functional/medical needs tool, rather than based on disability or condition. This will include thoughtful review and adjustments to current institutional eligibility thresholds, allowing HCBS waiver services to be provided to individuals who meet specific program eligibility criteria that may be less stringent than the institutional threshold. Illinois hypothesizes that providing the appropriate home and community-based services at the critical point in the client's arc of need, may result in prolonging the client's independence in the community, and reducing need for more intense level of services.

7 Increase flexibility and choice of long-term supports for adults and children and support development and expansion of choice within tiered levels of community based options based on need.

8 Institute a provider assessment on residential habilitation providers to create greater access to home and community based residential services.

9 Reduce Prioritization of Unmet Need for Services (PUNS) wait-list maintained for access to services for individuals with a developmental disability.

10 Promote and foster greater community-integrated, competitive employment opportunities moving the system away from facility-based sheltered work programs;

11 Enhance access to community-based behavioral health and substance abuse services and encourage integration of these services with physical health care services;

II. Demonstration Eligibility and Enrollment

Illinois proposes to include all mandatory and optional eligibility groups approved for Medicaid or CHIP coverage per the Illinois Title XIX Medicaid or Title XXI CHIP state plans. (State Plan changes related to eligibility requirements for groups affected by the ACA are not yet finalized.) Note that Illinois generally refers to AABD related groups as Seniors and Persons with Disabilities or SPDs.

Groups for whom coverage includes comprehensive benefits that will be included under the waiver:

1. Children from birth through age 18
2. Parents and other caretaker relatives
3. Pregnant women full benefits
4. Persons eligible for Transitional Medical Assistance
5. CHIP Unborn Children
6. CHIP Postpartum Care Health Services Initiative
7. Aged, Blind and Disabled Persons in 209(b) states
8. Disabled Adult Children
9. Aged, Blind and Disabled Individuals Financially Eligible for SSI Cash Assistance
10. Persons with Disabilities eligible for Medicaid under Title 1619 (a) or (b)
11. HCBS waiver enrollees eligible under institutional rules
12. Aged, Blind or Disabled Poverty Level Group
13. Aged, Blind or Disabled individuals receiving only optional state supplements in 209(b) or certain SSI criteria states
14. Persons with disabilities who work per the Ticket to Work and Work Incentives Improvement Act (TWWIIA Basic Group)
15. Medically Needy Aged, Blind or Disabled persons, pregnant women and children
16. Persons who need treatment for breast or cervical cancer or related conditions
17. New group: ACA Adults
18. New group: Former Foster Children
19. Refugees
20. TANF recipients if not covered under one of the preceding groups

Groups for whom coverage includes partial benefits that will be included under the waiver:

- Reproductive Health Coverage for Persons Who Are Uninsured or Whose Insurance Does Not Cover Birth Control

III. Benefits

All eligible demonstration enrollees will have access to all Illinois Medicaid State Plan benefits as approved by CMS. No State Plan benefit changes are requested for this demonstration. Services will be sufficient in amount, duration and scope to reasonably achieve their purpose. An explicit objective of the demonstration is the provision of Long Term Services and Supports (LTSS) to eligible enrollees, in a restructured consolidation of nine (9) preexisting 1915(c) Home and Community Based waivers. The nine HCBS waivers are listed below.

1915 (c) Waiver Population	Operating Agency/Division
Adults with Developmental Disabilities	Department of Human Services—Developmental Disabilities(DDD)
Children and Young Adults with Developmental Disabilities-Support	Department of Human Services—Developmental Disabilities(DDD)
Children and Young Adults with Developmental Disabilities-Residential Waiver	Department of Human Services—Developmental Disabilities (DDD)
Children that are Medically Fragile/Technology Dependent (MFTD)	Care managed by the University of Illinois at Chicago
Persons with Brain Injury (TBI)	Department of Human Services—Rehabilitation Services (DRS)
Persons who are Elderly	Department on Aging
Persons with HIV/AIDS	Department of Human Services—Rehabilitation Services (DRS)
Persons with Physical Disabilities	Department of Human Services—Rehabilitative Services(DRS)
Supportive Living HCBS Waiver	Department of Healthcare and Family Services

The following LTSS will be available. The specific services, and level of intensity will be based on the individual's functional and medical needs as identified by a standardized tool and process:

- Adult Day Health Services
- Assistive Technology
- Behavior Intervention and Support
- Behavioral Services (Psychotherapy and Counseling)
- Child Group Home

- Cognitive Behavioral Therapies
- Community-based Day Habilitation
- Facility-based Day Habilitation
- Emergency Response Services
- Environmental Accessibility Adaptations
- Extended State Plan Services
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Intermittent Nursing
- Medically Day Care
- Non- Medical Transportation
- Nursing (CNA)
- Personal Care Services (Personal Assistant, Personal Support)
- Prevocational Services
- Residential Habilitation
- Respite
- Service Facilitation
- Skilled Nursing
- Specialized Equipment and Supplies
- Supported Employment
- Temporary Assistance (Emergency Support)
- Training and Counseling for Unpaid Caregivers
- Vehicle Modifications

Service definitions are included in Appendix A.

IV. Service Delivery Models

To achieve the goals outlined above, Illinois has designed the *Pathway to Transformation* around four primary focus areas, or "pathways":

- *Delivery system transformation.* One of the core principals of the state's Health Care Innovation Plan, Illinois' healthcare delivery system will be built off of integrated delivery systems (IDS) -- centered on 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. For the dually eligible, the integrated care financial alignment program recently awarded to Illinois is another example of the state's commitment to the integration of care model. Illinois intends to include the right-sizing of acute and long term care as part of this transformation.

- *Population health.* Illinois will expand the capability of the healthcare delivery system to coordinate with public health and population health resources. The state will incentivize delivery systems to focus on prevention, primary care and wellness.
- *Workforce.* Illinois will build a 21st century health care workforce that is aligned with the needs of the Medicaid program. This includes targeted efforts to address workforce shortages in high-need urban and rural areas. It also includes efforts to build a work force 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, training, and ability to meet standard credentialing requirements including appropriate certification and licensure.
- *HCBS infrastructure, choice and coordination.* Illinois will rebuild and expand its home and community-based services, especially for those with complex health and behavioral health needs. The state will expand access to and choice of HCBS for those who qualify and ensure that services and supports are based on individual needs.

Pathway 1: Transform the Health Care Delivery System

As described above, Illinois is in the midst of a rapid and significant shift from a largely fee-for-service model to a variety of risk-based managed care models including both traditional MCOs as well as new, provider-driven models. All of the entities will establish integrated delivery systems centered on 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 clients and timely transmission of patient clinical data among provider partners. The providers within the network will 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 coordination systems. These payment reforms will incorporate multi-payer strategies developed through the Illinois State Innovation Model Design initiative. While CCEs and ACEs will contract directly with the state, they will also have the ability to contract with traditional MCOs and MCCNs, 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 subsidized coverage under the Illinois Marketplace. With tens of thousands of people newly eligible for Medicaid likely to shift between Medicaid and Marketplace coverage 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, Illinois 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.

One of the cornerstones of the State Health Care Innovation Plan is the creation of a new Innovation and Transformation Resource Center (ITRC) within the newly created Governor's Office of Health Innovation and Transformation (OHIT) that will, among other functions, serve as a technical assistance "hub" for health system transformation. This may include, for example, technical assistance designed to:

  - Accelerate implementation of health homes
  - Assist in front-line performance improvement – transform physician office, use a registry, team-work
  - Assist in establishing payment methodologies within IDS to facilitate delivery system transformation
  - Disseminate best practices in models of care (particularly for specific populations)
  - Share and spread best practices to maximize the number of people benefitting from the innovations and accelerate the pace of positive change
  - Support the Multidisciplinary Team-based Care Learning Collaborative and promote team-based care across the IDSs
  - Provide technical assistance for adoption of tele-health and other emerging technologies to optimize efficient use of resources

Under the *Path to Transformation*, Illinois will invest $40 million annually Medicaid administrative dollars to support the creation and ongoing operations of the ITRC, which will be a critical element in the state's plan to drive delivery system transformation.

Delivery System Reform Incentive Payments (DSRIP) to Transform Public Providers

Illinois is home to two large public health and hospital systems – the University of Illinois Hospital and Health System (UI Health) and Cook County Health and Hospitals System (CCHHS). 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. As the only State government acute care hospital and health system, the U of I system is also positioned to leverage its own strengths to improve care and lower costs for patients statewide. Both of these public 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. However, the state also recognizes that large public providers face numerous unique barriers to transformation that extend beyond those faced by other providers. These include legal and political barriers that can inhibit integration with other providers, cost-based reimbursement methodologies that may not have always incentivized efficiency, and multiple layers of oversight that can slow the pace of change. For these reasons, Illinois proposes to invest $200 million annually during the waiver period for 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.

Brief descriptions of proposed DSRIP projects are outlined below. Please see Appendix B for a more detailed description. Specific project parameters, milestones, timelines and payment schedules will be negotiated individually with CMS.

Cook County Health and Hospital System

In late 2012, CCHHS launched a Medicaid managed care plan under an "early expansion" 1115 Waiver. Named "CountyCare," this plan met with a very high level of demand for coverage by low income,

uninsured eligible adults. Over 127,000 applicants sought this coverage in less than a year's time, making CountyCare one of the country's landmark Medicaid expansion success stories. Now, with health reform implementation rapidly evolving, CCHHS is poised to bring administrative efficiency to the challenge of providing direct services, while also serving as a health plan, a payer (i.e., purchaser of services), and a population health management entity with a public health department within its scope. Termed the "4Ps Strategy," the CCHHS vision will be implemented in these four domains—provider, plan, payer, and population health manager.

CCHHS proposes to pursue delivery system transformation within this 4Ps construct. With federal support, CCHHS will be able to pursue innovative transformative initiatives aimed at supporting the triple aim through significant changes in its service delivery model, targeted workforce development initiatives, and initiatives that address key social determinants of health.

- **Form a public-private partnership to consolidate selected resources across organizations.** This initiative is aimed at better positioning the organization to achieve the triple aim by improving efficiency and reducing service duplications.
- **Redirect resources to more appropriate locations for primary care, subspecialty consultation and diagnostics.** By placing adult subspecialty care in local community settings, CCHHS will be able to direct resources to geographic areas that have been long neglected and provide and economic boost to the surrounding communities.
- **Collaborate with the University of Illinois College of Nursing to improve CCHHS workforce capacity and competency.** The program will help address a chronic CCHHS nursing shortage and primary care shortage. Further, the partnership will strengthen the internal nursing competency assessment processes to embrace new delivery models and address the needs of a changing patient population.
- **Develop a community health worker residency program and collaborate on other training programs to address workforce shortages.** In collaboration of Malcolm X College of the City Colleges of Chicago, CCHHS will develop a residency program to train community health worker students in supervised direct practice community setting. This collaboration will strengthen the community health worker role by offering a team-based training experience in a delivery setting.
- **Integrate behavioral health and primary care**. Both CCHHS and its CountyCare network of contracted providers will implement a population screening measure that allows better identification of patients with mild to moderate depression and related behavioral health

disorders (anxiety, grief, substance use). Using its leverage as a payer, CountyCare will promote screening and referral, using incentives and penalties to increase screening, early identification, care coordination and enrollment in treatment to address costly, prevalent mental health issues.

- **Promote continuity of care for the justice-involved population**. As a significant provider of care for this population, CCHHS will implement new strategies to improve outcomes and reduce recidivism. Strategies include care coordination initiatives and targeted medical respite services.
- **Address food insecurity –** CCHHS will collaborate with local private non-profits to provide a comprehensive approach to food insecurity, with a particular focus on vulnerable adults, to address this critical social determinant of health.

University of Illinois Hospital and Health Sciences System

The projects below present ways that the only State hospital and health system can leverage its own strengths to improve care and lower costs for patients statewide. As a major provider of both primary and specialty care services to the Medicaid population, UI Health also intends to transform care within its own system in order to achieve the triple aim of improved quality of care, improved health outcomes, and reduced costs. By transitioning to new payment models, through both the development of a UI Health Medicaid care coordination network and partnership with entities that have other models (including the MCOs, MCCNs, CCEs, and ACEs described elsewhere in this application), the UI Health system can lower its own costs at the same time as it improves healthcare outcomes for some of the most vulnerable patients in the state.

- **Build medication therapy management (MTM) capacity --** This project will identify Medicaid beneficiaries that are not assigned to coordinated care network and/or in rural areas that are in need of medication therapy management (MTM) services and provide the service to patients with identified drug-related problems (DRP).
- **Create specialty PCMH for Individuals with Sickle Cell and HIV -** For some high cost, high need populations, traditional primary care medical homes (PCMH) are not the ideal way to manage patient care. We propose to focus on two such populations – sickle cell and HIV – that would benefit from intensive, specialized services. The focus of the project is to reduce inpatient admissions in Medicaid sickle cell and HIV patients by improving patient activation and health literacy through specialized care coordination and personalized solutions.
- **Build on and expand Emergency Patient Interdisciplinary Care (EPIC) Coordination for Frequent ER Visitors Model --** The EPIC model (ER Patient Intensive Interdisciplinary Care) will

provide care coordination services to some of our region's most complex and costly patients: frequent ER visitors (≥ 4 ER visits/year). EPIC uses interdisciplinary care coordination to address both the medical and psychosocial determinants of health. The project will: 1) expand the annual caseload to include patients from other ERs in or near the Illinois Medical District (IMD); 2) enable creation of a care pathway for these patients into an ER Observation Unit for rapid evaluation, management and referral of these patients, reducing hospital admissions and re-admissions; 3) create a statewide telehealth system based upon an effective remote patient management model in New Mexico.

- **Build telemedicine capacity --** We propose to build on our experience in telemedicine to offer new services to patients in regions of Illinois where such services are not available. This includes capabilities in areas such as telepsychiatry and teledermatology. We also propose to expand the telemedicine services the University of Illinois College of Medicine currently provides to Illinois Department of Corrections (IDOC) inmates. Currently these services include treatment of HIV and Hepatitis C.
- **Offer preventive dental services to adult Medicaid patients --** Working with primary care providers (internists, family practitioners and allied health care professionals) the College of Dentistry will provide preventive care for two cohorts of patients. One cohort will be patients diagnosed with diabetes and the second cohort will be pregnant women.
- **Medicaid care coordination network at UI Health --** As stated elsewhere in this application, Illinois is in the process of implementing alternative models of care in addition to traditional managed care programs. These strategies require that we shift from traditional fee-for-service payment to fee-for-value payment arrangements, which means that we must implement substantial changes to care delivery that involve significant investment. We propose to use DSRIP funds to support the infrastructure development that will be required to make this transition.

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 some hospitals' revenue. The *Path to Transformation* waiver will invest in hospitals that are committed to transitioning to a modern service delivery model through the creation of two new programs:

Health System Integration and Transformation Performance Program

Under this proposal, Illinois would establish a Health System Integration and Transformation Performance Program to allow participating hospitals and health systems to earn incentive payments by meeting specific performance objectives. The performance objective would be designed to advance health system transformation, drive integration of services across the full continuum (including behavioral health, substance abuse treatment, community-based care and long-term care), reduce costs, and improve patient safety. The Illinois Department of Healthcare and Family Services will appoint an advisory committee to review and recommend three to five performance standards based on potential return on investment, impact on quality of care, and other factors. The advisory committee will include representatives from hospitals, accountable care entities (ACEs), as well as experts in health care performance/outcomes measurement and evaluation. A sample of performance metrics to be considered by the advisory committee includes, but is not limited to, the following:

- Demonstrated movement toward an Integrated Delivery System by: 1) participation in an ACE, or 2) contractual arrangements with primary care and behavioral health providers caring for Medicaid patients. (NOTE: incentive payments could be stratified based on levels of formalization of integration).
- Decreased rate of patient visits to the ED, reported as per 1000 member months.
- Decreased rate of ED admissions for Ambulatory Sensitive Conditions.
- Decreased hospital readmission rate at 30 days.
- Total number of primary care visits delivered in a timely manner (assessed by CAHPS survey).
- Decreased hospital admissions for Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), asthma and diabetes.
- Increased rate of all outpatient activity (clinic, physician office, home health, urgent care) per 1000 member months.
- EHR adoption within hospital network: % of system providers deemed “meaningful users” .
- Rate of follow-up appointments kept with mental health provider within 7 days for patients hospitalized with mental health conditions.
- Rate of follow-up appointments kept with primary care providers within 7 days for patients hospitalized with chronic illnesses.
- Rate of pregnant women who received a prenatal visit within the first trimester.
- Percent of providers within the hospital system who will see Medicaid patients.

- Percent of children up to 15 months who had at least 6 well-child visits.

The State proposes to invest $100 million annually in the Health System Integration and Transformation Performance Program. Funds will be divided into two pools: one for designated Critical Access Hospitals and hospitals that meet the state's criteria for "safety net hospitals"[3] and one for hospitals that do not meet distressed criteria. This will ensure that those providers that need the greatest amount of support to achieve quality and integration objectives have an opportunity to participate. While these payments will be within allowable actuarial soundness limits, the State proposes to make these payments directly to providers to support delivery system transformation across multiple payment models.

Hospital Access Assurance Program

Illinois hospitals are key players in the State's safety net system for Medicaid and the uninsured. While the 2014 Medicaid coverage expansion will help to mitigate uncompensated care costs, safety net providers will continue to incur significant amounts of unreimbursed costs related to Medicaid and the uninsured. The State's *Path to Transformation Waiver* proposes to recognize this by establishing a hospital Access Assurance Program, which will help preserve the safety net system and provide financial stability as hospitals implement transformative reforms under the waiver.

The State of Illinois' disproportionate share hospital (DSH) allotment is largely paid only to certain publicly owned hospitals. As a result, private hospitals in Illinois are not able to access the DSH funds necessary to subsidize the actual uncompensated care costs relative to the inpatient and outpatient hospital services provided to Medicaid and uninsured individuals. The assessment-funded Medicaid UPL supplemental hospital payment program is a critical alternative to subsidizing the unreimbursed cost of furnishing hospital services to Medicaid (and the uninsured indirectly). The Access Assurance Program will help to ensure access to care for critical hospital services provided to the State's most vulnerable populations as the state moves forward with its planned expansion of Medicaid managed care. Under the Program, any losses in historical Medicaid UPL supplemental hospital payments would be converted to the Access Assurance pool. Payments under the Access Assurance pool would initially be made using the methodologies currently outlined in the approved State Medicaid plan, as modified by any approved changes resulting from the state's rate reform efforts. However, the State will implement a payment methodology during the waiver period that transitions access assurance payments to a methodology that is based on uncompensated care costs.

[3] See 305 ILCS 5/5-5e.1

Institution Transition Fund

As Illinois works to rebalance the array of long-term care options for Medicaid beneficiaries, the state recognizes the importance of appropriate supports and incentives for institutional providers to reduce excess capacity or convert facilities to currently needed uses. In some cases, institutions may desire to close, downsize or repurpose their space but are unable to do so due to existing debt service requirements. To address this issue, Illinois will create an Institution Transition Fund, funded at $25 million annually, which would allow eligible facilities to receive additional Medicaid reimbursement if they close their facility or convert it to alternative uses.

The amount of additional reimbursement available to each eligible facility under this section will be determined by taking into consideration multiple factors, including, but not limited to:

(1) The location of the facility.

(2) The number of beds proposed to be closed or converted.

(3) The current and historical census of the facility.

(4) The financial condition of the facility operator.

(5) The quality of care provided by the facility operator.

(6) The proposed time frame for closing or converting the facility.

(7) The availability of other facilities and services to meet the needs of residents.

(8) The economic impact of the closure on the surrounding community,

In order to receive additional reimbursement available under this section, providers will be required to comply with Health Facilities and Services Review Board requirements and submit a plan to the Departments of Healthcare and Family Services and Public Health that fully describes the proposed plan to close or convert the institution. The plan must include an assessment of community needs how such needs will be met if the closure/conversion proceeds.

Pathway 2: 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 pre-ACA Medicaid rules. In addition, another 500,000+ people will purchase 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, while others will have pent-up demand for health care.

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. 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 resources by investing in incentives that drive integration of public health services, with the goal to lower costs of traditional medical services

Population health considers the health outcomes of an entire population, focusing on the vulnerable to reduce health disparities. Population health addresses the social determinants of health, which are social, economic, environmental and behavioral factors (such as: lack of access to fresh fruits and vegetables, unemployment and violence) and are interdependent with medical care. Public health, with a focus on population health, has historically collaborated with the healthcare delivery system to provide science and data expertise, education, prevention, promotion of healthy lifestyles, and community-based health services. Thus, population health strengthens and enhances healthcare delivery systems by improving the health of patients presenting for care, informing care priorities, and supporting healthy communities. . Illinois is committed to building linkages between public health and health care delivery systems and expanding the capacity of the health care system to manage the health of a defined population.

Integrate Public Health and Health Care Delivery

To incentivize integration of public health and traditional health care delivery toward achieving better overall population health outcomes, Illinois will create a bonus pool, funded at $10 million annually, for health plans that agree to use the funds to develop population health interventions in conjunction with public health entities, including newly created Regional Public Health Hubs.

Recognizing that additional public health resources and improved integration are necessary to catalyze the efforts of isolated health systems and local communities, the Illinois Alliance for Health recommended the creation of Regional Public Health Hubs (Regional Hubs). The Regional Hub will serve as a “nexus” between the Illinois Department of Public Health (IDPH), local health departments (LHDs), communities, and the health plans and providers serving the region. The Regional Hubs will align and

coordinate the multiple community needs assessments performed in the same regions. Through technical assistance and the opportunity to promote regional collaboration, the Regional Hubs can ensure that the best available data is used to inform the health assessments. In addition, the Regional Hubs will promote the use of evidence-based assessment tools such as those recently released by the CDC. The Regional Hub will facilitate the cooperative selection of core health priority areas and selection of appropriate metrics using evidence-based tools. Factors such as health disparities, the impact of social determinants of health, availability of evidence-based interventions, and balanced outcomes will inform the prioritization process.

An important feature of the Regional Hubs will be to assist local communities to link community interventions and to provide technical assistance in selecting evidence-based interventions such as those endorsed by the Community Preventive Services Task Force. The Regional Hubs will afford anti-trust protection for hospitals and health systems, traditional marketplace competitors, to come together to collaborate on community health interventions. In addition, many locally-sponsored community health interventions are multi-faceted and too diffuse to have an observable impact on population health indices. By reinforcing and aligning multiple projects, the Regional Hubs can amplify local efforts and aggregate results. In addition to promoting the development of coordinated community health interventions, the Regional Hubs will work with LHDs and IDSs to promote policy, systems, and environmental changes that improve health. This may include interventions that address key social determinants of health, including crime/public safety, access to healthy foods, and environmental factors.

Expand Maternal-Child Home Visit Programs

Illinois proposes to utilize Medicaid administrative match to support the expansion of maternal-child home visitation models coordinated by the Departments of Public Health and Human Services, including the family case management, the Maternal, Infant, and Early Childhood Home Visiting Program (MIECHVP), and the Nurse-Family Partnership program. This $10 annual million investment will allow the state to increase the number of families receiving these services by 50%. These programs summarized below have a strong track record and extensive evidence base for improving social and health outcomes, and reducing future health care costs. For example, evidence from the NFP studies indicate that, on average, enrolling 1,000 low-income families in NFP will result in:[4]

- 38 fewer preterm births

[4] Ibid

- 73 fewer second births to young mothers
- 240 fewer child maltreatment incidents,
- Significant declines in violent crime and youth arrests.

This expansion of maternal-child home visit programs will be coordinated with existing integrated delivery systems, including risk-based managed care models.

Pathway 3: 21st Century Health Care Workforce

Illinois recognizes that transformation of the health care delivery system will also require concomitant transformation of the health care workforce. Over the last year, the state has engaged in an intensive planning process to develop specific workforce goals and strategies. As part of this process, the Governor directed the Illinois Department of Public Health (IDPH) Director to lead a Health Care Workforce Workgroup under the Health Care Reform Implementation Council. The Workgroup assessed the jobs needed to achieve the goals of health care reform and meet the health needs of Illinois' growing, increasingly diverse and aging population. The Workgroup also assessed the existing health care workforce landscape and developed an analysis of gaps that need to be filled both for current needs and the impending demand created by expansion of health coverage through the ACA. In addition to IDPH, the Workgroup includes the Governor's Office, departments of Commerce and Economic Opportunity, Healthcare and Family Services, Aging, Financial and Professional Regulation, Employment Securities, Veteran's Affairs, Human Services and Children and Family Services with support from the University of Illinois at Chicago School of Medicine, Health and Medicine Policy Research Group and participation from external stakeholders as needed.

The state also recently reconstituted Health Care Taskforce under the Illinois Workforce Investment Board (IWIB). The IWIB is appointed by the Governor and charged with the task of reviewing the progress of the state's workforce planning efforts. It facilitates workforce development services and programs in such a way that together the government and the private sector can meet the workforce needs of Illinois employers and workers. Finally, utilizing the resources provided by CMMI, the Illinois Alliance for Health applied for and subsequently received support for a half-day retreat for technical assistance on health care workforce planning. Members of the Health Care Workforce Workgroup attended this meeting.

Merging the findings and recommendations from each of these efforts, Illinois is committed to implementing a health care workforce development strategy that will: 1) create new and sustainable

health care worker roles, and ensure that all health care workers are paid a living wage; 2) enable medical professionals work at the top of their training and education; 3) create capacity to serve underserved communities; and 4) promote team-based care within integrated delivery systems.

Current Health Care Workforce and Projected Need

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 match the demand in certain high-need 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%.[5] 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%.[6] 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. Indeed, State of Illinois Industry Employment Projections show that Illinois will need more than 100,000 new workers in the health care field by 2020.[7]

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. While it is not possible to rapidly increase the pipeline of physicians, the State can and 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.

Illinois proposes to invest in training and preparing the kinds of healthcare providers that will be vital to the future of the State's Medicaid program, including 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

[5] 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.
[6] 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.
[7] State of Illinois Industry Employment Projections(Long-Term): 2010-2020

cooperation with state universities, community colleges and other certification programs. Illinois requests that the following be treated as Designated State Health Programs under the 1115 waiver.

Workforce Development and Training

To promote improved access and quality of care for Medicaid beneficiaries in the State by supporting the development of the health care workforce and to increase the rate of Medicaid participation among Illinois providers, the State is requesting that certain health workforce training programs and related supports that significantly impact the Medicaid program be treated as Designated State Health Programs (Appendix C). These programs train much of the provider workforce that serves the Medicaid population and, like other components of the health care system, must make immediate investments in curriculum development and residency program design to prepare future providers for a system built off of team-based care within integrated delivery systems. Please see Appendix D for examples of workforce training programs that may be targeted for expansion under the *Path to Transformation* waiver.

Illinois is also committed to training non-provider members of the health care workforce that play a critical role in outreach, access and direct care for vulnerable populations. This includes, but is not limited to, Community Health Workers and direct care workers. Within the care team, these workers often have the most frequent contact with the individual and their family. Team-based care requires that they be fully engaged with and integrated into the care team in order to optimize their role in serving vulnerable populations statewide.

Under the *Path to Transformation*, Illinois will invest at least $50 million annually to develop and expand educational opportunities through the universities, community colleges and other education partners to address multiple workforce needs and establish curricula and competency testing standards, including front-line workers and primary care professionals that meet the needs of the state Medicaid program. These priorities will be established by the Office of Health Innovation and Transformation and payments distributed by the Department of Healthcare and Family Services.

Health Care Workforce Loan Repayment

To supplement the workforce training efforts described above, Illinois will commit to funding a loan repayment program at $10 million annually, and seeks designation of this investment as a Designated State Health Program. The state has currently authorized loan repayment programs for family medicine,

nursing, allied health professions, dental, and psychiatry, but many of these programs were subject to budget cuts during the economic downturn have not been funded since 2009. By July 1, 2015, the state will establish a loan repayment assistance to providers and other health care workers who commit to serving Medicaid populations in rural or other underserved areas (as designated by the Secretary or using state-developed criteria approved by the Secretary). The state is currently reviewing the existing loan repayment programs and will modify them as needed to ensure alignment with health care workforce needs and based on available funds. This will include adding additional professions (e.g., social workers and other mental health and substance use disorder professionals, community health workers, direct care workers) that qualify for loan repayment and ensuring that all loan repayment programs are contingent on the recipient practicing in an underserved area.

In addition to funding the state loan repayment program, Illinois will establish a bonus payment pool for hospitals that are designated as Critical Access Hospitals or classified by the state as a "safety net hospital" that establish their own loan repayment programs. Many of these safety net hospitals struggle to maintain a stable and adequate work force to serve the Medicaid population, often investing substantial resources in training staff that leave for other opportunities after they are trained. This program would incentivize hospitals and health systems to create their own loan repayment programs to attract and stabilize their workforce. Hospitals can customize their loan repayment programs based on their specific workforce needs and the workforce profile of the communities they serve.

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:

- increasing the number of providers in Illinois providing care to medically underserved populations
- increasing the number of primary care providers
- increasing the number of providers in specialties in high demand in medically underserved areas
- increasing the number of providers in Illinois providing patient-centered and population-centered care

Consistent with the approach taken by at least 10 other state Medicaid programs,[8] Illinois' Medicaid GME program will be designed to address state workforce goals through payments for performance on specific GME program metrics. Proposed program parameters are outlined below.

The program would incentivize GME programs in Illinois to address state workforce goals through two mechanisms. First, the state will invest $10 million annually in a program that mirrors the current Department of Health and Human Services/HRSA's Teaching Health Center Graduate Medical Education Program (THC) program in the state of Illinois. During its brief existence, this program, funded by the Affordable Care Act (ACA) in 2010, has been effective in supporting the training of primary care providers committed to working in underserved areas. Indeed, despite uncertain federal funding, nearly half of the trainees in THCGME programs have gone on to practice in related safety net care settings.[9] Illinois is currently home to just one THC. This program just launched its first fully-trained cohort of eight Family Physicians, all of whom took positions in Community Health Centers. The Illinois program requires applicants to be bilingual and received more than 860 applications for the eight positions available this year. During their three years of training, these residents take on progressive responsibility (under faculty supervision) to provide ambulatory care to panels of patients, most of whom are Medicaid recipients.

At the expiration of federal statutory funding for the THC program in 2015, the state would provide continued funding of the current THC supported GME program(s). Other GME programs in Illinois would be encouraged to seek state funding under the same criteria currently operative for the THC program. Illinois HFS would oversee the administration of this program, including the development of performance metrics to ensure that programs generate primary care practitioners that serve in underserved areas in order to continue receiving funding.

Second, the state will invest $26 million annually in incentive-based payments for performance on specific metrics achieved by current Illinois GME programs in designated medical specialties. A number of primary care and primary care-related specialties will be included that have been recognized in Illinois, as well as nationally, as sources of physicians that are in high demand in medically underserved areas. Designated GME programs must be accredited by either the Accreditation Council on Graduate

[8] AAMC, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey,* April, 2010.
[9] Phillips RL, Petterson S, Bazemore A. Do Residents Who Train in Safety Net Settings Return for Practice? Academic Medicine. 9000;Publish Ahead of Print:10.1097/ACM.0000000000000025

Medical Education (ACGME), the American Osteopathic Association (AOA) or the Commission on Accreditation of the American Dental Association (ADA). These programs include the primary care programs Family Medicine, Internal Medicine, Pediatrics and Internal Medicine-Pediatrics. Other designated programs include Obstetrics and Gynecology, Psychiatry, General Surgery, General Dentistry, Pediatric Dentistry and Geriatrics. Programs that are dual accredited by the ACGME and AOA are only eligible for a single yearly payment. Eligible residency programs must have been in existence for two years before application for funds. New programs must meet the two year requirement.

The performance criteria for incentive payments will evolve over the first five years of the program to allow programs time to align training with the proposed incentives and to demonstrate desired physician workforce outcomes.

Years One and Two:

- 75% of funds will be set aside for funding of GME programs that provide significant training for residents with medically underserved populations. Sites used for determining eligibility will be GME clinics in which the residents receive their primary outpatient clinical training. For eligible GME programs, the numerator will be a population of patients with over 30% from the following categories of pay: Medicaid, dual Medicaid/Medicare eligible, CHIP and/or uninsured. The denominator should include all persons receiving care in the designated clinic in the specific GME specialty. When more than one site is used for resident continuity of care practice, the designated practice site or sites used to calculate percent medically underserved must contain over 90% of patients seen by residents in their primary outpatient training site. Primary clinic location in a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC) will automatically qualify GME programs. Each program meeting these standards will receive an equal share of the designated funds.
- 25% of funds are set aside for written curricula in population medicine based on practice in primary/general outpatient care settings. The curriculum must contain competencies in the following areas of population medicine: preventive care, the use of information technology for managing clinic patients, appropriate management of patient transitions of care, inter-professional team-based care and patient-centered decision making. Programs must document that all residents received at least 20 hours a year in instruction in these areas. Each program meeting these standards will receive an equal share of these funds.

Years Three and Four:

- 40% for GME residency clinic practice with underserved communities as in Year 1 above.
- 10% for GME residency programs with a population medicine curriculum as described in Year 1 above.
- 25% of funds will be set aside for GME residencies with >20% of graduates working as full-time providers in a HRSA-designated Health Professions Shortage Area (HPSA) or with Medically Underserved Areas/Populations, or other health professions shortage areas defined by the state. The eligible cohort would be those graduating no less than 12 months but no more than 24 months prior to a yearly designated time. From participating programs, eligible residents would include all those entering practice directly after graduation from the specialty residency programs listed above. Practice that begins after a chief residency year would be counted for eligibility at the end of the chief residency year. Other full-time postgraduate training would disqualify graduates from meeting eligibility criteria. Each residency program meeting this criterion will receive an equal share of these funds.
- An additional 25% of funds will be divided among programs and provide a per capita funding for each graduate of eligible programs entering practice in Illinois working in a HRSA- defined Health Professions Shortage area or equivalent. Eligibility is defined as above. Of the set-aside funds, the per resident amount will be the share of the 25% of available funds divided by all eligible recent graduates entering practice in Illinois in a HPSA or equivalent shortage area.

In years 5 and beyond, the criteria for payment will shift to a heavier emphasis on graduate placement and a smaller emphasis on residency training locations. Specific parameters for years 5 and beyond will be developed as the program progresses.

Training of the state's future physician workforce cannot be done at the expense of ensuring access to care, however. Therefore, Illinois requests that payments made under its Medicaid GME program be exempt from federal upper payment limit requirements, as defined in 42 CFR 447 and be paid directly by the state to qualified teaching hospitals and federally qualified health centers.

Workforce Planning and Evaluation

To ensure that the state's workforce development programs continue to align with the projected workforce needs of the Medicaid program, Illinois will coordinate all workforce development programs

under the Innovation and Transformation Resource Center. The ITRC will take a comprehensive approach to evaluating future workforce needs by collecting and analyzing data and developing data-driven projections. This may include:

- Periodic real time tracking of sentinel providers to understand impact of ACA on patient supply/demand an inform corrections long before national data is available;
- Working with the Illinois Department of Financial and Professional Regulation to understand provider activity in a given location when they are listed as having multiple offices.
- Evaluating the impact of various programs and approaches on primary care supply and retention
- Tracking community worker supply and demand,
- Tracking other extenders such as medical assistants, patient care technicians.

This work will inform any future changes to the state loan repayment program, Medicaid GME program, Teaching Health Center GME program, and other investments in health care workforce training.

Pathway 4: LTSS Infrastructure, Choice, and Coordination

Providing the right care, in the right setting, at the right time is critical to ensuring individuals can safely remain in the home and community and realize their highest level of independent functioning and quality of life. In order to achieve this goal, we will ensure that an adequate array and supply of long term services and supports (LTSS) are available, and level of care thresholds are appropriate to offer eligible participants a non-biased choice of service settings.

Illinois will leverage the actions underway in implementing consent decrees related to three *Olmstead*-related class action lawsuits, by helping residents of nursing homes and other institutions transition to the community. Early work on these consent decrees, as well as the Money Follows the Person (MFP) Program, has revealed that the existing community infrastructure needs to be strengthened to enable individuals to achieve their highest level of independent functioning and live in the most community integrated setting possible.

Illinois will expand home and community-based service options, especially for those with complex health and behavioral health needs and ensure that services are based on individual needs and not arbitrarily limited based on a particular disability. Currently, persons with serious mental illness (SMI) and substance use disorders are not served through a waiver; however, these populations will be included in this 1115 Waiver..

Illinois will also develop a comprehensive health homes program under Section 2703 of the Affordable Care Act for individuals with complex health needs, including HIV/AIDs. Under the *Path to Transformation* waiver, we are requesting 90/10 federal match for this program.

Moving from a Disability-Based to Needs-Based System

In Illinois, LTSS 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 for portions of day to day operations.

The nine waivers are very traditional service arrays tied to a specific age, physical, developmental or behavioral disability rather than identification of essential services needed to help avoid unwanted placement in a facility. The current waiver structure impedes the ability of healthcare providers and community organizations to forge new relationships and service delivery models that encourage and incent coordination and cooperative care for clients. Therefore, Illinois will consolidate its nine 1915(c) waivers under the umbrella of this 1115 demonstration, eliminating barriers to needed services, enhancing transparency, implementing common service definitions, provider qualifications and reimbursement schedules and simplifying the claims payment process for both fee for service and for managed care encounter data. For example, some LTSS service providers submit service claims to multiple departments or agencies. The transformation claims process will allow claims to be submitted directly to the Medicaid agency or its designee. The State heard from many providers that this planned change is a welcome simplification.

The *Path to Transformation* Waiver will assist the State in developing and implementing, across disabilities and across agencies, a universal assessment tool, a consolidated waiver structure, and enhanced LTSS capacity. 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 1115 demonstration will provide the flexibility needed to deliver appropriate and essential LTSS in a coordinated fashion through managed care entities and their provider networks. In addition, the state is in the process of developing an integrated web-based 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 Pathway 4 the *Path to Transformation:*

- Reduce administrative complexity and cost inherent in managing nine separate waivers.
- Rationalize service arrays and choices so that they are based on helping beneficiaries achieve their highest level of independent functioning possible.
- Increase flexibility, choice and transparency for beneficiaries.
- Support development and expansion of community based options.
- Reduce and ultimately eliminate waiting lists for HCBS waiver services.
- Develop outcome-based reimbursement strategies that emphasize quality of care and align payments with the goals of the program including system enhancements and procedures to mirror institutional type retroactive reimbursement when needed, removing the institutional bias.

Administrative Simplification

Universal Assessment

Illinois' current functional eligibility process for accessing community-based LTSS is the completion of a level of care determination for each of the HCBS Waivers or an assessment for Mental Health Rehabilitation Option services. Under the present service delivery system, individuals requiring LTSS who have complex needs, including co-occurring behavioral health needs, are not necessarily assessed in a holistic fashion nor are all of the LTSS options presented. The table below includes specific information about current functional eligibility requirements of Illinois' Medicaid LTSS programs.

LTSS Program	Functional Eligibility Tool
Alcohol and Substance Abuse	DSM4/ASAM
Children and Young Adults with Developmental Disabilities -Residential Waiver	Inventory for Client and Agency Planning (ICAP)
Children and Young Adults with Developmental Disabilities -Support Waiver	Inventory for Client and Agency Planning (ICAP)
Children that are Medically Fragile/ Technology Dependent Waiver	Illinois MFTD Level of Care (LOC) instrument
Community Care Program (CCP)	Comprehensive Community Assessment
Developmentally Disabled Adult Waiver	Inventory for Client and Agency Planning (ICAP)

Persons with Brain Injury Waiver	Determination of Need (DON)
Persons who are Elderly Waiver	Determination of Need (DON)
Persons with HIV or AIDS Waiver	Determination of Need (DON)
Persons with Physical Disabilities Waiver	Determination of Need (DON)
Rule 132 – Mental Health Community Services	LOCUS – ACT/CST & residential programs
Supported Living Facilities Waiver	Determination of Need (DON)

There are a variety of tools used, depending on the population or if someone is accessing services under the Medicaid Rehab Option (for mental illness). Under the present service delivery system, individuals requiring LTSS who have complex needs, including co-occurring behavioral health or other needs, are not necessarily assessed in a holistic fashion nor are all of the LTSS options presented. The table above includes specific information about current functional eligibility requirements of Illinois' Medicaid LTSS programs.

Through the Balancing Incentive Program, the state is enhancing its current standardized assessment tools and developing a uniform, person centered tool that can be used consistently across the State to determine an individual's needs for support services, medical care, transportation, and other services. The tool will be phased in for adults and children. The State has contracted with a national consultant and convened a workgroup of state agencies to develop policy and processes around the adoption of a new universal assessment tool (UAT). Once finalized, the UAT will be used to replace the current Determination of Need (DON) assessment tool that has been used since 1983 to determine the functional level of care for institutional and home and community-based long term care services for the elderly and individuals with physical disabilities. The UAT may also replace other LTSS assessments and/or incorporate existing LTSS assessments into the UAT. A stakeholder process will be employed to review the draft tool.

In general, the UAT instrument/process will:

- Assess the consumer in a holistic manner

- Contain a valid and reliable weighting algorithm(s) that will result in a functional eligibility determination and level of need assignment for LTSS consumers
- Standardize and streamline the collection of functional eligibility information for consumers who may be eligible for LTSS
- Allocate resources and inform LTSS care planning and coordination

By implementing this new tool and accompanying policy and processes, the State intends to streamline consumer intake and service eligibility across all populations and reduce administrative burden and cost through improved system performance and efficiency. As previously noted, in the varying operational and oversight structures of the nine HCBS waivers, there is a lack of standardization concerning service eligibility rules, assessment tools, service definitions, service packages, and rate development. This lack of uniformity across the system leads to inequities in the manner in which different target populations experience the service delivery system. To address these issues, Illinois will design a system that relies on a UAT that identifies the beneficiary's unique constellation of needs. The information gathered via the UAT will then be used to identify a service tier that coincides with the beneficiary's identified needs. This data will be available in a standardized format across multiple agencies and programs to facilitate better continuity and consistency in services provided. Following a person-centered planning process, the beneficiary/family will use the information form the UAT and the service tier, to develop a plan of services for the individual.

Common service definitions, provider qualifications and reimbursement rates

Consolidating nine waivers under the 1115 waiver authority will result in numerous efficiencies for the State of Illinois. The administration and operation of a single waiver, for example, will cut down on redundant administrative activities related to provider enrollment and monitoring, waiver amendments and renewals, records management, reporting, financial tracking, quality assurance, and other functions that will benefit waiver participants and service providers as well as the State.

As part of the 1915(c) waiver consolidation process, the State will develop a common set of service definitions and provider qualifications for each of the waiver services that will be available to eligible waiver recipients. The service definitions included in Appendix A are incorporated from the current HCBS waivers, but will be made more consistent through ongoing stakeholder involvement. As noted above, persons with serious mental illness (SMI) and substance use disorders are not served through a

waiver; however, these populations will be included in this 1115 Waiver and specific service definitions and provider qualifications unique to this population will be developed.

These changes will reduce and/or eliminate the service-level variability and disparity that exists across populations and assist waiver providers in delivering the right service to the right person at the right time. This includes children and youth who meet eligibility for behavioral health services. See Appendix A for the complete listing of consolidated home and community based service definitions under the *Path to Transformation* Waiver.

Streamlining monitoring, paperwork, and other reporting requirements

Consolidating nine waivers under the 1115 waiver authority will result in numerous efficiencies for the State of Illinois. The administration and operation of a single waiver, for example, will cut down on redundant administrative activities related to provider enrollment and monitoring, waiver amendments and renewals, records management, reporting, financial tracking, and other functions that will benefit waiver participants and service providers as well as the State.

Increased Access to Community-Based Services

Expanded Service Array

Under the current system, each of the nine HCBS waivers has its own discrete set of services. Access to an expanded array of community-based services will enable individuals to remain in their own community post-transition and avoid re-institutionalization. The *Path to Transformation* Waiver will provide eligible Medicaid waiver recipients access to a broader array of community-based LTSS options. Individual waiver recipients will be able to access these services based on their needs, as determined by the UAT and person-centered care planning process. Emphasis will be placed on service planning and quality oversight of case management to ensure there is appropriate use and utilization of available services.

Eligible waiver recipients will be assigned a service level tier based on their functional ability and support needs as determined by the UAT. Through the Universal Assessment Tool (UAT) the state will develop an institutional diversion process to emphasize Home and Community Based Services to determine when an individual on an institutional placement track may be more appropriately served with HCBS. Each tier will be assigned a budgetary range that increases with the functional need. The same array of services will be available to eligible individuals in all tiers regardless of disability. See Appendix A for the complete listing of consolidated home and community based service definitions. We believe the

expanded array of services and resource allocation process will increase flexibility and improve satisfaction for individuals receiving services.

Reduce Waitlist for Individuals with Developmental Disabilities

Illinois is committed to reducing the Developmental Disabilities waitlist through a phased approach over the next five (5) years. The Prioritization Of Unmet Need for Services (PUNS) lists 22,000 people waiting for Adult DD services. Other data sources indicate that approximately 35% of those individuals are already receiving either DD waiver services or LTSS services on another waiver. The Department estimates instituting a clean-up of the waitlist would potentially reduce the waitlist by another 15%. While these are estimates, the data indicates that through administrative efforts alone the waitlist could be significantly reduced.

In order to further reduce the waitlist and move individuals into services, Illinois will utilize a variety of mechanisms which may include: establishment of new priority criteria and identification of new funding sources and additional waiver slots. HFS will work with DDD to develop a strategy and implementation plan for achieving this reduction over time. Illinois is committed to reducing the Developmental Disabilities waitlist through a phased approach over the next five (5) years.

Quality Incentives and Outcomes

Illinois is seeking to adopt outcome-based reimbursement strategies to ensure that waiver recipients are not only receiving the right service at the right time, but that high quality services and support are being provided by qualified providers. This quality incentive program will be developed in conjunction with stakeholders, including waiver recipients, families, providers, state staff and other advocacy groups. While an incentive program will eventually be rolled out for all waiver populations, the State has opted initially focus on outcomes for the ID/DD population. The State has identified areas for systems-level improvement and will target incentive payments to increase:

- Employment opportunities for waiver recipients
- Development of smaller residential settings in the community (four beds or less)
- Consumer satisfaction
- Staff retention through wages and benefits and available training
- Community opportunities for persons with ID/DD

The stakeholder group will develop a series of objectives and performance measures with benchmarks aimed at moving the system towards the State's goals. New and expanded quality incentive payments will be developed and implemented through a continuous quality improvement process. Areas for improvement will be constantly evaluated through quality improvement activities that:

- Identify priority areas for improvement;
- Establish outcome-based performance measures and appropriate target goals; and
- Identify, collect, analyze and assess relevant data.

Waiver Consolidation: Integration of Behavioral Health

Illinois' current efforts to improve access to LTSS services and care coordination has produced data confirming that consumers transitioning from institutional care to the community often have very complex needs. Nearly half (42%) of MFP participants have five (5) or more major medical and behavioral health co-morbidities. These chronic health conditions include diabetes, heart disease, and COPD, and serious mental illnesses (SMI) (MFP 2011 End of Year Report, University of Illinois at Chicago). In addition, research has shown that the increased morbidity and mortality of persons with serious mental illness (SMI) are largely due to preventable conditions, highlighting the need to better integrate services targeting these illnesses as well as substance use disorders for individuals receiving HCBS.

Within the current system, multiple waivers have led to care that is fragmented as well as potential gaps in needed care. While individuals gain access to necessary LTSS, identification and referral to needed mental health and substance use disorder (SUD) services can be inconsistent. When referrals do occur, minimal coordination exists across the mental health and SUD providers and HCBS Waiver providers. Additionally, individuals with some of the most complex needs are left to navigate the healthcare and human service delivery systems without the assistance of a care coordinator to help them in addressing/managing all of their needs. Therefore Illinois proposes to ensure co-occurring mental health and/or substance use disorders are identified (consistent with BIP and the recently developed Illinois Mental Health Services Five Year Strategic Plan) and needed services available to Medicaid eligible individuals with qualifying needs for both state plan and waiver services. In addition, Illinois will develop health homes for individuals with SMI as well as persons with SMI and a co-occurring chronic health condition(s). It is believed that health homes will address the current lack of a whole health approach to care and the necessary care coordination across multiple providers to improve health outcomes for persons with complex health care needs.

Behavioral Health Expansion and Integration

The *Path to Transformation waiver* will allow Illinois to reinvest resources to rebuild and maintain a robust continuum of community based mental health and substance abuse services better integrated within the larger and broader health care system. By 2015, it is expected that 60% of Illinois Medicaid clients will have selected or will be assigned to one of the managed care models in managed care regions. All of these entities are required to integrate behavioral health services within their networks. In order to achieve this goal, Illinois Medicaid managed care entities as well as those providers outside of managed care regions will be required to:

- Promote increased coordination of care across physical health and mental health and substance use disorders through health homes for high cost high needs individuals with co-morbid conditions;
- Initiate utilization management strategies to ensure the right service, to the right individual, at the time of need; and
- Employ program/service structures designed to be proactive, incentivizing timely access and identification of behavioral health issues within a variety of health care settings and across the life span while maintaining access to crisis services.

Furthermore, as they become integrated delivery systems (IDSs), these managed care entities 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. Because IDSs will be held accountable for the health outcomes of individual patients within their networks, as well as for their overall patient population, it will be important for all behavioral health services and the populations accessing them to be well integrated into these systems. The initiatives outlined below will support the overarching goals for IDSs to improve quality through management of care and care transitions and thereby reduce costs and be provided incentives to ensure the right care at the right time in the most appropriate setting.

Health Homes for Adults with SMI

Illinois will work together with physical health and behavioral health stakeholders to develop a health home program for adults with SMI, including those with co-occurring chronic health conditions. Understanding that a small number of individuals account for a large portion of the health care costs, we will utilize data to support the target population for these efforts with an initial focus on reduction of emergency room and inpatient utilization, as well as ensuring access to primary care, including routine

screenings of the physical health conditions that have led to increased morbidity and mortality in the SMI population. Care coordination will focus heavily on care transitions, especially those individuals being discharged from institutional settings into the community. While case management of mental health needs has been a longstanding service, enhanced whole health care coordination will require significant planning, service redesign and workforce development as part of the state's implementation. Also of importance will be the development and use of health information technology (HIT) for mental health and substance use disorder programs, to make necessary seamless exchange of clinical data possible across behavioral health, primary care, and hospital providers. Illinois plans to formalize its health home program through a formal submission under the health home provision authorized by section 2703 of the Affordable Care Act. To accelerate the development of health homes, we will offer technical assistance services through the new state Innovation and Transformation Resource Center (ITRC; see Pathway 1 for additional information).

Improved Access and Outcomes through Improved Utilization Management

Illinois plans to engage behavioral health stakeholders, including consumers and their families, to redesign the behavioral health system. This process will include a review of existing programs for their efficacy and evidence base and the addition of services through state plan amendments. As part of the *Path to Transformation* planning process, Illinois engaged internal and external stakeholders to begin this process. Gaps in services and subsequent new service recommendations are already in progress and included within this submission; others, such as State Plan access for certain services, are also envisioned. Emphases on services that support social as well as physical integration within the community are being prioritized. Efforts to discharge individuals as part of the Williams and Colbert Consent Decrees have highlighted the need for improved home-based supports for those with the highest need. In order to offer new services within the continuum, a system redesign will occur to create improved efficiency within the current system to support the addition of services and the anticipated increase in individuals newly eligible under the Medicaid expansion.

Improved utilization management will be achieved through implementation of service packages consistent with the model being proposed under the waiver consolidation, and part of larger system redesign. Service eligibility will be based on diagnosis and a functional assessment, building upon efforts within the current Balancing Incentive Program (BIP). Service packages can be customized to meet the needs of co-occurring waiver populations, adults with SMI and/or substance use disorders, youth with serious emotional disturbance (SED) and those with co-occurring mental health and substance use

disorders. A service package structure lends itself to capitated payment structures as well as pay for performance strategies which the state intends to continue to pursue.

In an effort to transition a large number of individuals from nursing facilities to more community integrated settings, the Illinois General Assembly included in Senate Bill 26 (PA 98-0104), along with Medicaid expansion, the creation of Specialized Mental Health Rehabilitation Facilities (SMHRFs). These facilities will specialize in the treatment of serious mental illness and often co-occurring substance use disorders. SMHRFs' four levels of care encompass crisis intervention, acute stabilization, intermittent stays and long term services and supports within a residential setting. As Illinois plans for and implements a more robust community based system to support individuals with high needs it will be essential to maintain access to the SMHRF services during this transition to more community based services. Illinois requests that SMHRF services be treated as costs not otherwise matchable for the five years of the waiver period to allow for crisis and acute inpatient reimbursement in SMHRFs during the state's transition period. This will create funding for increased access to community-based services that support discharge to more independent living arrangements. Specifically increased access will be achieved through expanded: Assertive Community Treatment (ACT) teams and Community Support Teams (CST) to support individuals at high risk for or transitioning from institutional care and/or correctional settings, community-based Medicaid Rehabilitation Option (MRO) services that include expansion of services to treat substance use disorders, and System of Care (SOC) for youth.

Timely Access and Identification of Behavioral Health Needs

Illinois proposes to provide an expanded continuum of services through a state plan amendment to meet the needs of children and adults. Evidence supports that prevention and early intervention can bend the cost curve on health care spending. A robust health care system identifies emerging illnesses and when appropriately treated can decrease the long term costs of treatment. Therefore Illinois proposes to implement a series of prevention and early intervention programs that include Screening, Brief Intervention, and Treatment (SBIRT), as well including access to services and supports that prevent or limit residential placements for children with both mental health and/or substance use disorder needs. State agencies will develop strategies that incorporate Medicaid 1115 funding along with other existing federal funding streams, such as SAMHSA SAPT and MHBG funding, to create a robust proactive system of health care. We will reinvest savings to support enhanced skills training and assistance, peer support services, and assistance with non-medical needs associated with long term disability and soon to be eliminated learned dependency on institutional settings. Expansion of substance use disorder

services will also include peer recovery supports and case management for those with high needs. Illinois will work with our stakeholders to prioritize access to the most vulnerable and at risk populations including those leaving the criminal justice system who are living with mental health and/or substance use disorders and individuals and families with socioeconomic challenges associated with poverty.

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.[10] For example:

- A Chicago study of chronically ill homeless individuals found that stable housing coupled with case management reduced hospital admissions by 29% and ED visits by 24%.[11]
- A Seattle study focused on chronically ill homeless individuals with alcohol abuse problems found that, when placed in a supportive housing program, the use of publicly funded healthcare program and associated costs decreased significantly. Total costs, including healthcare and other related public expenses of the intervention group were 53% less than the control group. Much of the decrease was attributed to reduced emergency department and inpatient hospital use.[12]

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[10] See also 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.

[11] Sadowski LS, Kee RA, Vander Weele TJ & Buchanan D. (May 2009). Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults. The Journal of the American Medical Association.

[12] Larimer, Mary E Ph.D. et al. (2009, April 1) Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. Journal of the American Medical Association (Vol. 301, No. 13) 1349-1357.

- A study of residents of a supportive housing program in Los Angeles with very high health care costs found a 57% reduction in ED visits, a 75% reduction in hospital admissions, and a 75% reduction in inpatient hospital charges.[13]

Through the *Path to Transformation* waiver Illinois seeks to expand access to supportive housing by incentivizing the health care delivery system to invest in and build linkages with providers of housing and supportive housing services.

An estimated 80% of individuals diagnosed with serious mental illness and high overall health care costs do not have access to stable housing. Many of these individuals are in need of temporary rental assistance until they qualify for SSI. An SSI application can take up to two years to be approved. With a SOAR application (SSI Outreach, Access and Recovery), SSI typically is approved within six months. Under the incentive pool program described below, plans and providers could utilize incentive payments to pay for transitional rental assistance, completion of SOAR applications, or make capital investments in housing for patients. These incentives are aimed at individuals with severe mental illness (SMI) and/or substance use disorders (SUD), including, but not limited to those who are homeless. As summarized above, there is a significant body of research to show that getting these individuals into stable housing can have a large, positive impact on health care outcomes and costs. In addition, the provisions are also aimed at individuals who could be cared for in the community, but – due to lack of stable housing -- are unable to be in the community and, therefore, reside in a more costly, more restrictive institutional setting.

Incentivize Managed Care Entities to Invest in Stable Housing

Illinois will incentivize Medicaid health plans to invest in housing and housing supports for their patients by establishing an incentive-based bonus pool. Plans will be eligible for payments from the pool if they demonstrate beneficiaries diagnosed with serious mental illness (SMI) and/or substance use disorders (SUDs) attributed to them that are maintained in stable housing for an extended period of time. If there is sufficient evidence demonstrating effectiveness, the State will extend bonus eligibility under the pool to ACEs and CCEs once these entities become risk-bearing.

[13] Corporation for Supportive Housing (2012, October 10) "Frequent Users Programs Seeing Posi-tive Early Results in Los Angeles" Retrieved from http://www.csh.org/news/frequent-users-programs-seeing-early-results-in-los-angeles(Accessed October 31, 2012) & Los Angeles Frequent Users Systems Engagement (FUSE) Program Retrieved from http://www.csh.org/csh-solutions/community-work/systems-change/local-systems-change-work/los-angeles-fuse (Accessed October 31, 2012).

Build Linkages Between Behavioral Health Providers and Supportive Housing

In regions of the state that do not have a significant Medicaid managed care presence, the State also proposes to establish an incentive-based pool for community behavioral health providers to support the maintenance of at-risk populations in stable housing. Providers will be eligible for payments from the pool if they demonstrate meaningful improvements in the number of beneficiaries diagnosed with serious mental illness (SMI) and/or substance use disorders (SUDs) attributed to them that are maintained in stable housing for an extended period of time.

V. Cost Sharing

Illinois law (305 ILCS 5/5-4.1) requires cost sharing, with certain exceptions, to be maximized to the extent permitted by federal law. Federal regulations impose tracking requirements that require systems capacity and functionality that are not currently available. The new MMIS will have both the capacity and the functionality to meet the federal requirements for cost sharing. The State requests that the requirements described below be waived pending implementation of the new MMIS now being developed.

Aggregate Limits

Federal law requires that cost sharing must not exceed an aggregate limit of 5 percent of the family's income applied on either a quarterly or monthly basis, as specified by the agency. Federal regulations impose tracking requirements on these aggregate limits that are administratively difficult and costly to implement. Accordingly, the State proposes to waive the requirement that Illinois must track each family's incurred cost sharing through an effective mechanism that does not rely on beneficiary documentation. The State also proposes to waive the requirement that Illinois must notify the beneficiaries and providers of the beneficiaries' aggregate limit and notify beneficiaries and providers when a beneficiary has incurred out-of-pocket expenses up to the aggregate family limit and individual family members are no longer subject to cost sharing for the remainder of the family's current monthly or quarterly cap period.

Native Americans

Illinois has historically exempted Native Americans (Indians), defined under 42 CFR 447.51, from copayments. Federal regulations require that Indians may be exempted from copayments only when they are currently receiving or have ever received an item or service furnished by an Indian health care provider or through referral under contract health services. Illinois proposes that Indians as a group

may be exempted from co payments without having to show that they received an item or service furnished by an Indian health care provider or through referral under contract health services.

Non-Emergency Services Furnished in an Emergency Department

Illinois proposes to waive the requirement that it may implement cost-sharing for non-emergency services furnished in an emergency department only when the hospital providing the care must, before providing non-emergency services and imposing cost sharing for such services, inform the individual of the amount of his or her cost sharing obligation for non-emergency services provided in the emergency department; provide the individual with the name and location of an available and accessible alternative non-emergency services provider; determine that the alternative provider can provide services to the individual in a timely manner with the imposition of a lesser cost sharing amount or no cost sharing if the individual is otherwise exempt from cost sharing; and provider a referral to coordinate scheduling for treatment by the alternative provider.

VI. Public Notice and Input

Prior to submission of this waiver application, Illinois had an extensive process for public input and dialogue. Our public notice and input process was consistent with the requirements outlined in 42 CFR Part 431 Subpart G. It should also be noted that many of the provisions included in this proposal grew out of the ongoing health reform dialogue in the state (including numerous opportunities for public input) as outlined in Section I of this proposal, including the Alliance for Health and the Governor's Health Reform Implementation Council.

Public Website

The State developed a website for the *Path to Transformation* waiver, which is accessible on the state's health reform page (http://www2.illinois.gov/gov/healthcarereform/Pages/1115Waiver.aspx). The web page includes a copy of the waiver concept paper, waiver drafts, slide decks from stakeholder meetings, attendance lists from stakeholder meetings, and instructions (with links) on how to submit comments on the concept paper and waiver drafts.

A copy of the waiver concept paper was posted on the state's website on November 7 and also distributed via e-mail to dozens of stakeholders. The State received written comments from 94 organizations and individual stakeholders on the concept paper. Comments were grouped by topic and summarized for review by state staff and consultants.

A draft of the waiver proposal was posted on the state's website on January and also distributed via e-mail to stakeholders. The State received written comments from 85 organizations and individuals on the draft waiver proposal. Comments were grouped by topic and summarized for review by state staff and consultants.

Stakeholder Meetings

The state held three large group stakeholder meetings to discuss waiver concepts and solicit input from stakeholders. Each stakeholder meeting was held more than once, and in-person, phone and video options were provided to maximize accessibility. The dates and topics of the stakeholder meetings are listed below:

October 18:	Waiver kick-off meeting; waiver goals and timeline
November 14 (two sessions):	Consolidation of 1915(c) waivers; concept paper discussion
January 9/10 (two sessions):	Consolidation of 1915(c) waivers; discussion of draft waiver

In addition to the large group stakeholder meetings, state staff and our consultants met individually with dozens of stakeholder groups and advocates, including, but not limited to the following. Please see Appendix E for a complete list of stakeholder meetings.

- Illinois Primary Care Association
- Illinois Hospital Association
- Illinois Human Services Commission
- AARP
- Illinois Health Care Association
- SEIU Healthcare Illinois/Indiana
- Illinois Association of Community Care
- Illinois Association of Rehabilitation Facilities
- Illinois Association of Area Agencies on Aging
- Illinois Council on Developmental Disabilities

Finally, our waiver consultant team met regularly with all interested state agencies, including the Medicaid agency (Department of Healthcare and Family Services) and the agencies with responsibility

for the current 1915(c) (Department on Aging, Department of Human Services). Cross-agency briefings on the waiver were held on December 9, December 16, December 23, December 30 and February 5.

Legislative Briefings and Hearing

Key legislative staff were briefed on the waiver on multiple occasions by the governor's office and agency leadership. In addition, several legislative hearings on the waiver were held, including:

- House Human Services/ House Human Services Appropriation Committee -- December 18, 2013
- House Human Services/House Human Services Appropriation Committee – January 22, 2014

Public Notice of Waiver Application

A public notice of the waiver application was published in the Illinois Register on February 7, 2014, allowing for a 30-day comment period. The waiver application was also posted on the state's website for public comment. Additional public stakeholder meetings were held on February 14 (Springfield) and February 20 (Chicago), in compliance with federal regulations.

VII. Approach to Budget Neutrality

Illinois understands that it must demonstrate budget neutrality for the *Path to Transformation* Demonstration, which means that Illinois may not receive more federal dollars under the Demonstration than it would have received without it. When submitting a Section 1115 waiver, states are required to include an initial showing that the Demonstration is expected to be budget neutral. This is the state's best estimate of cost and caseload at the time it submits its request. The test for budget neutrality will be applied according to the terms and conditions for the Demonstration that have been agreed to by the state and CMS, and will be measured periodically throughout the course of the Demonstration approval period and will finally be measured at the conclusion of the Demonstration. Appendix F contains all budget neutrality calculations.

VIII. Approach to Evaluation

The *Path to Transformation* Waiver touches every part of the Illinois Medicaid program. As a result, the evaluation design will be complex. At a minimum, the scope of the evaluation will include measuring

program objectives, identifying lessons learned, determining cost savings, and measuring quality improvements and clinical outcomes.

The State's evaluation design will also assess key program objectives such as: It is the state's hypothesis that successful restructure and expansion of LTCSS, transformation of the current delivery systems, emphasis on population health, and workforce development will result in improved access, capacity, and appropriate utilization.

- *HCBS infrastructure, choice and coordination*. The state will assess the impact of developing a comprehensive LTSS benefit package, particularly for those with complex health and behavioral health needs, analyzing changes in access, choice, and health outcomes.
- *Delivery system transformation.* The State will assess the impact of integrated delivery systems that include patient-centered health homes have on cost and quality of care, particularly looking at how the management of care and care transitions and aligned incentives have impacted the right care at the right time in the most appropriate setting.
- *Population health*. The state will assess the impact of expanding the capacity of the healthcare delivery system in order to focus on population health, have on prevention, primary care and wellness, including what elements of expansion are associated with improved health.
- *Workforce*. The state will assess the impact of using community health workers and other health professionals in integrated, team-based settings in geographies and disciplines in greatest demand, with the goal of identifying those practices necessary to ensure the health care workforce is sufficient to assume responsibility for patients in these settings.

Evaluation activities of performance will include the impact of the waiver implementation on the following:

- Hospital admissions and inappropriate use of ER;
- Health disparities;
- Utilization of HCBS;
- Utilization of health home services;
- Number of recipients enrolled in health homes; and
- Utilization of community health workers and other health professionals in integrated team-based settings.

As in the program design phase, stakeholder engagement in the program evaluation design will be critical. Through informal feedback and formal processes such as advisory groups and recipient satisfaction surveys, stakeholders will provide input on evaluation design elements including program evaluation questions, data sources and program impact.

The State will submit to CMS a specific design plan that includes the outcome measures, data sources and sampling methodology. Illinois is also agreeable to other approaches to the evaluation of the *Path to Transformation* through discussions with CMS.

To support the evaluation, the State will solicit outside funding from foundations, CMS, or other federal agencies.

IX. Waiver and Expenditure Authority Requests

Title XIX Waiver Requests

The following waivers of Title XIX of the Social Security Act are requested to enable Illinois to implement the *Path to Transformation* Section 1115 Demonstration.

Reasonable Promptness, Section 1902(a)(8), 42 CFR 435.911 and 435.930 and Comparability, Section 1902(a)(10)(B), 42 CFR 440.240

To be consistent with existing HCBS waiver authority (section 1915(c)), Illinois is requesting these waivers to the extent necessary to operate a waitlist for HCBS. The State will take into account current demand and utilization rates and will work to eliminate waitlists as capacity expands sufficient to meet the long term care needs of participants.

Amount, Duration, Scope of Services and Comparability, Section 1902(a)(10)(B), 42 CFR 440.240 and 440.230

To the extent necessary to enable the State to offer differences in HCBS to individuals who are Medicaid eligible and who meet level of care.

To the extent necessary to enable the State to offer certain HCBS (homemaker, personal assistant, adult day health, emergency home response service) to individuals enrolled in the Community Care Program and are not Medicaid eligible, have income at or below 100 percent of FPL but who meet level of care.

To the extent necessary to allow the State to place service cost maximums on HCBS.

To permit managed care entities to provide additional or different benefits to participants that may not be available to other eligible individuals.

Freedom of Choice, Section 1902(a)(23), 42 CFR 431.51

To the extent necessary for the State to require participants to receive benefits through managed care entities.

Upper Payment Limits for Hospitals, Section 1902(a)(30)(A)

To the extent necessary to permit the State to rely on its hospital inpatient and outpatient services upper payment limit calculations for 2013 for the duration of the waiver with one exception: The State will calculate separate UPLs for inpatient and outpatient services that take into account the newly eligible population beginning in 2014 and in subsequent years.

Efficiency, economy, quality of care, Section 1902(a)(30)(A)

To the extent necessary to allow direct payments from the state to providers in areas of the state where managed care has been implemented in order to permit non-managed care providers to receive quality incentive payments for integrating physical and behavioral health and payments for the Hospital Access Assurance Program.

Limits on Payments to Other Providers, 42 CFR 438.60

To enable the state to make payments directly to qualified providers under the Health System Integration and Transformation Performance Program. While these payments will be within allowable actuarial soundness limits, the State proposes to make these payments directly to providers to support delivery system transformation across multiple payment models.

Classes of health care services and providers for Provider Taxes, 42 CFR 433.56

To allow for a provider assessment fee to be imposed on residential habilitation providers in the state to support rate increases and to provide an additional financial incentive toward deinstitutionalization.

Expenditure Authority Waiver Requests

Under the authority of Section 1115(a)(2) of the Social Security Act, expenditures made by the State for the items identified below, which are not otherwise included as expenditures under Section 1903 shall, for the period of this demonstration, be regarded as expenditures under the Medicaid State Plan:

1. Expenditures made by the State to permit coverage of certain home and community-based services (homemaker, personal assistant, adult day health, emergency home response service) to people who meet the eligibility criteria of the Community Care Program and have income at or below 100 percent of FPL.
2. Expenditure authority to allow assessment of a health care related tax under section 1903(w) on the following class of providers: assisted living and residential rehabilitation providers rendering home and community based services to individuals with intellectual disabilities.
3. Expenditure authority under contracts with managed care entities (section 1903(m) and 42 CFR 438.6) for the following

    a. To allow alternative provider payment methodologies for reimbursement on the basis of outcomes and quality, including payment structures that incentivize prevention, person-centered care, comprehensive coordination, and maintenance of stable housing.
    b. To permit flexibility to provide services that may not always traditionally be reimbursed as a Medicaid State plan service but help keep people living in the community.
    c. To allow incentive payments for stable housing and public health infrastructure in excess of 105 percent of the approved capitation payments.
    d. To allow the State to make GME payments directly to qualified teaching hospitals and federally qualified health centers.

4. Crisis and acute inpatient reimbursement in Specialized Mental Health Rehabilitation Facilities (SMHRFs) on a short term basis during the state's transition period, allowing for a redistribution of state matching funds to increase community based services that support discharge to more independent living arrangements.
5. Expenditures made by the State to permit coverage for home and community based services with detailed person-centered plans of care (POCs) are developed. The state intends to develop standard POCs approved by the Medicaid agency that will allow almost immediate entry into services upon a finding of eligibility. A more robust person-centered plan will be developed on a

rapid timeline. This approach is intended to mitigate institutional bias and provide equal opportunity for beneficiaries to elect HCBS.

In addition to the above, Illinois has identified a number of State-funded programs for which it is seeking federal matching payments under demonstration authority. These "Designated State Health Programs" include programs that contribute directly to the ability of the Medicaid program to control costs, maintain beneficiaries in the least restrictive settings, and maintain beneficiary access to needed services. Securing federal support for these programs will allow the state to make the investments in services and infrastructure outlined in this waiver proposal. These investments are critical at this time as the State seeks to incentivize delivery system and payment innovation, increase access to community based options, and positively impact social determinants of health that are driving up health care costs.

A list of identified programs is included as Appendix C. These programs are vital for the success of health system transformation, spanning mental health, public health, community services, and child health services. Currently, state funds support these services and programs to meet health needs that Medicaid, as it is currently structured, does not.

Illinois' request is patterned after similar approved requests in other states (e.g., California, Oregon and Massachusetts), and Illinois hopes to be given the same opportunity. Approval of this request will allow Illinois to move forward with our mutual reform goals without eroding services that are vital for transformation.

The proposed DSHPs include:

- Workforce training programs at the University of Illinois and Southern Illinois University that train much of the workforce that treats Medicaid beneficiaries.;
- Certain residential and respite services for the ID/DD population managed by the Department of Human Services;
- Certain specialized and crisis response mental health services managed by the Department of Mental Health;
- Certain programs operated by the Department on Aging that seek to maintain the elderly in independent settings;

- Certain programs operated by the Department of Corrections aimed at ensuring parolees have access to services and medications to prevent unnecessary ED visits, inpatient admissions and recidivism.
- Certain programs managed by the Department of Public Health that promote healthy lifestyles for Illinois citizens, especially in areas that disproportionately affect the Medicaid population, including tobacco cessation, cancer prevention and cardiovascular disease risk reduction.

Please see Appendix C for a complete list of proposed Designated State Health Programs.

X. Appendices

Appendix A: 1115 Waiver HCBS Service Definitions Draft

Homemaker

Services consisting of general household activities (meal preparation and routine household care) and personal care provided by a trained homecare assistant. Homemakers shall meet such standards of education and training as are established by the State for the provision of these activities.

Specific components of in-home services may include the following:

Teaching/performing of meal planning and preparation; routine housekeeping skills/tasks shopping skills/tasks; and home maintenance and repairs.

Assisting with self-administered medication

Performing/assisting with personal care tasks (e.g.: shaving, hair shampooing and combing; bathing and sponge bath, shower bath or tub bath; dressing; brushing and cleaning teeth or dentures and preparation of appropriate cleaning supplies; transferring participant; and assisting participant with range of motion.

Performing/assisting with essential shopping errands may include handling the participant's money (proper accounting to the participant of money handled and provision of receipts are required).

Escort to medical facilities, errands, shopping and individual business as specified in the plan of care.

In-home services may include transportation to medical facilities, or for essential errands/shopping, or for essential participant business with or on behalf of the participant as specified in the plan of care.

Observing client's functioning and reporting to the supervisor.

All activities will be performed as specifically required by the plan of care; and monitored by the in-home service supervisor.

Adult Day Health Services

Adult Day Service is the direct care and supervision of adults aged 60 or over, in a community-based setting for the purpose of providing personal attention; and promoting social, physical and emotional well-being in a structured setting. Required service components include:

An assessment of the participant's strengths and needs and development of an individual written plan of care for each participant that establishes specific goals for all service components is required.

The individual plan of care is to be established by the adult day service team consisting of program coordinator/director and program nurse, and may include other staff at the option of the program coordinator/director. The plan will address the needs identified by the Case Coordination Unit (CCU) as described in the, Client Agreement-Individualized Plan of Care process and approved by the client's physician/nurse practitioner/registered nurse/Christian Science practitioner.

The participant, caregiver, and other service providers shall have the opportunity to contribute to the development, implementation, and evaluation of the individualized plan of care.

Reassessing the participant's needs and reevaluating the appropriateness of the individualized plan of care shall be done as needed, but at least semi-annually.

Activity programming shall take into consideration individual differences in age, health status, sensory deficits, lifestyle, ethnicity, religious affiliation, values, experiences, needs, interests and abilities by providing for a variety of types and levels of involvement.

Time for rest and relaxation shall be provided as needed or prescribed.

Activity opportunities shall be available whenever the service provider's facility is in operation and participants are in attendance.

A monthly calendar of activities of daily living shall be prepared and posted in a visible place.

Assistance with or supervision of activities of daily living (e.g., walking, eating, toileting, and personal care) as needed.

Provision of health-related services appropriate to the participants needs as identified in the provider assessment and/or physician's orders, including health monitoring, nursing intervention on a moderate or intermittent basis for medical conditions and functional limitations, medication monitoring, medication administration or supervision of self-administration, and coordination of health services.

A meal at mid-day meeting a minimum of one-third of the Dietary Reference Intakes (DRI) as established by the Food and Nutrition Board of the National Academy of Sciences, 10th Revised Edition, 2006, or subsequent current revisions. Supplementary nutritious snacks and special diets shall also be provided as directed by the client's physician.

The service will include arrangement of transportation, with at least one vehicle physically accessible, to enable clients to receive adult day care service at the adult day care service provider's site and participate in sponsored outings. The adult day care transportation is billed as a separate service component.

The service provides emergency care as appropriate in accordance with established adult day care service providers' policies.

Home Health Aide

Home Health Aide (HHA) services are part of the treatment plan outlined by the attending physician. Services will include the use of simple procedures as an extension of therapeutic services; ambulation and exercise; personal care; household services essential to healthcare at home; assistance with medications that are ordinarily self-administered; and reporting changes in a participant's condition and needs to the registered nurse or appropriate therapist.

The provided services are as defined in 42 CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable.

The services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) through completion of an approved course. The CNA must provide a copy of the certificate of completion or be listed on the Illinois Department of Public Health Registry website.

Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services are based on identified needs.

Personal Assistant

Personal Assistants will provide assistance with eating, bathing, personal hygiene, and other activities of daily living in the home and at work (if applicable). These services may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the plan

of care, this service may also include housekeeping chores, such as bed making, dusting, vacuuming, which are incidental to the care furnished or which are essential to the health and welfare of the consumer rather than the consumer's family. Personal care providers meet state standards for this service. Personal care will only be provided when it has been determined by the case manager that the consumer has the ability to supervise the personal care provider. The personal assistant is the employee of the consumer. The state acts as the fiscal agent for the consumer.

State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Personal Support Services

Personal Support services teach adaptive skills to assist the participant to reach goals related to activities of daily living, and are provided on a short-term basis because of the absence, incapacity or need for relief of those persons who normally provide care (typically referred to as respite).

Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, meal preparation (excluding the cost of the meals), transportation and other activities of daily living.

Supports may be provided to assist the participant to perform such tasks as light housework, laundry, grocery shopping, using the telephone, and medication management, which are essential to the health and welfare of the participant, rather than for the participant's family. Supports may be provided to develop skills in money management or skills necessary to self-advocate, exercise civil rights and exercise control and responsibility over other support services. Such assistance also may include the supervision of participants as provided in the support plan.

Personal Support may function as an extension of behavioral and therapy services. Extension of services means activities by the Personal Support worker that assist the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the individual service plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Personal Support is not intended to include professional services, home cleaning services, or other community services used by the general public. Personal Support may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home. The need for Personal Support and the scope of the needed services must be documented in the participant centered service plan.

Personal Support will not be duplicative of other services in the Waiver, i.e., Residential Habilitation, Developmental Training, etc., since the scope of Personal Support services are already included in those services.

Personal Support services are included in the participant's monthly cost limit. For participants still enrolled in school, Personal Support services may not be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

Community-Based Day Habilitation

Community-based day habilitation includes assistance with the acquisition of, retention of, or improvement in self-help, socialization and adaptive skills that takes place outside of the Participant's home. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, personal choice and are intended to build relationships and natural supports.

Services are furnished four or more hours per day on a regularly scheduled basis as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Community-based day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.

In addition, Community-based day habilitation services may serve to reinforce skills or lessons taught in other settings.

Community-based day habilitation also includes a range of adaptive skills in the areas of motor development, attention span, safety, problem solving, quantitative skills, and capacity for individual living. Community-based day habilitation also enhances a participant's ability to engage in productive work activities through a focus on such habilitative goals as compliance, attendance, and task

completion. Community-based day habilitation may also include training and supports designed to maintain skills and functioning and to prevent or slow regression.

Community-based day habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

Community-based day habilitation does not include the following:

-Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the participant through a local education agency.

-Vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.

Activities may consist of job exploration activities (not paid employment) or volunteer work, recreation, educational experiences in natural community settings, maintaining family contacts and purposeful activities and services where persons without disabilities are present.

Community-based day habilitation includes transportation between the residence and other community locations where Community-based day habilitation occurs. Transportation is provided and billed as an integral part of Community-based day habilitation. The cost of transportation is included in the rate paid to providers of Community-based day habilitation services. Training and assistance in transportation is provided as needed.

Community settings are defined as non-residential, integrated settings that are primarily out in the community where services are not rendered within the same building(s) alongside other non-integrated participants.

Facility-Based Day Habilitation

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place outside of the Participant's home in an approved facility that support learning and assistance outside of the Participant's home. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, personal choice and are intended to build relationships and natural supports.

Services are furnished four or more hours per day on a regularly scheduled basis as specified in the participant's service plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Facility-based day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the service plan.

In addition, Facility-based day habilitation services may serve to reinforce skills or lessons taught in other settings.

Facility-based day habilitation also includes a range of adaptive skills in the areas of motor development, attention span, safety, problem solving, quantitative skills, and capacity for individual living. Facility-based day habilitation also enhances a participant's ability to engage in productive work activities through a focus on such habilitative goals as compliance, attendance, and task completion. Facility-based day habilitation may also include training and supports designed to maintain skills and functioning and to prevent or slow regression.

Facility-based day habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

Facility-based day habilitation does not include the following:

-Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the participant through a local education agency:

-Vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.

Facility-based day habilitation includes transportation between the residence and other community locations where Facility-based day habilitation occurs. Transportation is provided and billed as an integral part of Facility-based day habilitation. The cost of transportation is included in the rate paid to providers of Facility-based day habilitation services. Training and assistance in transportation is provided as needed.

Facility settings are defined as non-residential, non-integrated settings that take place within the same building(s) for the duration of the service rather than being out in the community.

Residential Habilitation

Residential Habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs.

Residential Habilitation also includes personal care and protective oversight and supervision. Payment is not made for the cost of room and board. Included in the cost not covered are building maintenance, upkeep and improvement (other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code). Residential Habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods. Payment is not made, directly or indirectly, to members of the participant's immediate family. Transportation provided as a component part of Residential Habilitation is included in the rate paid to providers of Residential Habilitation services.

In addition, Residential Habilitation may include necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the participant’s health and welfare. These include monitoring of health status, medication monitoring, and administration of injections or suctioning. It also includes administration and/or oversight of the administration of oral and topical medications consistent with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65) and the Mental Health and Developmental Disabilities Administrative Act.

Nursing services are considered an integral part of Residential Habilitation services. Meeting the routine nursing needs of participants receiving 24-hour residential services is the responsibility of the residential service provider who must employ or contract with a professional nurse to perform their professional duties including the oversight and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with

Developmental Disabilities (ICF/DD), are not available to participants in the Waiver. These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.

Residential Habilitation services are available to participants who require this intensity of service based on their identified needs. Factors involved in the assessment of the need for this service include the urgency of the situation (e.g., the unexpected loss of a caregiver) and the individual's health and welfare concerns (e.g., an abusive or neglectful situation). To ensure criteria are fairly applied to all initial applicants and to those whose circumstances may change once they are enrolled in the Waiver, the Operating Agency staff convenes an internal committee to review each request from a statewide perspective.

Residential Habilitation sites are limited in size, depending on the licensure standards for the setting. Community Individual Living Arrangements (CILA) and Community Living Facilities are limited to no more than four individuals. Current settings as of 1/1/14, of 8 to 16 individuals will be eligible for funding subject to a an approved plan for moving to four person settings.

This service will not be duplicative of other services in the Waiver. For example, non-medical transportation is an integral component of Residential Habilitation services.

Service Facilitation

Service Facilitation includes services that assist participants in gaining access to needed Waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. The Service Facilitator assists the participant and guardian, if one has been appointed, in designing an array of habilitation and support services to meet the participant's needs.

The Service Facilitator assists the participant and guardian (if applicable) to convene a service planning team, or may convene the team as directed by the participant or guardian (if applicable). The team consists of the participant, guardian (if applicable), family members and/or other individuals important to the participant,

Service Facilitator, Individual Service and Support Advocate (ISSA), as well as any other professionals and service providers needed. Based on assessment information and discussions among members of the service planning team, the Service Facilitator develops/updates the participant-centered support plan at least annually or more often if needed.

The Service Facilitator assists the participant and guardian in choosing services and service providers as needed.

The Service Facilitator is responsible for ongoing monitoring of the provision of services included in the participant's service plan and for ensuring participant health and welfare. The Service Facilitator is responsible for ensuring the completion of Service Agreements between the participant and service providers and monitoring the expenditure of funds according to the individual budget, service plan and Service Agreements. The Service Facilitator also assists the participant in determining whether individual providers of services, such as Personal Support, Non-Medical Transportation and Behavior Intervention and Treatment, are competent to provide the specific services the participant is receiving.

Service Facilitation is only available to participants who are self-directing their waiver services. This service will not be duplicative of other services in the waiver. For example, case management/care coordination services are a component of residential services. This service is included in the participant's monthly cost limit. The individual service plan (ISP) and Service Agreement must set aside two hours per month to allow for routine required administrative activities.

Temporary Assistance (Emergency Support)

Temporary Assistance services (formerly called Crisis Services) are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation. Temporary Assistance services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

Temporary Assistance services include:

Teaching adaptive skills to assist the participant to reach personal goals;

Personal assistance in activities of daily living;

Services provided on a short-term basis because of the absence, incapacity or need for relief of those persons who normally provide care (typically referred to as respite).

Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, meal preparation (excluding the cost of the meals), transportation and other activities of daily living.

Supports may be provided to assist the participant to perform such tasks as light housework, laundry, grocery shopping, using the telephone, and medication management, which are essential to the health and welfare of the participant, rather than for the participant's family. Supports may be provided to develop skills in money management or skills necessary to self-advocate, exercise civil rights and exercise control and responsibility over other support services. Such assistance also may include the supervision of participants as provided in the service plan.

Temporary Assistance may function as an extension of behavioral and therapy services. Extension of services means activities by the Temporary Assistance/Personal Support worker that assists the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the support plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Temporary Assistance is not intended to include professional services, home cleaning services, or other community services used by the general public. Some professional services are covered elsewhere under the home-based supports option.

Temporary Assistance may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home.

The need for Temporary Assistance and the scope of the needed services must be documented in the participant-centered service plan.

The rate, amount and frequency for this service must be specified in the Service Agreement(s) and in the individual service plan (ISP).

This service will not be duplicative of other services in the Waiver. For example, Temporary Assistance services are a component of Residential Habilitation services.

This service is not included in the participant's monthly home-based services cost maximum. Temporary

Assistance services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days.

For young adults between age 18 and 22 who attend school, Temporary Assistance services may not be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided. This service is subject to prior approval by the Operating Agency.

Medically Supervised Day Care

This service offers the necessary technological support and nursing care provided in a licensed medical day care setting as a developmentally appropriate adjunct to full time care in the home. Medically supervised day care serves to normalize the child's environment and provide an opportunity for interaction with other children who have similar medical needs.

Such services are to be an alternative to otherwise necessary private duty nursing services in the home and are to include required safe and supervised transport between the home and day care center, while school age children may utilize day care facilities, HFS provides no reimbursement for education services nor is it part of the rate methodology for day care facilities. For purposes of this waiver, authorization of day care services requires: a prescription by the physician managing medical care; a request by the child's parent(s) and/or legal guardian; the use of a facility licensed by the State to provide day care services and assurances of staffing ratios that are at least one licensed staff nurse for each three children.

Maximum of 12 hours per day, five days per week, based on identified need and service maximums.

Home Accessibility Modifications

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's support plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the adaptive equipment that are necessary for the welfare of the participant.

Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. Seasonal

items such as swimming pools and related equipment are excluded. All services shall be provided in accordance with applicable State or local building codes.

This service is not included in the participant's monthly cost limit/individual budget.

There is a $15,000 maximum per participant per five-year period for any combination of Adaptive Equipment/Assistive Technology, Home and Vehicle Modifications.

Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. This service is subject to prior approval by the Operating Agency.

Vehicle Modifications

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the service plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a nonrelative who provides primary long-term support to the participant and is not a paid provider of such services.

This service will not be duplicative of other services in the waiver. For example, vehicle modifications are within the transportation component of Residential Habilitation and Developmental Training services.

The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant;

2. Purchase or lease of a vehicle; and

3. Regularly scheduled upkeep and maintenance of a vehicle.

For participants who choose home-based supports, this service is not included in the participant's monthly cost limit. There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications.

This service requires prior approval by the Operating Agency.

Specialized Medical Equipment and Supplies

This service is the provision of equipment or supplies needed to maintain a participant in the home and the coverage of operational and maintenance costs of equipment, not otherwise available through the State Plan or through other third party liability.

Medical supplies, equipment and appliances are provided only on the prescription of the primary care physician as specified in the plan of care. Since each home care waiver case addresses a unique set of needs, provision of an all-inclusive list is not possible. Therefore, the State assures that these services will only be provided to meet the medical, health and safety needs of the participant. These will be limited in scope to the minimum necessary to meet the participant's needs and will be utilized in accordance with manufacturer's suggested standards.

This service differs from that offered under the State Plan in that it includes operational and maintenance costs for equipment. (Maintenance costs are incurred only for Department leased or owned equipment not otherwise available under the State Plan.)

Assistive Technology/Adaptive Equipment

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes --

(A) the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant;

(B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants;

(C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;

(D) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the support plan;

(E) training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant; and

(F) training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Items reimbursed with Waiver funds do not include any assistive technology furnished by the school program or by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include the performance of assessments to identify the type of equipment or technology needed by the participant.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of the equipment or technology.

This service is subject to prior approval by the Operating Agency.

This service is not included in the individual's annual cost maximum.

There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications.

Home Delivered Meals

Prepared food brought to the client's residence that may consist of a heated luncheon meal, a dinner meal, or both which can be refrigerated and eaten later. This service is designed primarily for a client who cannot prepare his/her own meals but is able to feed him/herself. This service will be provided as described in the service plan and will not duplicate those services provided by personal care services or homemaker provider.

Meals provided shall not constitute a full nutrition regimen (participants are not receiving 3-meals per day).

The amount, duration, and scope of services are based on need and must be within the service cost maximum.

Respite

Respite services provide relief for unpaid family or primary care givers, who are currently meeting all service needs of the customer. Services are limited to personal assistant, homemaker, nurse, adult day care, and provided to a consumer to provide his or her activities of daily living during the periods of time it is necessary for the family or primary care giver to be absent. FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence. It may be provided in the waiver participant's home; or in an appropriate care setting for the waiver participant, based on identified needs. Residential respite is limited to no more than 14 consecutive days and must be within the service cost maximum.

The amount, duration, and scope of services are based on need and the service cost maximum.

Emergency Home Response Service

Emergency home response service (EHRS) is defined as a 24-hour emergency communication link to assistance outside the participant's home for participants based on health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the participant to a professionally staffed support center. The support center assesses the situation and directs an appropriate response whenever this system is engaged by a participant. The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized plan of care, and thereby help reduce the need for nursing home care.

Services cover both initial one time installation and monthly rental costs. The amount, duration and scope of services is based on need and the service cost maximum

Prevocational Services

Prevocational services not available under a program funded under section 110 of the Rehabilitation Act of 1973 or section 602(16) and (17) of the Individuals with Disabilities Education Act (20 U.S.C. 1401 (16 and 17). Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Services include teaching such concepts as compliance, attendance, task completion, problem solving and safety. Prevocational Services are provided to persons expected to be able to join the general work force or participate in a transitional sheltered workshop within one year (excluding supported employment programs). When compensated, individuals are paid at less than 50 percent of

the minimum wage. Activities in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as span and motor skills. All prevocational services will be reflected in the individual's plan of care as directed to habilitative, rather than explicit employment objectives. Documentation will be maintained in the file of each individual receiving this service that: The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

The amount, duration, and scope of services is based on need and service cost maximum level as approved by the OA.

Supported Employment

Supported Employment services consist of intensive, ongoing supports to participants who, because of their disabilities, need intensive ongoing supports to obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The outcome of the service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals. Supported Employment services are individualized and may include any combination of the following services:

- vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, negotiation with prospective employers, job analysis, job carving, training and systemic instruction, job coaching, benefits supports, training and planning, transportation, asset development and career advancement services, and other workplace support services including services not specifically related to job skill training than enable the participant to be successful in integrating into the job setting.

Transportation will be provided between the participant's place of residence and the employment site or between habilitation sites (in cases where the participant receives waiver services in more than one place) as a component of Supported Employment services. The cost of this transportation is included in the rate paid to providers of Supported Employment services.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals

with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:
1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
2. Payments that are passed through to users of supported employment programs.

Supported Employment does not include sheltered work or other similar types of vocational services furnished in specialized facilities. Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Such assistance may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) the ongoing assistance, counseling and guidance once the business has been launched.
This service is included in the participant's monthly cost limit. Supported Employment services are subject to prior approval by the Operating Agency.
The annual rate is spread over 1,100 hours for any combination of day programs.

Supported Living Facilities (Assisted Living)

Personal care and supportive services that are furnished to waiver participants who reside in a homelike, non-institutional setting that includes 24-hour on-site response capability to meet scheduled or unpredictable participant needs and to provide supervision, safety and security. Services also include social and recreational programming, and medication assistance. Additionally, medication administration, intermittent nursing services and periodic nursing evaluations are provided. Transportation for activities must be supplied, as well as arrangement for transportation to scheduled medical appointments. Additionally, Personal Emergency Response Systems (PERS) are required in participant apartments and facility common areas. The system is connected to a supportive living facility's emergency call system staffed by nursing and response personnel. Other services include: well-being checks, laundry, housekeeping, three meals/day, snacks, maintenance, assistance with shopping and assistance with access to the larger community. Services that are provided by third parties must be coordinated with the supportive living provider.

Case management services are provided to assist participants in gaining access to needed waiver and other State Plan services, as well as medical, social, educational and other services, regardless of the funding source for the services to which access is gained.

Nursing and skilled therapy services are incidental rather than integral to the provision of assisted living services. Payment is not made for 24-hour skilled care. Nursing services required in the Supportive Living Program include: assessments, service plan development/approval and implementation, health promotion or disease prevention counseling and teaching self-care, medication set-up and medication administration. The use of home health services are also allowed in supportive living facilities, as ordered by a physician, but is not a required service. SLF staff are expected to coordinate care and services with home health care providers. This includes among other skilled services, wound care and physical and occupational therapy. Supportive living facilities must assist participants with obtaining such services.

Access to the larger community is achieved through scheduled activities and assistance with individual preferences with regard to community involvement. Activities in the larger community may include volunteer/charity opportunities, musical presentations, religious programs, sporting events, shopping, cultural destinations and outdoor activities, like fishing. Additionally, community members are invited to participate at the facility.

All assisted living services are provided by employees of the supportive living facility. Staff provide individualized participant services based on the comprehensive assessment and a participant's preferences as determined through the service planning process. All participants are entitled to receive all of the services provided by the Supportive Living Program. Participants and others of their choosing, such as a designated representative, are involved with the development of the service plan. Participants are able to identify which services they would like to receive and the frequency. The Medicaid agency monitors supportive living facilities to ensure that this individualization occurs and verifies that participant care needs are being met. This monitoring occurs during annual/bi-annual on-site certification reviews and complaint investigations.

Non Medical Transportation

Non-Medical Transportation is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the service plan. This service is offered in addition to medical transportation required under the Code of Federal Regulations (42 CFR §431.53) and transportation services under the Medicaid State Plan, defined in the Code of Federal Regulations at 42 CFR

§440.170(a) (if applicable), and does not replace them. Transportation services under the Waiver are offered in accordance with the participant's service plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

Excluded is transportation to and from covered Medicaid State Plan services. Also excluded is transportation to and from day habilitation program services.

For participants who choose home-based supports, this service is included in the participant's monthly cost limit.

This service will not be duplicative of other services in the Waiver. For example, Non-Medical Transportation is an integral component of residential and day services.

No more than $500 of the participant's monthly cost limit may be used for Non-Medical Transportation services.

Training and Counseling for Unpaid Caregivers

Training and Counseling services are provided to individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Waiver participant. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the service plan, and includes updates as necessary to safely maintain the participant at home. All training for individuals who provide unpaid support to the participant must be included in the participant's individual service plan.

Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the service plan.

Counseling must be aimed at assisting the unpaid caregiver in understanding and meeting the needs of the participant.

This service also provides short-term, issue-specific family or individual counseling for the purpose of maintaining the participant in the home placement. This service is prescribed by a physician based upon his or her judgment that it is necessary to maintain the child in the home placement. This service must be provided by a licensed clinical social worker (LCSW), a licensed clinical psychologist (LCP), or an agency certified by the Department of Human Services, Division of Mental Health or Department of Children and Family Services to provide Medicaid Rehabilitation Option services. The service provider must accept HFS payment, as payment in full, and provide services in the home if the participant or participant's family is unable to access services outside the home.

This service will not be duplicative of other services in the Waiver. For example, the Adaptive Equipment/Assistive Technology service includes training for family members in the use and/or maintenance of the device, therefore, Training and Counseling could not cover this type of training.

This service may not be provided in order to train paid caregivers or school personnel.

Nursing

Service provided by an individual that meets Illinois licensure standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable. Services provided in this waiver shall be in addition to any available under the state plan.

Services provided are in addition to any services provided through the State Plan. The amount, duration, and scope of services is based on assessment of need and the service cost maximum

Intermittent Nursing

Nursing services are provided within the scope of the State's Nurse Practice Act by registered nurses, licensed practical nurses, or vocational nurses licensed to practice in the state and are not otherwise covered through Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

The amount, duration, and scope of services is based on the assessment of need and the service cost maximum.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

Services provided through the state plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiate within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the state plan service

Skilled Nursing

Services listed in the participant-centered service plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State.

These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.

This service will not be duplicative of other services in the Waiver. For example, nursing services beyond those covered in the State Plan, are a component of residential services.

For participants who choose home-based supports, this service is included in the participant's monthly cost limit.

There is a State fiscal year combined maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse.

Behavior Intervention and Treatment

Behavior Intervention and Treatment includes a variety of individualized, behaviorally-based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. Interventions include, but are not limited to: Applied Behavior Analysis, Relationship Development Intervention (RDI), and Floor Time. These services are designed to assist

participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. Key elements are:

• Approach is tailored to address the specific behavioral needs of the participant;

• Targeted skills are broken down into small attainable tasks;

• Direct support staff and informal caregiver training is a key component so that skills can be generalized and communication promoted;

• Services must be directly related to the participant's therapeutic goals contained in the service plan; and

• Success is closely monitored with detailed data collection.

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant's individual needs. The strategies are a component of the participant-centered service plan and must be approved by the participant, guardian if one has been appointed, responsible QIDP/Service Facilitator, Individual Service and Support

Advocate (ISSA) and the other members of the planning team. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant's outcomes. A progress report is prepared by the behavior consultant and sent to the service planning team at least every six months. This progress report is available to State staff upon request to evaluate the efficacy of the intervention and treatment.

The behavior consultant supervises implementation of the behavior plan. This includes training of the direct support staff and unpaid informal caregivers to ensure that they apply the interventions properly, understand the specific services and outcomes for the participant being served, and know the procedures for regularly reporting participant progress.

Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments. Direct support staff and unpaid informal caregivers of participants receiving Behavior Intervention and Treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services, and must remain involved with the behavior consultant so that they are able to carry through

and reinforce the behaviors being worked on. A client may receive an annual maximum of 66 hours of behavior intervention and treatment.

Behavioral Services

Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development. Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.

For participants who choose home-based supports, this service is included in the participant's monthly cost limit.

There is a State fiscal year maximum of 60 hours for any combination of psychotherapy and counseling services.

Cognitive Behavioral Therapies

Cognitive/Behavioral services are not covered in the Illinois State Plan. These services are specific to persons with brain injury and are initiated as a result of a clinical recommendation. The overall goal is to assist waiver participants in managing their behaviors, by decreasing maladaptive behaviors, and/or enhancing their cognitive functioning. The ultimate goal is to improve waiver participant's capacity for independent living.

Cognitive/behavioral therapies are performed by individuals who are licensed to provide speech therapy or clinical counseling services. Qualified providers are listed below:

LPC (licensed professional counselor)

LCPC (licensed clinical professional counselor)

LCSW (licensed clinical social worker)

PhD (licensed clinical psychologist)

Licensed Speech Therapist

Counseling may be provided in either individual or group settings. Typically, this is for short-term periods, although some individuals may require more intensive, longer sessions. Depending on the theory followed by the practitioner, different approaches are used including counseling, psychotherapy, and behavior modification.

Behavioral modifications may also include social/environmental modifications.

Cognitive therapies are provided by a speech therapist. Cognitive therapies may include assisting with communication problems by having the person complete basic reading and vocalizing tasks, or by teaching alternative communication methods.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the service plan. The amount, duration, and scope of services is based on the assessment score and service cost maximum.

Extended State Plan Service (ESPS) HHA

Home Health Aide in the waiver is an extended State Plan version of the "Home Health Aide" service in the State Plan and on the HFS Fee Schedule for Home Health Nursing Agencies. Services provided through the State Plan are provided on a short-term or intermittent basis. These services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan the first 60 days following discharge from a hospital or long term care facility do not require prior approval when services are initiated within 14 days of discharge. Home Health Aides in the State Plan are paid per visit; rather than hourly. Visits are limited to two hours or less.

Home Health Aide services, under the waiver are paid hourly and may be provided when the individual does not meet the prior approval requirements for the State Plan services. The waiver services are in addition to any Medicaid State Plan Home Health Aide services for which the participant may qualify. Home Health Aide services through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Services are provided by an individual that meets Illinois standards for a Certified Nursing Assistant (CNA) and provides services as defined in 42CFR 440.70, with the exception that limitations on the amount, duration, and scope of such services imposed by the State's approved Medicaid state plan shall not be applicable. Specific tasks follow:

Home Health Aides may provide basic services to persons, assisting with the assessment and care planning, nutrition and elimination needs, mobility, personal hygiene and grooming, comfort and anxiety relief, promoting patient safety and environmental cleanliness. Home Health Aide duties may include but are not limited to: checking and recording vital signs, measuring height and weight, measuring intake and output, collecting specimens, feeding, assisting with bed pans, assisting with colostomy care, turning and positioning, transferring to wheelchairs/stretchers, bathing, assisting with oral hygiene, shaving, preparing hot and cold applications, making beds, observing response to care, reporting and recording observations of person's condition, cleaning and caring for equipment, and transporting.

The amount, duration, and scope of services is based on the assessment conducted by the case manager/counselor and the service cost maximum.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the service plan. Participants receiving personal assistant or personal support services are not eligible for this service.

ESPS Physical Therapy

Physical Therapy services under the waiver differ in nature and scope from Physical Therapy services in the Medicaid State Plan. Waiver Physical Therapy focuses on the long-term therapeutic needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan.

For participants who choose home-based supports, this service is included in the participant’s monthly cost limit.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours). Services are subject to prior approval by the Operating Agency.

ESPS Occupational Therapy

Occupational Therapy in the waiver is an extended State Plan version of the Occupational Therapy service in the State Plan. Services provided through the State Plan are provided on a short-term or intermittent basis. Under the

State Plan, adults are allowed 20 therapy visits, per year. Prior approval is required. For children there are no limits. State Plan services are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. These services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State Plan services.

Service are provided by a licensed occupational therapist that meets Illinois licensure standards. Waiver services are in addition to any Medicaid State Plan services for which the participant may qualify. Occupational therapy through the waiver focuses on long term habilitative needs rather than short-term acute restorative needs.

Specific tasks may include: instructing persons on techniques and equipment that can make daily living and working easier. The OT treats persons with injuries, illnesses, or disabilities, through the therapeutic use of everyday activities. They help develop, recover, and improve the skills needed for daily living. Duties include but are not limited to evaluating the person's condition and needs, establishing a treatment plan, determining the types of activities and specific goals to be reached, demonstrating exercises that can help relieve pain, evaluating a home or workplace, identifying how it can be better suited to the person's health needs, educating the family about how to accommodate and care for the person, recommending special equipment, such as wheelchairs and eating aids, instructing on how to use the equipment, assessing and recording activities and progress, and reporting information to physicians and other healthcare providers.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

The amount, duration, and scope of services is based on the assessment score and service cost maximum level.

ESPS Speech Therapy

A medically prescribed speech and/or language based service identified in the service plan that is used to evaluate and/or improve a customer's ability to communicate. The service is provided by a licensed speech therapist that meets Illinois licensure standards. Speech therapy through the waiver focuses on long-term habilitation needs rather than short-term acute restorative needs.

Services may be approved under the waiver if the individual is no longer eligible for therapies under the state plan, but continues to need long-term habilitative services.

All waiver clinical services require a prescription from a physician. The duration and/or frequency of these services are dependent on continued authorization of the physician, and relevance to the customer's service plan.

The amount, duration, and scope of services is based on the determination of need and the service cost maximum.

Services provided through the State plan are of a curative or rehabilitative nature and demonstrate progress toward short-term goals. State plan services are provided to facilitate and support the individual in transitioning from a more acute level of care, e.g., hospital, long-term care facility, etc. to the home environment to prevent the necessity of a more acute level of care. Under the State plan, the first 60 days following discharge from a hospital or long-term care facility do not require prior approval when services are initiated within 14 days of discharge. Services may be provided under the waiver when the individual does not meet eligibility requirements for the State plan services.

Child Group Home

Residential services for children, must meet residential facility certification requirements.

Appendix B: Additional Detail on DSRIP Projects

The following give potential examples from Cook County and University of Illinois health systems. Specific projects will be under the direction of HFS and focus on transformation of service delivery by these two public entities.

Cook County Health and Hospital System

In 2013, CCHHS embarked on an epic initiative to launch a Medicaid managed care plan under an 1115 Waiver authority. Launched early in 2013 as "CountyCare," this plan met with a very high level of demand for coverage by low income, uninsured eligible adults. Over 127,000 applicants sought this coverage in less than a year's time and over 70,000 were enrolled, making CountyCare one of the country's landmark Medicaid expansion success stories.

Now, with health reform implementation rapidly evolving, CCHHS is poised to bring administrative efficiency to the challenge of providing direct services, while also serving as a health plan, a payer (ie purchaser of services), and a population health management entity with a public health department within its scope. Termed the "4Ps Strategy," the CCHHS vision will be implemented in these four domains—provider, plan, payer, and population health manager.

CCHHS will pursue transformation within this 4Ps construct. With federal support, CCHHS will be able to pursue innovative transformative initiatives across several of these areas, as follows:

Form a public-private partnership to consolidate selected resources across organizations. CCHHS will consider partnership opportunities that better position the organization to implement the triple aims in line with our mission through consolidation with one or more partners of our clinical service delivery, teaching and research functions. Such a consolidation will afford CCHHS the opportunity to participate in bringing a full array of comprehensive services to the delivery of patient care, including highly specialized interventions, while reaching a larger target population in a cost effective manner. Through partnership and consolidation, CCHHS will aim to offer high quality graduate medical education and training in community health as well as in subspecialty care. Further, partnership and consolidation opportunity will be explored to increase research capacity and expand expertise to pursue investigations and studies in line with our mission.

- **Proposed Metrics**: milestones in consolidation activity that demonstrate cost-effective delivery of care, or expanded teaching and research capacity.

Redirect resources to more appropriate locations for primary care, subspecialty consultation and diagnostics. To upgrade and expand subspecialty services beyond those offered on the Stroger Hospital Campus, CCHHS will reconfigure its delivery of ambulatory services to provide multispecialty adult consultation and diagnostic services in two or more community settings as well as in new, efficient space at or near its historic location. These "hubs" will provide primary and specialty care as well as preventive and group educational services, and will serve as a referral resource for local patients seeking specialty consultation. By placing adult subspecialty care in local community settings, CCHHS will be able to direct resources to areas that have been long neglected and provide and economic boost to the surrounding communities.

- **Proposed Metrics**: subspecialty utilization by referral source; preventive service utilization with associated improved health outcomes and more efficient use of inpatient resources.

Collaborate with the University of Illinois College of Nursing to improve CCHHS workforce capacity and competency. Located adjacent to the CCHHC campus, the University of Illinois at Chicago offers a nationally ranked nursing curriculum with special expertise in advanced practice nursing, nursing leadership, and research. CCHHS will collaborate with this program to offer specialized nursing education and training tailored to meet the immediate needs of our inpatient and ambulatory settings. The program will help address a chronic CCHHS nursing shortage and primary care shortage. Further, the partnership will strengthen the internal nursing competency assessment processes to embrace new delivery models and address the needs of a changing patient population. Finally, this program will increase the number of CCHHS nurses prepared with leadership training who can in turn attend to the demands of change management in a rapidly changing environment.

- **Proposed Metrics**: number of advance practice nurses trained and recruited into CCHHS ambulatory and other primary care positions, and number of nurses completing leadership training.

Develop a community health worker residency program and collaborate on other training programs to address workforce shortages. In collaboration of Malcolm X College of the City Colleges of Chicago,

CCHHS will develop a residency program to train community health worker students in supervised direct practice community setting. This collaboration will strengthen the community health worker role by offering a team-based training experience in a delivery setting. Through community health worker residency program design and implementation, we intend to contribute a replicable training model as well as recommended practices for ongoing workplace supervision of this emerging role. As part of this collaboration, CCHHS will participate as an advisor to the Malcolm X College curriculum development process for preparation of future community health workers. In addition, CCHHS will serve as a post-graduate employment setting for selected highly qualified Malcolm X health sciences graduates as needed within our system. Finally, through the CCHHS collaboration with Malcolm X College, we will also build workforce training programs specific to CCHHS needs.

- **Proposed Metrics**: completion of a model residency training program plan for community health workers, number of community health workers completing the residency, and number of community health workers and other health professionals trained and recruited through the collaboration.

Integrate behavioral health and primary care. Approaching their model of care through the PCMH lens, both CCHHS and its CountyCare network of contracted providers will implement a population screening measure that allows better identification of patients with mild to moderate depression and related behavioral health disorders (anxiety, grief, substance use). Using its leverage as a payer, CountyCare will promote screening and referral, using incentives and penalties to increase screening, early identification, care coordination and enrollment in treatment to address costly, prevalent mental health issues.

- **Proposed Metrics**: screening levels, number of patients identified with mental health conditions treatable in the community health setting, co-morbidity profiles, number of patients enrolled in care by payer class and type of intervention, number remaining involved in care coordination.

- **Promote continuity of care for the justice-involved population**. As the provider of medical care for the inmates of Cook County Jail, CCHHS has successfully reached out to over 7,500 adults to apply for CountyCare while entering jail. CCHHS will build on this experience by helping the justice-involved population obtain health benefits available under ACA, and provide care coordination through CountyCare to help them find a sufficiently stable living situation to maintain post-release continuity of care and self-management, including medication adherence,

thereby reducing recidivism. One element of this program will be to explore and possibly model a temporary medical respite setting for patients at risk for a high level of post-release morbidity, allowing care coordinators a chance to develop a comprehensive plan and draw on resources for the homeless which are not readily available post-release (as the jail is considered a domicile). The respite setting could also provide an alternative to re-imprisonment for patients who need to reinvigorate their plan of care.

- **Proposed Metrics:** recidivism rates, number of patients remaining in care coordination, medication adherence markers.

Address food insecurity – CCHHS would collaborate with local private non-profits to provide a comprehensive approach to food insecurity, with a particular focus on vulnerable adults. This comprehensive approach would include: a public health campaign on the relationship of food to health, vending of fresh food at CCHHS and other CountyCare contracted network provider sites through community partnerships, patient education regarding interaction of food with chronic illness and with medication, and specialized health professions training on food as an element of a planned approach to health care delivery, including for emerging professions such as community health workers.

- **Proposed Metrics**: number of pounds of fresh food to food vended to food-insecure adults at CountyCare network settings through partnerships, changes in food insecurity rates for an enrolled population, patient knowledge regarding "food as health," knowledge retention by health professionals trained in food security practices.

University of Illinois Hospital and Health Sciences System

The below projects present ways that the state's only hospital and health system can leverage its own strengths to improve care and lower costs for patients statewide. As a major provider of both primary and specialty care services to the Medicaid population, UI Health also intends to transform care within its own system in order to achieve the triple aim of improved quality of care, improved health outcomes, and reduced costs. By transitioning to new payment models, through both the development of a UI Health Medicaid care coordination network and partnership with entities that have other models (including the MCOs, MCCNs, CCEs, and ACEs described elsewhere in this application), the state's healthcare system can lower its own costs at the same time as it improves healthcare outcomes for some of the most vulnerable patients in the state.

Build medication therapy management (MTM) capacity -- This project will identify Medicaid beneficiaries that are not assigned to coordinated care network and/or in rural areas that are in need of medication therapy management (MTM) services and provide the service to patients with identified drug-related problems (DRP). Medicaid claims will be used to identify patients most at risk of potential DRP, including patients late to fill prescriptions (medication adherence), unnecessarily receiving multiple medications for the same indication (therapeutic duplication), not receiving needed medications (omission errors), and receiving multiple medications (greater potential for polypharmacy, medication adherence issues, medication errors, suboptimal therapy, etc.). Once identified, patients will be contacted telephonically by a MTM pharmacist to identify if DRP exist using a validated systematic screening tool. Services may also be provided through the use of telehealth technology. If DRP are identified, MTM pharmacists will triage patients to receive telephonic consultation by the MTM pharmacist or be referred to a regional MTM pharmacist for in-person MTM services. MTM pharmacists will address identified issues with the patient, primary care provider, and/or community pharmacy as needed.

Drug-related problems are defined as "an event or circumstance involving drug therapy that actually or potentially interferes with desired health outcomes." Causes of DRP include inappropriate drug selection (e.g. therapeutic duplication, drug interactions, and unnecessary use of higher-cost drugs), inappropriate dose or frequency selection (medication prescribing errors), and intentional or unintentional inappropriate use of the drug by patients. DRP are associated with adverse drug events, which lead to higher morbidity, mortality, and health care resources consumed. In a prospective, randomized, controlled trial of MTM services led by UI Health investigators, patients had a median of 2 DRP per person. Specific DRP, such as poor medication adherence, has been estimated to occur in approximately 50% of patients with chronic conditions and costs approximately $100 billion nationally in avoidable hospitalizations alone. Medication errors are estimated to cost approximately $89 per medication error identified.

- ***Patients impacted:*** We will target two groups of patients: Medicaid patients who are not enrolled in a care coordination model (particularly those in rural areas), and those who are enrolled but don't have access to meaningful MTM services. In a recent analysis of Medicare patients, approximately 9% of patients met the requirements for receiving MTM. There are no such estimates for Medicaid patients. We will utilize a validated method of estimating the risk for DRP using claims data that will allow us to change the threshold, prioritizing patients at higher

risk for DRP to receive care earlier in the program. We estimate that a clinical pharmacist could manage 200-500 patients annually (depending on number of DRP identified per patient, time required to resolve DRP, and patient case complexity). With a staff of 20 clinical pharmacists and appropriate administrative program support, the program would reach 4,000-10,000 patients annually.

- ***Proposed Metrics:*** Total number of drug-related problems identified; Number of drug-related problems identified stratified by the following categories: Medication adherence, errors of omission, therapeutic duplication, lower cost medication available, medication errors; Proportion of drug-related problems resolved; Proportion of patients adherent to medication

Create specialty PCMH for Individuals with Sickle Cell - For some high cost, high need populations, traditional primary care medical homes (PCMH) are not the ideal way to manage patient care. We propose to focus on two such populations – sickle cell and HIV – that would benefit from intensive, specialized services. The focus of the project is to reduce inpatient admissions in Medicaid sickle cell patients by improving patient activation and health literacy through specialized care coordination and personalized solutions. The sickle cell patients will take both a Patient Activation Measure (PAM13) survey as well as the Montreal Cognitive Assessment (MoCA©) screening test to determine if and what interventions will be most suitable for each patient. Personalized solutions will include hydroxyurea therapy, regular exchange blood transfusions, hematopoietic stem cell transplantation, day hospital use including daily infusions for pain control in selected patients, participation in support groups, transportation services, and appointment reminder phone calls. Personalized care plans will be executed by an integrated care teams composed of physicians, nurses, psychologists, social workers and vocational counselors. This model of sickle cell management will be shared with health care providers throughout Illinois and implemented by telemedicine. In effect this approach will permit UI Health to become the medical home for sickle cell patients across the state.

This project will use the PAM13 survey and the MoCA test to methodically determine behavior patterns of patients and why some sickle cell patients have more frequent hospitalizations than others. With a personalized focus on solutions to high inpatient utilization, the project will more accurately improve the patients' physical, mental, and social health while reducing inpatient hospital costs over time.

- ***Patients impacted:*** UI Health cares for about 411 unique Medicaid sickle cell patients. The initial focus will be to begin care coordination for these patients. With successful implementation at UI Health, we will then proceed expeditiously to reach out to sickle cell patients and their health care providers statewide through telemedicine efforts.
    - ***Proposed metrics:*** *The* proposed metrics include assembling the team for the project, initial screening of the patients with PAM13 and MoCA, percent improvement on the annual repeat PAM13, reduction in inpatient hospital days each year, reduction in 30-day readmissions, reduction in ED utilization, and number of patients enrolled statewide.

Create specialty PCMH for Individuals with HIV -- For the past 21 years, the University of Illinois has developed and operated a model of coordinated HIV care to the most marginalized members of our society through a network of community-based clinics located in Chicago's most dangerous and disadvantaged neighborhoods. Comprehensive HIV care is provided at these sites, which includes outreach by members of the local community, case management, behavioral health, pharmacy, referral to drug treatment and primary care. This coordinated care model has been highly effective in retaining patients in care and on therapy, thereby reducing hospital and ED utilization. We propose to expand this model, improve efficiency through the following aims: 1) re-engage 25% of the patients lost to follow-up back into care per year; 2) Increase percentage of patients with complete viral load suppression for at least 2 of their annual visits to 68% of the existing patients that attend UI Health clinics in year 1 of funding period; to 74% by year 2, 80% by year 3 and beyond; and 3) compare program costs to national and regional benchmarks in year one; reduce costs by 5% each year; Create a capitated model for coordinated HIV care incorporating all reimbursable and non-reimbursable as well as medication costs. This capitation and coordinated care model will be exported throughout the state to other population centers with HIV management needs.

This project will help the state achieve the triple aim by optimizing access and retention in our patient population using our community-based, coordinated HIV care model in the Chicago neighborhoods with high HIV prevalence served by the UIC HCCN by improving client/staff ratios and infrastructure. This will improve patients' virologic suppression, reduce morbidity, improve quality of life, and reduce inpatient and ED utilization. The project will also support optimizing the cost effectiveness of the services we currently provide. Finally, we will utilize the data we gather during the project period to develop a comprehensive capitated financial model that includes all costs currently covered by several federal and state funding programs.

- ***Patients impacted:*** Using 2012 data, we had enrolled 1192 persons for care in the UIC-HCCN system and of these, 53% have been retained in care (seen in the past 6 months); of those retained (N=632), 80% were virologically suppressed on their last visit, or 42% of the estimated total (if we assume that 1192 is the 66%, linked to care per CDC data) compared to 25% nationally, and 21% for African Americans. Our goals are to re-engage 25% of the 240 patients lost to follow-up back into care per year, and increase the percentage of patients with complete viral load suppression for at least 2 of their annual visits to 68% of the existing 1192 patients that attend UIC HCCN clinics in year 1 of funding period; to 74% by year 2, 80% by year 3
- ***Proposed Metrics*****:** For program performance, the patient metrics we use are number of patients retained in care, number re-engaged in care, number of both groups on antiretroviral therapy, and number of those virologically suppressed. We also track their CD4 count, a measure of their immune function. We will also track hospitalizations, ED visits, staff contacts and medical claims data.

  Data on health outcomes and program implementation processes will be collected on an ongoing basis in the UIC Medical Center electronic medical records (EMR) system, and in HCCN program records. Clinic visits, laboratory test results, patient referrals (internal and external), ED visits and hospitalizations, and medication adherence counseling are all recorded in the EMR. Case management contacts are recorded in a HCCN database. The community educator will track community outreach activities and hours. Patient experience data will be collected upon each clinic visit, and in annual surveys. Medical claims data are recorded in the UIC Medical Center billing databases, EPIC and McKessen.

Build on and expand Emergency Patient Interdisciplinary Care (EPIC) Coordination for Frequent ER Visitors Model -- The EPIC model (ER Patient Intensive Interdisciplinary Care) will provide care coordination services to some of our region's most complex and costly patients: frequent ER visitors ($\geq$ 4 ER visits/year). EPIC uses interdisciplinary care coordination to address both the medical and psychosocial determinants of health. The project will: 1) expanding our annual caseload to include patients from other ERs in or near the Illinois Medical District (IMD); 2) enable creation of a care pathway for these patients into an ER Observation Unit for rapid evaluation, management and referral of these patients, reducing hospital admissions and re-admissions; 3) create a statewide telehealth system based upon an effective remote patient management model in New Mexico. This new program

will target, via state claims data, Medicaid "ER super-utilizers". This expanded EPIC program will provide remote consultation and didactics to other ERs. The program includes the creation of shared Electronic Medical Records (EMR) via health information exchange (HIE); and 4) growth of a primary care referral service that will screen between 4,200-5,300 UI hospital ER patients annually, that will establish care in either Mile Square Health Centers or other urban Federally-Qualified Health Center (FQHC) for up to 2,200 patients.

Project goals are to improve patient health and system healthcare, and reduce inpatient and ER utilization, resulting in significant cost reductions. Over 59% of hospital admissions originate in the ER and there is significant overlap between ER frequent visitors and frequently admitted hospital patients. These patients often have primary care providers, but their hospital readmission rates and costs remain high due to: 1) Failure of the healthcare system to coordinate care between needed specialists, multiple ERs, and the patient's medical home and; 2) Failure to identify and intensively address underlying psychosocial challenges. Consultation with other state of Illinois ERs will provide important options in providing more cost-effective treatment pathways for patients who might otherwise require another inpatient admission, the most expensive encounter in the healthcare system.

Quality of care: This is improved through a comprehensive, coordinated scope of care across all sites of healthcare delivery. Screening and assessing these patients in an ER/23-hour Observation Unit will prevent hospitalization. The unit will provide innovative care that has never been seen before in the ER. Electronic tools in use and in development include a health information exchange system between ERs, with a centralized care coordination note that will be shared among inpatient, outpatient, primary care, specialty ER providers as well as community health workers. Other EMR tools will monitor disease risk, and electronic education modules will empower community health workers (CHWs) and their patients. High-risk clinics located in FQHCs within neighborhoods with a high-density of frequent visitors will partner with nearby ERs to provide post-acute care.

Improved outcomes and reduction in cost: The typical "super-utilizer" has extremely high costs to the health system. We have thus far identified three sub-groups that have healthcare costs that are 3.8, 4.5 and 15 times, respectively, when compared to an average Medicaid client. Ongoing research will allow us to identify and direct our interventions to additional high cost sub-groups. EPIC's evidence-based care transition plan will further decrease preventable hospital admissions while improving health

outcomes, resulting in drastic cost savings. We anticipate providing coordinated care for an additional 300 patients in the first year of the program, with additional telehealth consultation for up to 1200 "super-utilizers" across the state. The program will create regional ER-FQHC partnerships that will increase access to primary care, via the replication of a proposed High Risk clinic partnership with UI Heath's ER and Mile Square Health Centers. The model will be financially sustainable and will establish well-coordinated care and health for ER frequent visitors and "super-utilizers".

- ***Number of patients impacted*:** We anticipate screening over 1000 patients per year in order to meet a target annual caseload of 547-850 patients per year (54% increase in existing caseload). The dissemination of the EPIC model outside of Chicago will benefit ERs and their frequent visitors across the state, first, through the remote consultation/didactics model (first year telehealth consultations between 750-1,200), then with eventual adoption of the model by state ERs. Expansion of primary care access in the UI Health ER will result in the screening of 4,200-5,300 patients with the increase of primary care usage by ER patients estimated to be 2,200. In total, we estimate EPIC would impact approximately 5,000 patients per year.
- ***Proposed metrics (expanding the EPIC Service within the Illinois Medical District)**:* Number of patients screened; caseloads; average/min /max/median duration of cases; intensity-mix of cases (low-medium-high); prevalence rates for: mood, anxiety, somatization disorders; severe mental illness (SMI); cognitive Impairment; Substance Abuse Disorders (SUDS); poor social support; unstable housing, homelessness & chronically homeless; in-services given to Chicago Fire Department EMTs
- ***Proposed metrics (ER to ER Case Consultation): n***umber of didactic modules created; number of remote cases presented; region of participating ERs; report of remote site case outcomes using Charlson index, number of ER visits, decrease in utilization; decrease in cost and utilization using states Medicaid claims data
- ***Proposed metrics (PCMH Patient Enrollment):*** number and percentage of all ER patients without a PCMH; patients approached; patients acceptance rate; appointments made; show rates; "stickiness" – patients that subsequently returned to their PCP, demonstrating new health behaviors
- ***Proposed Metrics (Observation Unit): c***ase mix; number of EPIC patients screened and referred to treatment, case management and care coordination services; number of Observation visits by PCP in ED

Build telemedicine capacity -- We propose to build on our experience in telemedicine to offer new services to patients in regions of Illinois where such services are not available. This includes capabilities in areas such as telepsychiatry and teledermatology. We also propose to expand the telemedicine services the University of Illinois College of Medicine currently provides to Illinois Department of Corrections (IDOC) inmates. Currently these services include treatment of HIV and Hepatitis C.

We propose to provide statewide psychiatric telepsychiatry services to connect adult and child /adolescent patients with an Attending Physician Psychiatrist, permitting effective diagnosis, education, treatment, consultation, transfer of medical data, research, and other health care activities to Federally Qualified Health Centers (FQHCs).

The State of Illinois has several population centers with relatively high concentrations of chronic infection with hepatitis C and/or human immunodeficiency virus (HIV). However, many of these geographic areas are not within a reasonable travel distance from an academic medical center or subspecialty providers. Several studies have shown the benefits of subspecialty care for HIV infection including our own (submitted, unpublished) data in the Illinois Department of Corrections (IDOC), which showed greater virologic suppression and higher CD4 T-cell counts. Telemedicine is an excellent way of removing barriers of geography and transportation, increasing and simplifying access to subspecialty care. In studies, telemedicine has proven to be an excellent way to provide care for persons with hepatitis C, HIV, and other acute and chronic conditions. This should improve outcomes and decrease costs, such as travel, for patients across the state.

We propose a pilot project, which would be an extension of our established hepatitis C and HIV telemedicine clinics. The project will partner with two medical centers: 1) Trinity Regional Health System (Moline, IL), which serves the Quad-Cities area (combined statistical area population in 2012 = 474,226 persons); and 2) Vista Health System (Waukegan, IL), which is the 9th largest city in Illinois (population in 2012 = 94,267 persons) and approximately 40 miles from Chicago. Both are medical centers serving a relatively large patient population, but without reasonable proximity to an academic medical center in Illinois. The pilot project would begin with one half-day per week of clinic per site, staffed by a subspecialty-trained physician and pharmacist from the University of Illinois Hospital and Health Sciences System. We anticipate two half-day clinics per week, per site, by the end of the first year.

Telemedicine clinics would be multidisciplinary (physician, pharmacist, case manager), and provide access to expert care in a timely fashion. Telehealth technologies would be used to conduct real-time, synchronous subspecialty clinics for the management of patients with hepatitis C and/or HIV infection.

Patients with myriad chronic medical conditions may benefit when an expert with subspecialty training is involved in their care, including those with HIV and/or hepatitis C infection. Improved access to a higher quality of care may lower disease-associated morbidity (e.g. opportunistic infections), drug-related toxicities, adverse drug-drug interactions, transmission of infection in the community, and possibly mortality. Treating patients with HIV and hepatitis C earlier and with more appropriately administered and monitored therapies, could provide significant benefits. In addition to lowering medical expenses from complications of HIV and hepatitis C, travel expenses could be lowered for patients and their families and caregivers.

- ***Patients impacted (tele-psych)*:** There are approximately 18,000 patients/years currently receiving primary care services at the identified 12 FQHC sites of which approximately 3,600 are in need of psychiatric specialty care.
- ***Proposed metrics (tele-psych)*:** Increased number of patients receiving comprehensive psychiatric assessments and services provided by an Attending Psychiatrist utilizing telemedicine technology at the 12 FQHC telepsychiatry sites (including decreased no-show and cancelation rate at the 12 FQHC sites); decreased rate of psychiatric in-patient hospitalization and psychiatric emergencies at the 12 FQHC telepsychiatry sites; increased cost savings at FQHC associated with coordination of care of appointment with primary care and telepsychiatry occurring on the same day; improved patient care outcome as measured by psychiatric symptom reduction of psychosis and mood related indices using standardized diagnostic specific measures; high patient satisfaction pertaining to increased access and decreased time to appointment and quality of care.
- ***Patients impacted (HIV/HCV)***: This would account for nearly 150 unique patients per year. Prevalence estimates for hepatitis C vary widely, from as low as 1.6% of the general population to as high as 40% in some high-risk groups. UIC would offer 100 telemedicine clinic slots per month (approximately 25 per week), consisting of both new visits (30 minutes) and follow up visits (15 minutes) with a physician, a pharmacist and a case manager in a multidisciplinary subspecialty clinic. The pilot project would offer these clinic times with the understanding and expectation of expansion as needed, based on demand. In addition, partnerships with other

clinics and hospitals across the State of Illinois could be established in the future, removing the need for long-distance travel for most persons, even those in rural areas.

- ***Proposed metrics (HIV/HCV):*** proportion with HIV who have virologic suppression (viral load undetectable or <20 copies/mL); proportion with hepatitis C who complete therapy; proportion with hepatitis C who achieve ETR; proportion with hepatitis C who achieve SVR; time from referral to first visit (goal <2 weeks); patient satisfaction surveys; travel time surveys.

Offer preventive dental services to adult Medicaid patients -- Working with primary care providers (internists, family practitioners and allied health care professionals) the College of Dentistry will provide preventive care for two cohorts of patients. One cohort will be patients diagnosed with diabetes and the second cohort will be pregnant women. Each patient will receive appropriate periodontal and restorative care to assure the establishment and maintenance of infection free oral health. Patients will be seen at least semi-annually at the College of Dentistry. An additional third cohort of patients will be those patients with cancer diagnoses who need pre cancer therapy oral care and/or post therapeutic oral care.

Orofacial infections (caries, gingivitis and periodontitis) remain at high levels in the at risk population served by the Medicaid system. There is evidence that diabetes potentiates periodontitis and that periodontitis potentiates diabetes. Treating oral infections will improve systemic health and concomitantly reduce health care costs for systemic health by reducing physician visits and emergency room visits for diabetes related reasons in the patient cohort as compared to dentally untreated patients.

Research strongly suggests that untreated periodontal disease contributes to preterm, low birth weight deliveries. Treating oral infections will improve systemic health and concomitantly reduce health care costs for systemic health by reducing physician visits and emergency room visits during pregnancy and delivery and will reduce costs related to neonatal complications for the child as compared to dentally untreated patients.

Most cancer chemotherapeutic and some radiological protocols call for pre-therapy or post-therapy oral care. Such care is intended to minimize the potential for complications stemming from the cancer interventions. Providing that care routinely will reduce opportunistic infections and potential intervention related complications.

- ***Patients Impacted*:** Considering only Medicaid patients currently being seen in the College of Dentistry, we have nearly 400 active Medicaid patients with a documented diagnosis of diabetes. It is anticipated that a closer affiliation with Miles Square and the UI Hospital would significantly increase the number. As part of the initial examination, every patient has a blood test done as a screening for diabetes. The number of pregnant patients seen at the College is not tracked. It is anticipated that the affiliation with Miles Square and the UI Hospital will assure a significant number of at risk women. The College currently performs about 45 head and neck cancer surgeries per year. Once again the affiliation with the UI Hospital, Miles Square and the Cancer Center will enhance the number of patients in need of care and the types of cancers and therapies seen.
- ***Proposed metrics*:** urgent care visits to primary care provider; emergency room visits; post-partum care needs; neonatal care costs; opportunistic infections; therapeutic complications

Medicaid care coordination network at UI Health -- As stated elsewhere in this application, Illinois is in the process of implementing alternative models of care in addition to traditional managed care programs. These strategies require that we shift from traditional fee-for-service payment to fee-for-value payment arrangements, which means that we must implement substantial changes to care delivery that involve significant investment. We propose to use DSRIP funds to support the infrastructure development that will be required to make this transition.

The creation of integrated delivery systems that can offer comprehensive services is a core component of the state's plan to adopt meaningful delivery system change. Our new model will involve more coordinated care that improves patient outcomes by providing assessments of the whole needs of the patient and family, increased preventive services, better communication between providers, and appropriate follow-up care. This will reduce unnecessary healthcare utilization (particularly hospital stays) and thus reduce costs.

- ***Patients Impacted:*** Initially 16,500, which represents the Illinois Health Connect patients who are already receiving care with a primary care provider in our system.
- **Proposed metrics:** Studies have shown consistent reductions in unnecessary healthcare utilization (particularly inpatient hospital stays) when patients are enrolled in a program with meaningful managed or coordinated care. For example, a report by the Lewin Group examined state Medicaid managed/coordinated care programs and found that these programs saved

Medicaid anywhere from 2.2% to 19% over traditional fee-for-service arrangements, depending on the state (Appendix B). (Source: “Medicaid Managed Care Cost Savings: A Synthesis of Fourteen Studies,” The Lewin Group, July 2004.)

Preliminary analysis of our Medicaid patient population has shown that the average annual cost per patient in FY 2012 was $3,643. We believe that an assumption of 10% in cost reduction – the average of the above state results – is conservative and reasonable. Applying this 10% savings to the population of 16,500 enrollees results in total savings of $6M per year far, exceeding the estimated program costs.

Appendix C: Costs Not Otherwise Matchable/Designated State Health Programs

Department of Human Services - DDD	**Annual $**
DD FFS - Respite (87D) (89D) (DD Billable Respite)	$ 7,101,500
DD FFS - DD Legacy Model Community Serv (DD Billable Residntial)	$ 1,165,200
DD FFS - Specialized Services (DD Billable Residntial)	$ 2,644,500
DD FFS - Child Care Institutions (CCI 19D) (DD Billable Residntial)	$ 4,495,300
DD Grant - Individual Service Coordination (DD Case Mgt.)	$ 4,970,000
DD Grant - Pas Bogard (Defined Pop Case Mgt.)	$ 1,210,300
DD Grant - ARC Lifespan (DD Service Outreach)	$ 376,100
DD Grant - Autism - The Hope School (Education and Referral)	$ 4,300,000
DD Grant - Best Buddies (Education and Awareness)	$ 500,000
DD Grant - Epilepsy (Education and Referral)	$ 2,075,400
DD Grant - Dental (DD Dental not billed ind.)	$ 1,103,400
DD Grant - Group Respite (DD Respite)	$ 973,000
Total Department of Human Services - DDD	**$ 30,914,700**
Department of Human Services - DMH	
Juvenile Justice	$ 2,370,947
Psychiatrist Services in Mental Health Center	$ 26,921,471
Special Projects	$ 34,316,075
Specialized Direct Clinical Services	$ 618,432
Crisis Staffing	$ 12,467,473
Outreach	$ 580,081
Clinical Review	$ 628,200
Reintegration Residential Forensics	$ 577,474
Individual Care Grant	$ 19,627,870
Total Department of Human Services - DMH	**$ 98,108,023**
Department of Healthcare and Family Services	
LTC- IMD	$ 97,419,400
Limited Benefit Package - Hemophilia	$ 12,500,000
Limited Benefit Package - Renal Dialysis	$ 300,000
Limited Benefit Package - Sexual Assault Treatment	$ 300,000
Total Department of Healthcare and Family Services	**$ 110,519,400**
Department on Aging	
Community Care Program (Grants/Admin)	$ 305,846,641
CCP Demo: Managed Community Care Program (MCCP)	$ 1,104,597

CCP Demo: Comprehensive Care in Residential Settings (CCRS)	$	1,228,457
CCP Demo: Senior Companion Services	$	91,978
CCP Demo: Money Management	$	254,769
CCP Demo: My Choices/ Cash and Counseling	$	407,214
CCP Demo: Money Follows the Person (MFP)	$	53,834
Adult Protective Service	$	19,259,700
Grandparents Raising Grandchildren Program	$	300,000
For Grants to Senior Health Assistance Programs	$	1,600,000
Planning and Service Grants to Area Agencies on Aging	$	7,722,000
Distribution to 13 Area Agencies on Aging - Home Delivered Meals/Mobile Food Equip	$	11,623,200
Total Department on Aging	**$**	**349,492,390**
Department of Corrections/Department of Juvenile Justice		
Parolee Resource - Substance Abuse & Mental Health Counseling	$	7,000,000
Parolee Resource - Psychotropic drugs given upon release	$	11,000
Aftercare Placements - Residential Placement of Youth	$	3,000,000
Total Department of Corrections/Department of Juvenile Justice	**$**	**10,011,000**
Department of Public Health		
Health Promotion	$	35,601,000
Women's Health	$	4,036,400
Illinois Breast and Cervical Cancer (IBCCP)	$	17,423,400
Public Health Laboratories	$	27,906,800
Health Policy, Planning, and Statistics	$	15,769,800
Total Illinois Department of Public Health	**$**	**100,737,400**
Department of Children and Family Services		
Substitute Care - Foster Care & IGH	$	111,587,700
Adoption & KinGAP	$	25,219,610
Cash Assistance (Norman Cash Assistance)	$	1,937,272
Children's Advocacy Centers	$	3,360,300
Counseling	$	19,164,040
Preservation	$	3,133,329
Foster Care Initiative	$	7,411,792
Day Care	$	17,810,803
Psychological	$	3,028,400
Total Department of Children and Family Services	**$**	**192,653,245**
Department of Human Services - Family and Community Services (FCS)		
Healthy Families	$	10,040,000
Parents Too Soon	$	4,379,900

Homelessness Prevention	$ 1,000,000
Rape Victims/Prevention Act	$ 6,159,700
Domestic Violence Shelters	$ 18,635,067
Youth Programs	$ 8,800,000
IL Chicago Area Project	$ 5,645,376
Comprehensive Community Services	$ 11,046,400
Redeploy Illinois	$ 4,885,100
Homeless Youth Services	$ 3,598,100
Total Department of Human Services - Family and Community Services (FCS)	**$ 74,189,643**
State Workforce Training	
University of Illinois (all campuses)	$ 90,000,000
Southern Illinois University - Carbondale	$ 49,090,613
Southern Illinois University - Edwardsville	$ 9,581,463
Governors State University	$ 3,367,848
State Loan Repayment Program	$ 10,000,000
New Workforce Training Programs	$ 50,000,000
Total State Workforce Training	**$ 212,039,924**
Poison Control	
Poison Control	$ 4,000,000
Total Poison Control	**$ 4,000,000**
Local Government Sources	
Local Government	$ 50,000,000
Total Local Government Sources	**$ 50,000,000**
Total CNOM	**$ 1,232,665,725**

Appendix D: Examples of Workforce Training Programs Being Considered for Targeted Investment

As described in the waiver narrative, Illinois proposes to make targeted investment in workforce training programs that directly benefit the Medicaid program. Below are examples of programs that are being evaluated for potential expansion at public universities in the Illinois, including the University of Illinois, Southern Illinois University, Governor's State University and Chicago State University.

Increasing Social Workers and Community Health Workers in Medically Underserved

- *Expand Community Health Degree Program (GSU).* Since its inception in 2010, Governor's State University's Bachelor of Health Science degree in Community Health has undergone rapid growth in response to demand for new types of health care professionals to serve underserved populations. The program is designed to a broad-based educational background to prepare graduates to design and implement programs that increase the quality, availability and effectiveness of health and wellness promotions. The program has a strong underpinning in cultural understanding and sensitivity, giving you the ability to appreciate—and respond to—cultural and community influences on health and wellness promotion. Targeted investments in this program are aimed at expansion, recruitment and curriculum development to further align the program with emerging workforce needs in community health.
- *Increase the Supply of Social Workers and Community Health Workers (U of I*). By recruiting social work students and community health workers (outreach) from medically underserved areas, the overall supply of social workers will increase while focusing on: (1) the critical social work/case management services necessary for the management of chronic conditions; and on (2) the training of social workers specifically to deal with the targeted health needs of urban populations.

Increasing Primary Care Physicians and Placement in Medically Underserved Areas

- *Increase residency opportunities in Family Medicine, Internal Medicine, Pediatrics, OB/GYN, psychiatry and surgery (U of I).* Increasing the availability of primary care and specialty physician in coordination with efforts to place residents in medically underserved areas is to access to medically necessary healthcare.

- *Train Physicians via Clerkships in Medically Underserved Rural and Urban Areas (U of I).* There are currently multiple programs coordinated through the UIC Chicago, Rockford and Peoria campus which place medical students and residents in medically underserved areas of the state under the clerkship education and training model. These programs have been very successful in increasing the supply of physicians who go on to establish a medical practice in the targeted areas of the state upon completion of their training. The availability of additional funding will expand these programs and increase the supply of physicians who will practice in medically underserved areas of the state.
- *Increasing residency opportunities in Family Medicine, OB/GYN and General Surgery (SIU).* SIU will expand its family medicine residency programs in Springfield and Decatur by ten residents per year for a total of thirty additional residency slots. Springfield's family medicine residents train in SIU's federally qualified health center (FQHC) clinic located in Springfield. SIU's obstetrics and gynecology residency program will expand by two per year for a total of eight additional residency slots. General surgery will expand its residency program for a specific rural surgery track by two residents per year for a total of ten additional residency slots. As published in a 2013 study in Academic Medicine journal, among free-standing medical schools who sponsored more than two hundred residency graduates from 2006-2008, SIU ranked third in the production of primary care physicians, first in those physicians practicing in HPSAs and medically underserved practice sites and second in those practicing in rural areas.
- *Expand medical student educational experiences in rural, underserved locations (SIU).* SIU School of Medicine will expand educational experiences for medical students conducted in the state's rural and underserved locations. These experiences bring medical students into direct contact with Medicaid and uninsured patients, enhance the students' understanding of the needs of these populations, and increase the likelihood that the students will return to practice in rural and underserved areas. Currently, SIU's medical school has a required six-week Family and Community Medicine rotation during the third year of medical school that is designed to immerse the student in the delivery of comprehensive patient care provided in the community setting. This initiative will expand community-based clinical training for medical students in these underserved locations.
- *Expand support for physician pipeline programs preparing students from rural and underserved areas of Illinois to enter and succeed in medical school (SIU).* Under this initiative, SIU will expand its two physician pipeline programs – MEDPREP and P^4 – to recruit and prepare additional

students who are likely to complete their medical training and return to practice in Illinois' rural and underserved communities. SIU's Medical/Dental Education Preparatory Program (MEDPREP) serves the community by preparing underrepresented minority and educationally/economically disadvantaged students for careers in medicine or dentistry. This nationally recognized two-year, post-baccalaureate "pipeline program" was established in 1972 by the SIU School of Medicine. The Physicians Pipeline Preparatory Program (P^4) is a cooperative educational pipeline program of SIU School of Medicine and the Springfield Public School District 186 designed to encourage local high school students interested in becoming physicians. Through this initiative, P^4 will be expanded to serve rural communities in the Springfield area.

Increasing the Supply of Dental Services in Underserved Areas

- *Increase the Recruitment and Training of Pediatric Dentists in Coordination with SIU (U of I).* Recruiting and training additional dental students will begin to address the acute shortages of dentists and the availability of dental care to children throughout the state thereby increasing access to dental services for children covered by Medicaid.
- *Develop training programs for Pediatric Dental Residents, emphasizing service in the underserved areas of southern Illinois (SIU).* The immediate benefit is increased care of the underserved directly through the training program efforts/direct patient care. Long term benefit is the increase in availability of practitioners to serve Medicaid clients in southern Illinois.
- *Develop training programs for Oral & Maxillofacial Surgery Residents, emphasizing service in the underserved areas of southern Illinois (SIU).* The immediate benefit is increased care of the underserved directly through the training program efforts/direct patient care. Long term benefit is the increase in availability of practitioners to serve Medicaid clients in southern Illinois.

Increasing the Supply of Nurses in Medically Underserved Areas

- *Increase Access to Nurse Practitioner care in Medically Underserved Areas through urban outreach and training as well as increasing downstate educational opportunities (U of I).* By recruiting nursing students from medically underserved areas of the state and by providing

direct nursing experiences in urban and rural areas of the state, the overall supply of nurses will increase while specifically targeting the downstate and rural educational and training opportunities for nursing students who would go on to provide medical care in downstate and rural practice locations (e.g. the availability of nurse practitioners and RN levels of nursing is a critical need both in downstate and rural hospitals as well as in the FQHC system).

Train additional advanced practice nurses (Nurse Practitioners) and provide healthcare to medically underserved, predominately Medicaid patients in the East St. Louis area through expansion of the SIUE WE CARE Clinic (SIU). University proposes to increase the number of nurse practitioners practicing in the area by utilizing the WE CARE Clinic for clinical rotations of advanced practice nursing students and at the same time provide medical services in this medically underserved and primarily Medicaid region.

- *Increase the number of baccalaureate (BSN) prepared nurses to address healthcare needs in medically underserved rural southern Illinois through a 50% expansion of the SIUE Regional Program in Carbondale* (SIU).Illinois continues to see a shortage of BSN prepared nurses which directly affects the Medicaid population. This shortage is even more acute in Southern Illinois. The university proposes to expand nursing program to increase the availability of BSN nurses ultimately practicing in the Carbondale region.

Increasing the Supply of Pharmacists in Medically Underserved Areas

- *Increase Access to Pharmacy Services in Medically Underserved Areas (U of I).* By recruiting pharmacy students from medically underserved areas and by providing direct pharmacy experiences in targeted areas of the state, the overall supply of pharmacists will increase while focusing on establishing pharmacy practice(s) in the underserved areas of the state.
- *Increasing residency opportunities for primary care pharmacy in rural Illinois (SIU).* There is a well-documented shortage of health care providers in rural Primary Care environments. Through collaborative practice with physicians, clinical pharmacists have a proven ability to manage chronic diseases in Primary Care settings. To perform effectively in this role, pharmacists require post-graduate residency training. A shortage of residency training programs for pharmacists exists in rural downstate Illinois. Of all pharmacy practice residency programs in Illinois, there is only one program located south of Springfield. While the SIUE School of Pharmacy has an excellent record of placing its graduates in residency programs, most of these graduates leave the state for training and never return. We propose to create a

residency infrastructure in southern Illinois that will address the Primary Care workforce shortages in rural Illinois counties with large Medicaid enrollments. This proposal includes four residents and two residency coordinators. Through partnerships with existing clinics and billing for clinical services, the program should be self-sufficient in 5 years.

Increasing the Supply of OT and PT in Medically Underserved Areas

- *Increase Access to OT and PT in Medically Underserved Areas (U of I).* By recruiting OT and PT students from medically underserved areas and by providing interdisciplinary training in the areas of occupational therapy, physical therapy, disability studies, and nutrition, will increase the overall supply of PT and OT while specifically focusing on the needs of children with chronic health conditions and adults with disabilities (expect an increase in new mid-level providers with diverse training to meet the needs of targeted populations).

Increasing Mental Health Services in Medically Underserved Areas

- *Increase Access to Mental Health Programs and Services in Medically Underserved Areas (U of I).* By recruiting mental health students from medically underserved areas and by providing mental health therapy education and training at the Bachelor and Graduate levels, the overall supply of mental health social workers will increase while focusing on the specific mental health needs of individuals in urban areas.

Increasing the Supply of Registered Dieticians and Their Placement in Medically Underserved Areas

- *Increase the availability of registered dieticians serving in medically underserved areas through recruitment and training in medically underserved areas or rural regions (SIU).* Illinois continues to see a shortage of registered dietician professionals, which directly affects the Medicaid population. Recruiting students from medically underserved/rural areas and providing dietetic experiences in such areas increases the supply and likelihood of their practicing in an area where their services are most needed in serving the Medicaid population.

Increasing the Availability of Public Health and Community Health Workers in Underserved Areas

- *Increase the recruitment and training of Community Health and Health Education students in medically underserved areas (SIU).* Recruiting students from medically underserved/rural areas and providing public health experiences in such areas increases the supply and likelihood of their practicing in an area where their services are most needed in serving the Medicaid population.

Appendix E: 1115 Waiver Stakeholder Meetings

AARP - IL Chapter

Access Living

ADDUS HealthCare

Affordable Assisted Living Coalition (AALC)

AIDS Foundation of Chicago

Aronberg Goldgehn Davis & Garmisa/Safety Net Hospital Association

Association of Community Mental Health Authorities in Illinois (ACMHAI)

Chicago Commons

Child Care Association of Illinois (CCA-IL)

Community Behavioral Health Association of Illinois (CBHA)

Cook County Health & Hospital Systems (CCHHS)

Corporation for Supportive Housing (CHS)

Governors State University

Health & Disability Advocates

Health & Medicine Policy Research Group

Health Care Council of Illinois (HCCI)

Healthcare Plus Senior Care

Heartland Alliance

Help at Home, Inc.

Illinois Alcoholism and Drug Dependence Association

Illinois Human Services Commission Steering Committee and full commission

Illinois Association of Area Agencies on Aging

Illinois Association of Community Care Program Homecare Providers (IACCPHP)

Illinois Association of Medicaid Health Plans (IAMHP) and member plans

Illinois Association of Rehabilitation Facilities (IARF)

Illinois Council on Developmental Disabilities (IADD)

Illinois Health Care Association (IHCA)

Illinois Hospital Association (IHA)

Illinois Network of Centers for Independent Living (INCIL)

Illinois Optometric Association (IOA)

Illinois Primary Health Care Association (IPHCA)

Illinois Rural Health Association (IRHA)

Institute on Public Policy for People with Disabilities

Life Services Network (LSN)

Lurie Children's Hospital

Lutheran Social Services of Illinois (LSSI)

Michael Reese Health Trust

National Association of State Directors of Developmental Disabilities Services (NASDDDS)

ResCare

Rush University Medical Center

SEIU Healthcare Illinois, Indiana, Missouri, Kansas

Southern Illinois University (SIU)

Statewide Independent Living Council of Illinois (SILC)

Stricklin and Associates

Supportive Housing Providers Association (SHPA)

The Arc of Illinois

The Center for Developmental Disabilities Advocacy and Community Supports

The Chicago Community Trust

Thresholds

Universal Health Services (UHS)

University of Illinois Hospital & Health Sciences System (UI Health)

Southern Illinois University

WestCare Foundation

Western Illinois Area Agency on Aging

Appendix F -- Budget Neutrality Detail and Expenditure Plan

The *Path to Transformation* waiver is focused on increasing access to critical, community-based services and supporting the creation of integrated delivery systems that are incentivized to provide the right care at the right time in the right setting with the right provider. While many of the provisions proposed in the waiver will have large returns on investment over time in quality and cost, our financial analysis is focused on the areas where we expect to see a significant impact within the five-year waiver period. Specifically, the waiver:

- Includes a significant investment in strengthening HCBS services, as well as mental health and substance use disorder services. The waiver also proposes the development of a statewide tele-health network to improve access to specialty care and behavioral health services in hard-to-reach rural areas. These provisions will directly impact the use of ED, inpatient utilization including readmissions, and utilization of institutional care.
- Includes incentives for plans and providers to address critical social determinants of health, including stable housing for populations with severe mental illness and/or substance use disorders. A substantial and growing base of evidence indicates that stable housing for this target group can significantly improve treatment compliance, reduce the need for institutionalization, and significantly reduce overall costs.
- Provides a transition path for hospitals to incentivize them to move more quickly to appropriate managed care vehicles and integrated delivery systems.
- Keeps critical providers and their employees stable during this rapid evolution, through creation of an Access Assurance Pool.

We believe these and other provisions outlined in the waiver will bend the cost curve over the next five years and beyond and will allow Illinois to meet the aggressive budget neutrality goals we have set. We also anticipate that the benefits and savings from the waiver will be significant for the newly eligible population and have incorporated this estimated impact into our analysis.

Baseline Trends

To calculate baseline trends without innovations, Medicaid data files with dates of service occurring in years 2009, 2010, 2011, 2012 and 2013 were used. Additionally, we added the impact of state plan and 1915(c) waiver amendments filed recently to the overall trend rates and base year costs.

Specific Characteristics of Illinois Medicaid

The Illinois Medicaid program has relied on rate freezes and provider-funded payments to help control state spending. With the exception of some recent rate reductions (discussed below), most reimbursement rates to Medicaid providers have remained stagnant for 20 years. Given the state-initiated Medicaid reforms, as well as the new opportunities presented through the Affordable Care Act, it is clear that the old method of controlling spending through rate freezes and dependence on supplemental institutional payments does not contribute to an efficient health care delivery system. In fact, HCBS waiver providers and the behavioral health providers have been unable to meet the needs of their population due to a lack of funding, while the institutional providers have been able to prop up rates through a provider assessment. This has contributed to the inefficiency of the system.

Due to an unprecedented state budget crisis, Illinois enacted the Saving Medicaid Access and Resources Together (SMART) Act, which implemented $1.6 billion in savings through more than 60 specific program changes for dates of service beginning July 1, 2012. While these savings measures were well planned and required, they have had the unfortunate effect of further weakening both HCBS and behavioral health services. If we are unable to make the changes contemplated in this waiver, costs will rise more quickly and quality will suffer. It is important to note that Medicare spending on a per capita basis rose by 4.85% over the period (see CMMI report).

Anticipated Cost Savings from Waiver

Based on the current cost and utilization trends across those populations, the state estimates that Illinois and the federal government will realize a total cumulative savings of $2 billion in Medicaid/CHIP spending by the end of the waiver period as a result of implementing the innovations specified in the State Innovation Plan and in the waiver. While budget neutrality is calculated over a five-year period, it is important to note that we project large, ongoing savings well-beyond the waiver period attributable to the investments made in the early years of the waiver.

Impact of Innovations Through the State Innovation Plan and the Waiver

Illinois' innovations are expected to result in quantifiable changes in utilization and cost savings on a per capita basis. The outcome measures we will use to quantify these changes are: 1) reducing avoidable emergency room visits; 2) reducing ambulatory sensitive inpatient admissions; 3) reducing avoidable inpatient readmissions within 30 days of being discharged from a hospital for the same or related admission; 4) reducing overall cost of medical care; and 5) reducing spending on institutional services.

Reducing Avoidable Emergency Room Visits

Through the Alliance for Health innovations, and the clinical integration and payment reform innovations in particular, Illinois expects to reduce preventable emergency department (ED) room visits for the Medicaid and CHIP populations by 20% by the third year of the waiver. To determine the base of preventable ED visits per 10,000, Illinois used the New York University algorithm as a nationally recognized methodology for classifying ED data. These included the following classifications:

1. Non-emergent
2. Emergent/Primary Care (PC) treatable
3. Emergent-Preventable/Avoidable
4. Emergent-Not Preventable/Avoidable
5. Injury
6. Psychiatric
7. Alcohol
8. Drug
9. Unclassified

Data from CY2010 through CY2012 were reviewed based on the principal diagnosis code (ICD-9). In the case of uncertainty in assignment, visits were deliberately grouped into emergent/non-preventable classifications in order to avoid overstating the savings of innovations. Other visits that did not contain enough information were assigned as being unclassified.

Based on these results, 51.6% (sum of non-emergent and emergent/primary care treatable for 2012) was used as the percentage of ED visits that are considered to be potentially preventable. For Waiver Year 1, we have predicted a reduction of 6.66%, increasing to 13.33% by Waiver Year 2, and to 20% by Waiver Year 3. In subsequent waiver years, we expect to maintain that reduction. However, since it is assumed that the avoidable ED visits are more likely to be paid at a lower ED reimbursement rate, the value of each service is reduced by 10%. It is also assumed that in order to achieve these savings, the ED visits are likely to be replaced by physician services. Therefore, the savings realized from the reduced ED visits are offset by an equal increase in the number of professional services. The resulting applications of projected savings can be summarized as follows:

Waiver Year 1:
(Total ED Visits) x (6.66%) x 51.6%) = (Predicted # of reduced in ED visits)
(Reduced ED visits) x (ED Unit Cost) x (90%) = Gross Savings

(Gross Savings) – (cost of proportional increase in professional services) = (Net Savings)

Subsequent waiver years use the same approach, reaching 20% by Waiver Year 3.

Avoiding Ambulatory Sensitive Hospital Admissions

National PQI data indicates that 5.4% of all hospital admissions can be classified as ambulatory sensitive and potentially preventable. However, the rate in Illinois, as calculated by the Illinois Department of Public Health, is 6.8% which is a statistically significant increase. In addition, it is common for the uninsured to have a higher admission rate. If we assume 2.8 million current Medicaid clients to be at 5.4% and the addition of 350,000 newly eligible residents under the Affordable Care Act will have a rate of 9.9%, prorating the combined population during the first three years of the waiver results in a rate of 5.9%. This percentage is considered to be conservative, given that it is still well below the Illinois-specific estimate of 6.8% for all residents.

Using a base of 5.9% of all Illinois Medicaid admissions as ambulatory sensitive and potentially preventable, we anticipate that the innovations will gradually reduce these admissions by 20% by the end of Waiver Year 3 and maintained in Waiver Years 4 and 5. We assume that to achieve these savings, reductions in admissions are likely to be replaced with proportional increases in professional services, outpatient services, and pharmaceuticals. The resulting application of savings is similar to that of avoidable ED visits, but with the additional proportional offsetting increases in pharmaceuticals and outpatient services.

Avoiding Preventable Readmissions Within 30 days

Illinois is implementing 3M software to identify potentially preventable readmissions within 30 days of a discharge from the same or another hospital for an identical or related admission. The methodology identifies outliers within peer groups of similar diagnosis, with the exclusion of certain unavoidable readmissions such as cancer treatment and obstetrical care. Through this methodology we are projecting a gross savings of $30 million by Waiver Year 3 that will be maintained in Waiver Years 4 and 5. The savings will be implemented through rate reductions for hospitals that exceed peer group thresholds. However, it is also anticipated that these savings may be offset by some additional costs, such as improved care coordination and follow-up after discharge. To offset these costs, we estimate a total net savings of $20 million by Waiver Year 3 that will be maintained in Waiver Years 4 and 5.

Reducing Total Cost of Care

We anticipate a reduction in the total cost of care on a per member per year basis, for a total anticipated Medicaid savings of $2 billion by the conclusion of Waiver Year 5 as a result of implementing innovations. Additional savings will be realized through shifting the focus away from institutional care and a relative increase in spending on long-term support services.

Rebalancing to Increase Long Term Support Services

Independent of the specific Plan innovations, Illinois has made strides in rebalancing resources from institutional care to community settings. Historical trends from CY2010 through CY2012 show decreases in utilization per thousand for nursing homes, institutions for the developmentally disabled, and state operated mental health facilities. These decreases in institutional utilization are consistent across all populations groups. For the same time period, we see a dramatic increase in waiver services across each population group.

Unlike other innovations that can easily quantify the value of change on spending and utilization, we anticipate the shift toward long term support services to accelerate through the implementation of several changes. These include the dramatic increase in care coordination through the implementation of the integrated delivery systems contracting directly with the state, as in the CCE and ACE Medicaid options, traditional Medicaid capitation contracts with MCOs and MCCNs, and the Cook County County Care model. In addition, anticipated implementation of three new initiatives will affect the way in which long term care services are provided. These include, 1) a new rate methodology for nursing homes, 2) development of a more objective and verifiable screening assessment prior to admission into a long-term care facility and 3) expanded access to home and community-based services for individuals with qualifying LTSS needs and behavioral health services for adults with SMI or SUD and children with SED. With a new nursing home rate methodology based on Resource Utilization Groups, Illinois anticipates that rates for nursing home residents will increase when medical needs are high, and decrease for those with lower medical needs. This, coupled with a new screening tool prior to admission and increased availability of community resources, will have the combined effect of rewarding nursing facilities that accept the responsibilities of high-need residents, and expanding service options for those that are able to remain in the community. Over 7 years, Illinois projects reducing the number of people residing in nursing facilities by up to 10,000.

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 includes 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.

The with-waiver baseline also incorporates the following:

- *Savings resulting from waiver innovations*. Many of the innovations outlined in this waiver application 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.

- *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. Specifically, we are requesting a without-waiver trend rate of 4.85%

Illinois will maintain budget neutrality over the five-year life of the *Path to Transformation* Wavier, with per capita 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.

Path to Transformation Expenditure Plan

Waiver Provision	Funding Source	Year 1 $	Year 2 $	Year 3 $	Year 4 $	Year 5 $
Pathway #1						
Technical Assistance/ITRC	CNOM/Savings	$ 40,000,000	$ 40,000,000	$ 40,000,000	$ 40,000,000	$ 40,000,000
DSRIP	IGT	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000
Access to Care Pool	Self Financed	$ 2,353,600,000	$ 2,353,600,000	$ 2,353,600,000	$ 2,353,600,000	$ 2,353,600,000
Quality and Transformation Pool	CNOM/Savings	$ 100,000,000	$ 100,000,000	$ 100,000,000	$ 100,000,000	$ 100,000,000
Institution Transition Fund	CNOM/Savings	$ 25,000,000	$ 25,000,000	$ 25,000,000	$ 25,000,000	$ 25,000,000
Pathway #2						
Public Health Integration	MCO tax	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Expand Maternal-Child Home Visits	CNOM/Savings	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Pathway #3						
Loan Repayment reinstatement and expansion	CNOM/Savings	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
Safety Net Hospital Loan Repayment	CNOM/Savings	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000	$ 20,000,000
Workforce training/Curriculuum and Competency testing	CNOM/Savings	$ 25,000,000	$ 50,000,000	$ 50,000,000	$ 50,000,000	$ 50,000,000
Teaching Health Center	CNOM/Savings	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,000,000
GME	CNOM/Savings	$ 26,000,000	$ 26,000,000	$ 26,000,000	$ 26,000,000	$ 26,000,000
Pathway #4						
Increase in service costs to bring parity to waivers	CNOM/Savings	$ 150,000,000	$ 150,000,000	$ 150,000,000	$ 150,000,000	$ 150,000,000
Addition of slots to IDD to reduce wait list.	CNOM/Savings	$ 60,000,000	$ 70,000,000	$ 80,000,000	$ 90,000,000	$ 100,000,000
Expansion of Behavioral Health Services; MRO expansion	CNOM/Savings	$ 140,000,000	$ 150,000,000	$ 160,000,000	$ 170,000,000	$ 180,000,000
Expansion of BH Services to include clinic option	CNOM/Savings	$ 40,000,000	$ 50,000,000	$ 60,000,000	$ 70,000,000	$ 80,000,000
Children's Mental Health Services	CNOM/Savings	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000	$ 30,000,000
2703 Health Homes for HIV/AIDs and other high-risk*	Savings	$ 50,000,000	$ 50,000,000	$ 50,000,000	$ 50,000,000	$ 50,000,000
Bonuses for stable housing	CNOM/Savings	$ 60,000,000	$ 60,000,000	$ 60,000,000	$ 60,000,000	$ 60,000,000
Increased rates for residential habilitation providers	Res Hab fees	$ 38,400,000	$ 38,400,000	$ 38,400,000	$ 38,400,000	$ 38,400,000
Bonuses for ACT/CST team start ups	CNOM/Savings	$ 9,000,000	$ 9,000,000	$ 9,000,000	$ 9,000,000	$ 9,000,000
Other						
Administrative costs for waiver implementation (HFS, DHS, DOA)	CNOM/Savings	$ 15,000,000	$ 15,000,000	$ 15,000,000	$ 15,000,000	$ 15,000,000
*90/10 FMAP rate						

5 YEARS OF HISTORIC DATA

SPECIFY TIME PERIOD AND ELIGIBILITY GROUP DEPICTED:

Children & Adults	**SFY2009**	**SFY2010**	**SFY2011**	**SFY2012**	**SFY2013**	**5-YEARS**
TOTAL EXPENDITURES	$ 5,502,435,518	$ 5,904,275,188	$ 6,127,578,654	$ 6,175,090,070	$ 6,116,535,772	$ 29,825,915,201
ELIGIBLE MEMBER MONTHS	23,973,805	25,757,264	26,978,323	27,835,586	27,724,340	
PMPM COST	$ 229.52	$ 229.23	$ 227.13	$ 221.84	$ 220.62	
TREND RATES						**5-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		7.30%	3.78%	0.78%	-0.95%	2.68%
ELIGIBLE MEMBER MONTHS		7.44%	4.74%	3.18%	-0.40%	3.70%
PMPM COST		-0.13%	-0.92%	-2.33%	-0.55%	-0.98%

Aged, Blind & Disabled	**HY 1**	**HY 2**	**HY 3**	**HY 4**	**HY 5**	**5-YEARS**
TOTAL EXPENDITURES	$ 6,694,594,168	$ 7,074,178,369	$ 7,436,143,259	$ 7,574,382,525	$ 7,221,731,153	$ 36,001,029,474
ELIGIBLE MEMBER MONTHS	4,985,138	5,169,967	5,436,013	5,668,532	5,733,367	
PMPM COST	$ 1,342.91	$ 1,368.32	$ 1,367.94	$ 1,336.22	$ 1,259.60	
TREND RATES						**5-YEAR**
			ANNUAL CHANGE			**AVERAGE**
TOTAL EXPENDITURE		5.67%	5.12%	1.86%	-4.66%	1.91%
ELIGIBLE MEMBER MONTHS		3.71%	5.15%	4.28%	1.14%	3.56%
PMPM COST		1.89%	-0.03%	-2.32%	-5.73%	-1.59%

HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Existing Adults ACA	$ 1,860,655,765	$ 1,950,897,569	$ 2,045,516,101	$ 2,144,723,632	$ 2,248,742,728	$ 10,250,535,796
New Eligibles	$ 3,796,790,873	$ 3,980,935,231	$ 4,174,010,589	$ 4,376,450,103	$ 4,588,707,933	$ 20,916,894,730
TOTAL	$ 5,657,446,638	$ 5,931,832,800	$ 6,219,526,691	$ 6,521,173,735	$ 6,837,450,662	$ 31,167,430,526

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Hypo 1	$ 1,860,655,765	$ 1,950,897,569	$ 2,045,516,101	$ 2,144,723,632	$ 2,248,742,728	$ 10,250,535,796
Hypo 2	$ 3,796,790,873	$ 3,980,935,231	$ 4,174,010,589	$ 4,376,450,103	$ 4,588,707,933	$ 20,916,894,730
TOTAL	$ 5,657,446,638	$ 5,931,832,800	$ 6,219,526,691	$ 6,521,173,735	$ 6,837,450,662	$ 31,167,430,526

HYPOTHETICALS VARIANCE	$ -	$ -	$ -	$ -	$ -	$ -

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00	TREND RATE 2	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WOW
Children & Adults										
Pop Type:	**Medicaid**									
Eligible Member Months	3.7%		27,724,340	3.7%	28,750,141	29,813,896	30,917,010	32,060,939	33,247,194	
PMPM Cost	4.9%	18	$ 236.86	4.9%	$ 248.35	$ 260.39	$ 273.02	$ 286.26	$ 300.14	
Total Expenditure					$ 7,140,097,413	$ 7,763,240,323	$ 8,440,962,050	$ 9,177,764,482	$ 9,978,812,821	$ 42,500,877,088
Aged, Blind & Disabled										
Pop Type:	**Medicaid**									
Eligible Member Months	3.56%	0	5,733,367	3.6%	5,937,475	6,148,849	6,367,748	6,594,440	6,829,202	
PMPM Cost	4.85%	18	$ 1,352.33	4.9%	$ 1,417.92	$ 1,486.69	$ 1,558.79	$ 1,634.39	$ 1,713.66	
Total Expenditure					$ 8,418,864,361	$ 9,141,432,276	$ 9,925,981,895	$ 10,777,886,501	$ 11,702,930,094	$ 49,967,095,127
New Spend in Base Year										
Pop Type:	**Medicaid**									
Eligible Member Months	0.0%	0	1	0.0%	1	1	1	1	1	
PMPM Cost	0.0%	0	$ 1.00	4.9%	$ 1,511,400,000.00	$ 1,585,458,600.00	$ 1,663,146,071.40	$ 1,744,640,228.90	$ 1,830,127,600.12	
Total Expenditure					$ 1,511,400,000	$ 1,585,458,600	$ 1,663,146,071	$ 1,744,640,229	$ 1,830,127,600	$ 8,334,772,500
Existing Adults ACA										
Pop Type:	**Medicaid**									
Eligible Member Months			2,011,200	0.0%	2,011,200	2,011,200	2,011,200	2,011,200	2,011,200	
PMPM Cost			$ 882.35	4.9%	$ 925.15	$ 970.02	$ 1,017.06	$ 1,066.39	$ 1,118.11	
Total Expenditure			1774588235		$ 1,860,655,765	$ 1,950,897,569	$ 2,045,516,101	$ 2,144,723,632	$ 2,248,742,728	$ 10,250,535,796
New Eligibles										
Pop Type:	**Expansion**									
Eligible Member Months			4,104,000	0.0%	4,104,000	4,104,000	4,104,000	4,104,000	4,104,000	
PMPM Cost			$ 882.35	4.9%	$ 925.14	$ 970.01	$ 1,017.06	$ 1,066.39	$ 1,118.11	
Total Expenditure			3621164400		$ 3,796,790,873	$ 3,980,935,231	$ 4,174,010,589	$ 4,376,450,103	$ 4,588,707,933	$ 20,916,894,730

DEMONSTRATION WITH WAIVER (WW) BUDGET PROJECTION: COVERAGE COSTS FOR POPULATIONS

ELIGIBILITY GROUP	DY 00	DEMO TREND RATE	DEMONSTRATION YEARS (DY) DY 01	DY 02	DY 03	DY 04	DY 05	TOTAL WW
Children & Adults								
Pop Type:	**Medicaid**							
Eligible Member Months	27,724,340	3.70%	28,750,141	29,813,896	30,917,010	32,060,939	33,247,194	
PMPM Cost	$ 236.86	3.35%	$ 245.74	$ 253.97	$ 262.48	$ 271.27	$ 280.36	
Total Expenditure			$ 7,065,059,546	$ 7,571,835,112	$ 8,115,096,765	$ 8,697,171,002	$ 9,321,183,323	$ 40,770,345,748
Aged, Blind & Disabled								
Pop Type:	**Medicaid**							
Eligible Member Months	5,733,367	3.56%	5,937,475	6,148,849	6,367,748	6,594,440	6,829,202	
PMPM Cost	$ 1,352.33	3.35%	$ 1,403.04	$ 1,450.04	$ 1,498.62	$ 1,548.82	$ 1,600.71	
Total Expenditure			$ 8,330,514,735	$ 8,916,076,961	$ 9,542,834,498	$ 10,213,600,286	$ 10,931,571,741	$ 47,934,598,221
Additional Spending								
Pop Type:	**Medicaid**							
Eligible Member Months	1	0.00%	1	1	1	1	1	
PMPM Cost	$ 1.00	3.35%	$ 1,511,400,000.00	$ 1,562,031,900.00	$ 1,614,359,968.65	$ 1,668,441,027.60	$ 1,724,333,802.02	
Total Expenditure			$ 1,511,400,000	$ 1,562,031,900	$ 1,614,359,969	$ 1,668,441,028	$ 1,724,333,802	$ 8,080,566,698
CNOM								
Pop Type:	**Medicaid**							
Eligible Member Months			1	1	1	1	1	
PMPM Cost		0.00%	$ 402,500,000.00	$ 442,500,000.00	$ 457,500,000.00	$ 472,500,000.00	$ 487,500,000.00	
Total Expenditure			$ 402,500,000	$ 442,500,000	$ 457,500,000	$ 472,500,000	$ 487,500,000	$ 2,262,500,000
DSRIP								
Pop Type:	**Medicaid**							
Eligible Member Months			1	1	1	1	1	
PMPM Cost			$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	$ 200,000,000.00	
Total Expenditure			$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 1,000,000,000
Existing Adults ACA								
Pop Type:	**Medicaid**							
Eligible Member Months	2,011,200	0.0%	2,011,200	2,011,200	2,011,200	2,011,200	2,011,200	
PMPM Cost	$ 882.35	3.35%	$ 915.44	$ 946.11	$ 977.80	$ 1,010.56	$ 1,044.41	
Total Expenditure			$ 1,841,129,157	$ 1,902,806,984	$ 1,966,551,018	$ 2,032,430,477	$ 2,100,516,898	$ 9,843,434,533
New Eligibles								
Pop Type:	**Expansion**							
Eligible Member Months	4,104,000	0.0%	4,104,000	4,104,000	4,104,000	4,104,000	4,104,000	
PMPM Cost	$ 882.35	3.35%	$ 915.44	$ 946.11	$ 977.80	$ 1,010.56	$ 1,044.41	
Total Expenditure			$ 3,756,958,065	$ 3,882,816,160	$ 4,012,890,502	$ 4,147,322,333	$ 4,286,257,632	$ 20,086,244,692

Budget Neutrality Summary

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children & Adults	$ 7,140,097,413	$ 7,763,240,323	$ 8,440,962,050	$ 9,177,764,482	$ 9,978,812,821	$ 42,500,877,088
Aged, Blind & Disabled	$ 8,418,864,361	$ 9,141,432,276	$ 9,925,981,895	$ 10,777,886,501	$ 11,702,930,094	$ 49,967,095,127
New Spend in Base Year	$ 1,511,400,000	$ 1,585,458,600	$ 1,663,146,071	$ 1,744,640,229	$ 1,830,127,600	$ 8,334,772,500
DSH Allotment Diverted	$ -	$ -	$ -	$ -	$ -	$ -
Other WOW Categories						
Existing Adults ACA	$ 1,860,655,765	$ 1,950,897,569	$ 2,045,516,101	$ 2,144,723,632	$ 2,248,742,728	$ 10,250,535,796
New Eligibles	$ 3,796,790,873	$ 3,980,935,231	$ 4,174,010,589	$ 4,376,450,103	$ 4,588,707,933	$ 20,916,894,730
TOTAL	$ 22,727,808,412	$ 24,421,963,998	$ 26,249,616,707	$ 28,221,464,947	$ 30,349,321,176	$ 131,970,175,241

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01	DY 02	DY 03	DY 04	DY 05	
Medicaid Populations						
Children & Adults	$ 7,065,059,546	$ 7,571,835,112	$ 8,115,096,765	$ 8,697,171,002	$ 9,321,183,323	$ 40,770,345,748
Aged, Blind & Disabled	$ 8,330,514,735	$ 8,916,076,961	$ 9,542,834,498	$ 10,213,600,286	$ 10,931,571,741	$ 47,934,598,221
Additional Spending	$ 1,511,400,000	$ 1,562,031,900	$ 1,614,359,969	$ 1,668,441,028	$ 1,724,333,802	$ 8,080,566,698
Expansion Populations						
Existing Adults ACA	$ 1,841,129,157	$ 1,902,806,984	$ 1,966,551,018	$ 2,032,430,477	$ 2,100,516,898	$ 9,843,434,533
New Eligibles	$ 3,756,958,065	$ 3,882,816,160	$ 4,012,890,502	$ 4,147,322,333	$ 4,286,257,632	$ 20,086,244,692
Excess Spending From Hypotheticals						$ -
Other WW Categories						
CNOM	$ 402,500,000	$ 442,500,000	$ 457,500,000	$ 472,500,000	$ 487,500,000	$ 2,262,500,000
DSRIP	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 200,000,000	$ 1,000,000,000
TOTAL	$ 23,107,561,503	$ 24,478,067,117	$ 25,909,232,752	$ 27,431,465,125	$ 29,051,363,396	$ 129,977,689,892
VARIANCE	$ (379,753,091)	$ (56,103,118)	$ 340,383,956	$ 789,999,822	$ 1,297,957,781	$ 1,992,485,350