COLBERT CONSENT DECREE IMPLEMENTATION PLAN

November 8, 2012

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Illinois Department of Healthcare and Family Services
in Partnership with

Office of the Governor
Illinois Department of Aging
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1. Executive Summary

1.1. Background of the Consent Decree

On behalf of a class of Illinois residents with disabilities living in nursing facilities in Cook County, Illinois, *Colbert v. Quinn*, 07 C 4737, was filed on August 22, 2007, in the United States District Court for the Northern District of Illinois. The lawsuit sought declaratory and injunctive relief to remedy alleged violations of Title II of the Americans with Disabilities Act (ADA), 42 U.S.C. 12131-32, Section 504 of the Rehabilitation Act, 29 U.S.C. 794(a) and the Social Security Act, 42, U.S.C. 1396-1396v (SSA). Plaintiffs alleged that they and members of the Class were being unnecessarily segregated and institutionalized in Nursing Facilities and forced to live with numerous other people with disabilities and in situations in violation of the ADA and the Rehabilitation Act. Plaintiffs further alleged that Defendants the Office of the Governor of the State of Illinois, the Illinois Department of Human Services (DHS), the Illinois Department of Public Health (DPH), the Illinois Department on Aging (IDoA) and the Illinois Department of Healthcare and Family Services (HFS), denied them the opportunity to live in appropriate community integrated settings where they could lead more independent and productive lives. Plaintiffs sought injunctive relief requiring that Defendants (1) inform Class Plaintiffs as to their eligibility for Community-Based Services and their choice of such services; (2) provide comprehensive evaluations to determine the eligibility of Class Plaintiffs for Community-Based Services, both prior to and after admission to Nursing Facilities; and (3) provide, as appropriate, Class Plaintiffs with services and supports in the Community-Based Settings and refrain from providing services only in institutional settings.

The suit was settled, and on December 20, 2011, a Consent Decree was entered by the Court. This Implementation Plan is required by the Consent Decree and defines the strategies and mechanisms to implement the Decree and to meet the Court ordered benchmarks and timeframes. The Consent Decree requires Defendants to provide Class Members the necessary supports and services to allow Class Members to live in the most integrated settings appropriate to their needs in Community-Based Settings. The Consent Decree also requires Defendants to promote the development of integrated settings that attempt to maximize individuals' independence, choice, opportunities to develop and use independent living skills, and to afford them the opportunity to live their lives similar to individuals without disabilities.

1.2. Overriding Philosophy

The Colbert Decree and the Consent Decrees in *Williams v. Quinn*, 05 C 4673 (N.D. Ill.), for persons who reside in Institutions for Persons with Mental Disease (IMDs), and *Ligas v. Hamos*, 05 C 4331 (N.D. Ill.), for persons who reside or who are at risk of residing in Intermediate Care Facilities for the Developmentally Disabled (ICF-DD), advance the efforts to balance the long-term care system in the State of Illinois.

1.2.1. Principles

The Consent Decree's objectives are based on an individual's right to self-determination, informed choice and respect of that choice, person-centered planning, and the provision of the necessary services and supports to enable individuals to succeed in the community.

- Self-Determination is "the right of individuals to have full power over their own lives, regardless of presence of illness or disability. It encompasses concepts such as free will, civil and human rights, freedom of choice, independence, personal agency, self-direction and individual responsibility." (University of Illinois at Chicago (UIC) National Research Training Center on Psychiatric Disability.)

- Informed Choice requires the individual "to understand, or at least be able to understand, the information divulged, . . . [to] demonstrate a capacity for rational manipulation of information [and to] show that they not only understand the risks and benefits but also have weighed them in relation to their personal situation." (Lidz and Meisel, 1982.) To ensure Informed Choice, counseling a Class Member, listening to his/her expressed needs and desires, eliciting his/her concerns and offering pertinent information is necessary and will be required. The Qualified Professionals should confirm the Class Member's understanding of the available options and the expectations and consequences of a selection to affirm and document that an Informed Choice has been made.
- Person-Centered Planning is the "process designed to empower Class Members to make plans for their future according to their needs and desires, with the support of their legal guardians, family, friends, significant others or service providers as appropriate." For Class Members with Mental Illness, Person-Centered means a process based on a model of recovery.
- Care Coordination is the process and procedures to provide each Class Member with a single Care Coordinator (to the extent possible) throughout all stages–assessment, transition services and ongoing community supports and services–to enable the Class Member to build the necessary trusting relationship that facilitates transition to the community. Care Coordination is needed for all Class Members in the current fragmented healthcare environment in order to be able to attend to the complex health and behavioral health needs of Class Members in a holistic manner, and thereby produce better health outcomes.

The Qualified Professionals will be trained and expected to involve the Class Member, guardians, family, friends and/or his/her significant others, if applicable, in all aspects of Evaluation, care planning and transition. Class Members will be kept up-to-date to afford them the opportunity to make Informed Choices. The actions of the Qualified Professionals will be documented in Class Members' case records.

The Centers for Medicare and Medicaid Services (Federal CMS) guidelines for Home and Community-Based Medicaid Waiver and Money Follows the Person programs mandate enhanced quality assurance measures. These standards focus on participant-centered desired outcomes and address the development of performance measures, risk assessment and mitigation plans, 24-hour back-up capacity, and monitoring of health and welfare when and if critical incidents occur. Illinois' Medicaid waiver funded programs and services must comply with these Federal requirements. These quality assurance standards support a person's independence and promote a person's ability to live in the least restrictive environment.

Class Members' medical and behavioral health status will determine the Service Plan of Care and the environment required to support his/her state of health and well-being. The Parties anticipate that some Class Members may choose to remain in a nursing home even with proactive engagement and discussion of options to live elsewhere. An individual's choice, regardless of what that choice is, shall be respected. Class Members will be reEvaluated if needs and/or desires change.

1.3. Class Members

Class Members are all Medicaid-eligible adults with disabilities who are being, or may in the future be, unnecessarily confined to Nursing Facilities located in Cook County, Illinois, and who with appropriate supports and services may be able to live in a Community-Based Setting. Class Members include persons who have a primary diagnosis of mental illness but do not include persons with intellectual disabilities who are not likely to be residents of traditional nursing homes. There currently are between 16,000 and 17,000 Class Members residing in 186 long-term care facilities in Cook County, Illinois.

2. Implementation Plan Development

HFS has taken the lead responsibility for creating this Implementation Plan. HFS has worked collaboratively with Defendants the Office of the Governor, the IDoA, DPH, DHS and its Divisions of Mental Health (DMH) and Rehabilitation Services (DRS). HFS has conducted listening sessions with counsel for Class Plaintiffs. Public comments were heard in a series of face-to-face feedback forums and on-line responses to an Internet posting from July 13, 2012, through August 14, 2012, on an initial draft Plan. This document takes into account all of these comments.

3. Cost Neutrality

The Colbert Consent Decree requires the development of a Cost Neutral Plan 31 months after this Implementation Plan goes into effect. The Cost Neutral Plan must include a reasonable pace for transitioning all Class Members desiring to transition to Community-Based Settings at a cost the same or less in the aggregate to the State as if those Class Members had remained in the Nursing Facilities. This Cost Neutral Plan may not be implemented if the Defendants, Monitor and Counsel for Class Plaintiffs jointly determine, based on an analysis of the data and other information regarding the cost of moving the first 800 to 1,100 Class Members, that no remaining Class Member can be moved in a cost neutral manner. If the Parties cannot agree on a Cost Neutral Plan, the Parties may seek the remedies permitted in the Consent Decree. If a Cost Neutral Plan is agreed upon, then the Defendants shall develop a schedule to assess and transition the remaining Class Members. A workgroup comprised of the Court Monitor, representatives of HFS and counsel and experts for Class Plaintiffs is working on the issues relevant to the Cost Neutral Plan. This Cost Neutral Work Group will provide quarterly reports, starting on July 1, 2013.

4. Outreach and Education

The Implementation Plan includes informing and educating Class Members, their families, significant others and guardians about the Colbert Consent Decree. Some Class Members may have not yet considered transition to the community. For some, their original placement in a Nursing Facility followed an acute care hospital stay and moving to a Nursing Facility was required or perceived as the most appropriate option. Frequently, the health and welfare of the Nursing Facility resident has improved or stabilized so that transition to community residency is now appropriate and desirable. In other situations, Class Members were admitted to a Nursing Facility, because he/she lacked an alternative community residence and linkage to Community-Based resources for his/her health needs. Whatever the reason, an understanding that there are home and Community-Based options may not have been presented or appreciated at the time of the Nursing Facility admission. This Implementation Plan includes a proactive integrated approach by trained professionals to discuss alternative home and Community-Based programs and services to meet the needs of the nursing home resident, with a goal of transition to a Community-Based Setting. These trained professionals will use a person-centered approach and have expertise working with adults with physical disabilities and mental illness of all ages. It is anticipated that through the various strategies as defined in Section 5, the Class Members will have an opportunity to self-identify beginning with the implementation of the Plan.

4.1. Aging and Disability Resource Centers and Networks

The Aging and Disability Resource Center or Aging and Disability Resource Network (ADRC/ADRN) is a collaborative effort of the Federal Administration for Community Living and Federal CMS that were created in 2003. ADRCs currently operate in over 350 community sites across 54 States and Territories. The goal of an ADRC/ADRN is to streamline access to long-term care as a single one-stop and no wrong door entry using a coordinated system in a highly visible and trusted place where people of all ages,

incomes and disabilities can obtain information on the full range of long-term support options. ADRC/ADRNs will use the person-centered approach described as Options Counseling to assist consumers in exploring the full range of available long-term support options including home and Community-Based care.

The ADRC established in October 2008 in suburban Cook County is AgeOptions, an Area Agency on Aging working in collaboration with Community-based providers representing an array of disability populations and one of the 350 community sites mentioned above The Chicago Department of Family and Support Services (CDFSS) and the designated Area Agency on Aging for the City of Chicago, in collaboration with the Chicago Mayor's Office for Persons with Disabilities, is in process of developing an ADRN similar in concept to the ADRC. The ADRN is expected to form by the end of 2012. Both entities will be ready to perform Colbert Outreach and Education within 60 days of finalization of this Implementation Plan

Using the ADRC/ADRN for Outreach and Education builds upon an existing model of using cross-disability transition engagement specialists currently operational under a two year grant received by HFS from Federal CMS in the Fall of 2011. AgeOptions is one of the three sites in Illinois that is a recipient of this grant. Under this model, the Engagement Specialist speaks with Nursing Facility residents; develops professional relationships with Nursing Facility staff and convenes meetings with the stakeholder community. This Colbert Implementation Plan will extend and expand the existing model to the ADRN in Chicago.

Specific to the Consent Decree, representatives of the two ADRC/ADRNs will conduct Outreach to Class Members by conducting individual and small group meetings at the Nursing Facilities. The ADRC/ADRN will retain a total of two to three staff each, with the ADRN utilizing additional volunteers to conduct these Outreach and Educational sessions. AgeOptions will incorporate their current Engagement Specialist to support Colbert Class Member Outreach. In addition, the ADRC/ADRN will utilize Peer Support, as described in Section 4.2 to assist with engaging Class Members.

The ADRC/ADRN representatives will receive training to have a person-centered approach, and an expertise working and communicating with adults with physical disabilities and mental illness of all ages for their role in Outreach and Education. The training will include detailed information about the array of home and Community-Based options as alternatives to Nursing Facility care, an understanding of the strategies in the Colbert Implementation Plan and rights of Nursing Facility residents. The ADRC/ADRN representatives will enter into contract with HFS to implement the Outreach and Education portions of the Colbert Implementation Plan. HFS will inform the Nursing Facilities of the ADRC/ADRN role and expectations, the scope of their work and the start of these activities beginning in Fall 2012. The ADRC/ADRN actions are independent of the MCE schedules. However, they will initially use the same agreed upon schedule and expand their Outreach and Education activities to include up to 75 Nursing Facilities by the end of the first year. The ADRC/ADRN will utilize the Fact Sheet and Video in their individual and group sessions.

4.2. Peer Support Registry

The ADRC/ADRNs will develop, in partnership with the Defendants, a registry of peers of persons who have successfully transitioned to community residency. Staff of Community-Based agencies that have experience transitioning persons from a Nursing Facility to community residency also have a unique opportunity to further help identify peers of current nursing home residents to be participants in this peer support registry. The peers may be helpful to overcome Class Members' anxiety about moving and can be highly motivating by helping to answer Class Members' questions. Peers who agree to participate will

receive training on peer support, implementation requirements and expectations. The peers will also receive a small stipend for their efforts and assistance with transportation.

4.3. Ombudsmen

Ombudsmen have been engaged by IDoA to assist in the identification of Class Members desiring to transition to the community regardless of type of disability under the Pathways to Community Living/Money Follows the Person program. It is anticipated that this further strategy of outreach, education and information dissemination will continue to residents of Cook County Nursing Facilities.

4.4. Tracking Outcomes of Outreach and Education Activities

Class Members who self-identify through the Outreach and Education activities will either complete or be assisted in completing a self-referral by the representatives of the ADRC/ADRN on-line MFP referral form, which is available at http://www.mfp.illinois.gov as described in Section 5.1. Class Members who self-identify through engagement by an Ombudsman will either complete or be assisted in completing an on-line MFP referral form completed by the Ombudsmen. Regardless of the strategy, Class Members who self-identify will be reported to the Qualified Professionals performing the assessment and care planning activities for Evaluation. These actions will allow each Class Member to be tracked through the process from outreach and self-identification to Evaluation. Tracking, particularly from the Outreach and Education activities will provide data regarding the effectiveness of the Outreach and Education forums and conversations.

5. Informational Materials and Methods for Class Member Self-identification

All Class Members are entitled to request an Evaluation conducted by Qualified Professionals. Class Members already enrolled in a MCE will be encouraged by managed care staff to discuss community transition as part of their overall wellness plan.

5.1. Illinois Pathways to Community Transition/Money Follows the Person (MFP) and On-Line Referral Form

Pathways to Community Transition/MFP has an on-line referral form at http://www.mfp.illinois.gov. This on-line referral form allows individuals, families, significant others, guardians and Nursing Facility staff to self-identify or identify a Class Member for potential transition. HFS receives the referral and sends the referral to the Local Contact Agency (LCA) (Defined in Section 21.4) for follow-up. The Care Coordination entities for this Implementation Plan will be the LCA. HFS will track the self-referrals to ensure that a follow-up interaction has occurred with each of the Class Members.

5.2. Section Q Minimum Data Set (MDS)

The MDS 3.0 is a federally-required clinical assessment instrument used in nursing facilities to assess all Medicare/Medicaid residents. The tool assesses the Nursing Facility resident across multiple health domains, assists in the determination of health issues and drives the development of the resident's Plan of Care.

In 2010, the MDS instrument was substantially revised to require a more person-centered planning approach, with active participation of the Nursing Facility resident expected. Nursing Facility residents who indicate an interest in returning to the community will be referred to a LCA for follow-up. HFS will regularly monitor Nursing Facility compliance with referral requirements.

5.3. Fact Sheet

The Defendants will create a Fact Sheet to describe the key processes defined in this Implementation Plan, options available on how a Class Member can self-identify, what to expect in the Evaluation, development of the Service Plan of Care and transition to community residency. The Defendants will use the existing MFP brochure for MFP options**.**

5.4. Signage

Defendants will produce signage with the relevant terms of the Colbert Consent Decree. Defendants will require Nursing Facilities to post the signage**.**

5.5. Letters to the Guardians

Class Members may have court-appointed guardians. Class Members with appointed guardians, while not independently able to choose community residency, shall have the same rights as any other Class Member. Consequently, a letter from the Director of HFS or designee will be sent to the Office of the State Guardian, the Cook County Public Guardian and to appointed guardians to the extent the guardianship information is available, informing them about the Consent Decree and the processes defined in the Implementation Plan to reach Class Members.

In an effort to inform all guardians, beginning in the Fall of 2012, HFS staff will meet with each case worker of the Office of State Guardian and review their wards with the goal of identifying those who are likely to be candidates for transition. The names of the individuals initially identified will be shared with the Managed Care Entities (MCEs) for assessment. Once consent to participate has been given by the guardian, the Care Coordinator from the MCE will work closely with the guardian and the Class Member.

For those Class Members with a guardian, but not one from the Office of the State Guardian, beginning in the Fall of 2012, HFS will request that Nursing Facilities (subject to the Colbert Consent Decree) provide a list of all current Nursing Facility Class Member residents who have guardians and the name, address and contact information for all guardians. Guardians will be sent the above described letter. Once contact has been made, the Care Coordinator will be in contact with these guardians to discuss community re-integration of the Class Member.

5.6. Video

By January 31, 2013, HFS will develop a video for use at educational sessions and initial face-to-face pre-assessment meetings concerning transition to community living. The video will make every effort to include testimonials from former nursing home residents who have successfully transitioned to community residency and describe what to expect during the pre-assessment, assessment, care planning and transition phases.

6. Focused Approach to Class Member Identification Using Integrated Care Coordination

The Defendants will use MCEs to create integrated delivery systems to enable Class Members to access services in a coordinated and effective manner. Class Members will be identified using two parallel approaches. The first and primary approach is through participation in a MCE. Various methodologies to identify Class Members for transition are defined in this section. The second approach to identify Class Members for transition is self-identification. Once a Class Member is identified, by either strategy, a multi-disciplinary, integrated Care Coordination approach by Qualified Professionals will address all Class Members.

6.1. Focused Methodological Approach to Identification of Class Members

As shown in the Appendix Section 21.2 of this Plan, Defendants will select 1,175 Class Members for evaluation. These Class Members will be current enrollees in the Integrated Care Program (ICP) in suburban Cook County and will be selected from approximately 31 Nursing Facilities. From this selection, it is anticipated that 117 Class Members will be identified for transition to the community. Resource Utilization Groups (RUG), which categorizes Nursing Facility residents based on assessments of their clinical status and daily living needs data, will be used. HFS will select Class Members for transition from a variety of disability groups and ages in an effort to obtain a representative sample. From this group, at least the agreed upon number of Class Members as referenced in Appendix Section 21.2, will be identified to move to Community-Based Settings during the first year of implementation (Year 1). The process of Evaluating Class Members in these facilities and other facilities will be ongoing throughout the time period of the Consent Decree.

Also as shown in the Appendix Section 21.2 of this Plan, Care Coordination services through the contracted ICP vendors will be provided to Class Members who self-refer for transition under the Consent Decree and who are not already enrolled in one of the ICP Plans. Class Members who are also Medicare and Medicaid eligible (dual eligibles) will be able to participate in the Evaluation process. Defendants project that approximately 30 individuals who self-refer will be identified to move to Community-Based Settings in Year 1. The self-referral process will be reviewed near the end of Year 1 to determine whether it should be extended for a longer period of time. Class Members who are seen by one of the ICP vendors and are not enrolled in a managed care plan will be asked to sign an Informed Consent document authorizing the Qualified Professionals from the ICP to access his/her medical records.

By March 1, 2013, HFS will contract with the ICP vendors to serve nearly 2,000 Class Members in up to 30 additional Nursing Facilities in the City of Chicago. Each ICP vendor will be assigned approximately 15 Nursing Facilities. From this selection, it is anticipated that 153 individuals will be identified for transition to the community. This expanded selection of Nursing Facilities will cover Medicare/Medicaid dual eligible Class Members residing in Nursing Facilities in Suburban Cook County and Medicaid (non-dual eligible) Class Members residing in Chicago Nursing Facilities.

These strategies should result in at least 300 Class Members moving to Community-Based Settings during Year 1 as required by the Consent Decree. In Year 2, up to an additional 72 Nursing Facilities across Cook County will be selected. This selection will bring the total targeted number to 133 Nursing Facilities. By this time, Care Coordination will be provided through one of the MCEs to the extent necessary Federal approvals are obtained — the ICP, Care Coordination Entity (CCE), Managed Care Community Network (MCCN), or the Medicare/Medicaid Alignment Initiative. HFS will continue to contract for Care Coordination beyond Year 1 to the extent sufficient MCEs have not obtained Federal approval. At least 500 Class Members will move to Community-Based Settings for a total of 800 by the end Year 2.

As more MCEs become available, Class Members who have already transitioned to Community-Based Settings will be able to choose from among the MCE options in Cook County, including a CCE, MCCN or the Medicare and Medicaid Alignment Initiative for the dual eligible population.

Eighteen months following finalization of this Implementation Plan, a total of at least 2,000 Class Members then residing in a Nursing Facility will have received an Evaluation. By the end of the first half of Year 3, all 186 nursing homes in Cook County will be targeted, and the MCEs will be providing care coordination services. An additional 3,000 Class Members will receive Evaluations and an additional 300 Class Members, for a total of 1,100 Class Members, will have moved to Community-Based Settings.

6.2. Class Members in Managed Care Entities (MCEs)

State law requires at least 50% of Medicaid recipients to be enrolled in some form of Care Coordination by January 1, 2015. Care Coordination for all Seniors and Persons with Disabilities in Cook County, including Colbert Class Members, may be offered through a number of different MCEs. A MCE, may include: (1) either of the two managed care organizations on contract through the ICP currently operating in suburban Cook County and collar counties, (2) a new CCE being developed through the HFS Care Coordinations Innovations Project and covering the City of Chicago, (3) a new or existing Managed Care Community Network (MCCN) covering the City of Chicago, or (4) an entity on contract through the Federal Medicare and Medicaid Alignment Initiative, covering dual eligible Medicare-Medicaid clients in the City of Chicago and Cook County suburbs. MCEs selected for this Initiative will also be available to serve Medicaid only Seniors and Persons with Disabilities in Cook County.

All MCEs who have enrolled Seniors and Persons with Disabilities who will benefit from long-term care services, including Class Members, will be required to coordinate a service package consisting of healthcare services and Long-term Services and Supports (LTSS). All Medicaid clients who are Seniors and Persons with Disabilities who desire long-term care services, including Class Members, will be required to enroll in an MCE for LTSS.

At the present time, HFS anticipates that ICP healthcare services will be expanded to offer a service package of LTSS for its 40,000 members – including Class Members who reside in nursing facilities in the Cook County suburbs. The CCEs and MCCNs currently bidding through the HFS Care Coordination Innovations Project are expected to be under contract during Year 1 of implementation. The Medicare and Medicaid Alignment Initiative is expected to be ready for enrollment in late 2013 based upon approval from CMS. For dually eligible persons who are receiving LTSS services, HFS will require managed care enrollment in a Medicaid LTSS service package but will not require enrollment in a medical service package as Federal policy prohibits mandatory enrollment in Medicare managed care.

All of the Class Members will have a choice of at least two MCEs throughout Cook County on a phased-in basis, as various MCEs become available. As described above, initial contact will begin with currently enrolled ICP Class Members. As managed care options become available for the remaining Class Members, the Illinois Client Enrollment Broker (see Section 8) will begin the process of enrollment by explaining the choice of two or more MCEs and will make a referral to the appropriate MCE selected.

6.3. Analysis of Pathways to Community Living/Money Follows the Person Initiative

At the time of drafting this Implementation Plan, over 600 MFP participants have transitioned from Nursing Facilities to community living. At the end of 2011, 80% of the participants were still living in the community. HFS will examine the transition characteristics of these individuals to determine if a specific Illinois profile can be developed to help identify potential Class Members for successful transition and use the information learned to develop a focused selection and approach for those enrolled in a MCE.

6.4. MDS and RUG Groupings

The use of MDS 3.0 and Resource Utilization Groups (RUG) data clusters is one strategy to help identify Class Members in a systematic way. Group profiles from this analysis will be used to identify similar profiles among individuals currently residing in Cook County Nursing Facilities. Initial lower RUG score groupings will be used because this classification system uses information from the MDS assessment to classify Nursing Facility residents into a group that represents relative care resource requirements. Based on what the Defendants have learned from the MFP Initiative, Nursing Facility residents who have lower RUG scores are nonetheless likely to present with complex health histories and comorbilities.

6.5. Process and Goals to Achieve Benchmarks

Appendix Section 21.1 contains a chart that shows the breakdown of the current Class Members by age, presence or lack of a diagnosis of Serious Mental Illness (SMI), and the number of Class Members that are dual eligibles. The data is based on the MDS. Defendants are aware that a mix of Class Member characteristics is critical for Cost Neutral Plan data analysis. This mix will be accomplished through a review of Class Members by State of Illinois staff as Class Members are evaluated, and as they are encouraged to self-identify. A systematic tracking of their characteristics will be completed to ensure the transitions reflect the necessary complexity and diversity of population.

7. Colbert Consent Decree in Relationship to Pathways to Community Living/Money Follows the Person (MFP)

All Class Members who are eligible for MFP will be counted as MFP participants, but not all Class Members will be MFP eligible. To be eligible for MFP, a person must be a Nursing Facility resident for a period of 90 days or more, none of those days can be for the sole purpose of short-term rehabilitation, none of those days can be paid by other government sources such as Medicare, the participant must be a Medicaid recipient for at least one day prior to transition to community residency, and the participant must consent to the program. In addition, a participant of MFP must choose one of the following community settings: (1) a home owned or leased by the individual or a family member of the individual; (2) an apartment with an individual lease, secure access and living, sleeping, bathing and cooking areas over which the individual or his/her family has control; or (3) a community-based residential setting with no more than four unrelated individuals. In Illinois, a Supportive Living Facility (SLF) qualifies under #2 above. If a Class Member chooses a setting other than the three defined MFP options, he/she cannot be counted as an MFP transition.

The Consent Decree offers benefits to Class Members that are not part of the current MFP program. For example, a Class Member who has lived in a Nursing Facility for six months or more may be eligible for housing assistance under the Decree. Under MFP, a housing bridge subsidy is provided only to qualifying participants being transitioned by the Illinois Division of Mental Health, and MFP requires only a 90 day nursing home stay to qualify for this benefit.

The quality oversight and requirements defined in the MFP Operational Protocol will be beneficial to all Class Members regardless of whether they are eligible for MFP. The MFP Risk Inventory, Risk Mitigation Plan and 24-hour Back-up Plan provide tools to better ensure a successful transition. They consider how the needs of the Class Member will be safely met through pre and post transition planning by addressing and asking the participant and Care Coordinator to identify the Class Member's health, activities of daily living and social requirements. The 24-Hour Back-up Plan will help a Class Member identify alternative community resources in the event the primary supports break down or an unforeseen health crisis emerges.

All transitions under MFP enable the State of Illinois to receive an enhanced Federal match on the services provided to individuals for a one year period post transition. These additional dollars, under the MFP initiative, will be placed in a rebalancing fund that will be used for an expansion of home and Community-Based Services. Expansion of services will ultimately benefit all residents of Nursing Facilities including Class Members, transitioning to Community-Based Settings.

MFP transitions will be included in the benchmark number of transitions under the Decree where the MFP transition conforms with the benchmark requirements of the Consent Decree: the MFP qualified setting to which the Class Member is transitioned is a Community-Based Setting; the Class Member receives an Evaluation from a Qualified Professional; and the Class Member has a Service Plan. The Defendants

also intend to count Class Members who are enrolled in MFP in the projected benchmark numbers of transitions under the MFP program.

8. Illinois Client Enrollment Broker (ICEB)

As MCOs become available, each Class Member who is not yet enrolled in an MCE will be contacted by an Illinois Client Enrollment Broker (ICEB). The ICEB will be under contract with HFS to discuss options available to the Class Member to ensure he/she has an opportunity to make an informed choice regarding the managed care entity options. By enrolling in a MCE, the Class Member gives the MCE access to his/her medical records. Whatever option is chosen, the Class Member will be linked with a Primary Care Physician (PCP) and other allied health and mental health providers, as well as home and Community-Based Services in their network. Networks are to include current Medicaid Waiver programs, State Plan services and other governmental and non-governmental program resources.

9. Evaluation of Class Members Not Yet Eligible for MCE Enrollment

The timetable for Nursing Facility selection and Class Member identification represents a phasing-in of MCEs. In order that all Class Members have the opportunity for an evaluation prior to his/her enrollment in a MCE, HFS will contract with the ICP vendors to provide care coordination using an integrated approach. This strategy is to be in-place as noted in the chart in the Appendix Section 21.2.

10. Evaluation Using an Integrated Managed Care Approach

Every Class Member is a potential candidate for community transition. The Qualified Professionals charged with Evaluation will use a person-centered approach in all stages of Care Coordination, including the development of the Service Plan of Care. A Service Plan of Care must reflect the concept that a person should not be isolated in an institution or in the community. Some Class Members may suffer from a dementia where community residency may place them or others at risk of harm. Persons with a Severe Mental Illness may lack the capacity to perform tasks associated with community living such as shopping, cooking and medication management. While it would appear that these skills could be learned, Class Members must have the capacity and motivation to learn even under a framework of a person-centered approach. Evaluators will work with these Class Members to identify all possible resources in an effort to transition to less restrictive environments. Class Members will have planned reEvaluations except otherwise described in the Consent Decree.

10.1. Definition of the Qualified Professionals in the Multi-Disciplinary Team

All MCEs will retain a Care Coordination and management system consisting of a multi-disciplinary team which will constitute the Qualified Professionals described in the Consent Decree. The Qualified Professionals will ensure that Class Members' needs are addressed in a holistic fashion. The multi-disciplinary team will consist of Qualified Professionals holding the credentials required by each of their respective professions and disciplines. These members of the multi-disciplinary team are the Qualified Professionals. The team consists of:

- A health care professional, who will be an Advanced Practice Nurse, a Registered Nurse, or a Licensed Practical Nurse with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on physical health issues;
- A behavioral health specialist, who will be a Master level Clinical Social Worker with a minimum of two years prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities, who will focus on the mental health and social issues; and

- A Care Coordinator, who will be a Bachelor level professional with a degree in a health or human service area, or a Masters degree in Social Work, and a minimum of two years of prior direct service experience working with adults with physical disabilities or mental illness or older adults with disabilities.

These credentials are intended to ensure that the Qualified Professionals will possess the requisite skills in conducting Evaluations as described in the Consent Decree, assessments and interviews. Additional training, as set forth in Section 16 of the Implementation Plan, will be required to ensure team members are aware of community resources and benefits available to Class Members.

10.2. Quality Components – Evaluation, Risk Assessment and Mitigation

As part of the Evaluation, all possibilities and conditions, as well as the individual's strengths will be explored and addressed. Assessment instruments are only tools to further define and clarify. The Class Member's physical and mental health, including cognitive abilities, will ultimately determine who can transition. Transition decisions will depend on changes to the individual's physical and mental health. Where physical and/or mental health status may appear to place the individual at too much of a risk at the time of initial Evaluation (except where a medical doctor has diagnosed a medical condition that is unlikely to improve), a reEvaluation will take place to determine if improvement has occurred that would allow the individual to transition.

11. Successful Transition

The goal of this Implementation Plan is to provide Class Members with the resources they need in order to succeed in the community after they transition. A transition will not be viewed as successful if the Class Member is readmitted to a Nursing Facility or some other institutional setting in a short period of time. Class Members are likely to have complex needs and may have health conditions that are complicated. Class Members transitioned to Community-Based Settings are to maintain a relationship with their managed care professionals. Strong Care Coordination, at all phases of the process, is critical.

11.1. Responsible Entity for Conducting the Evaluation and Development of the Service Plan of Care of Class Members

In an effort to reduce redundancy and eliminate role confusion, all aspects of the process, from initial contact and engagement, Evaluation, development of Service Plan of Care and implementation of the Service Plan of Care will be the responsibility of the Qualified Professionals. These Qualified Professionals will be well-trained in available community resources and possess a multi-disciplinary skill set. The lead Qualified Professional assigned to and developing the long-term relationship with the Class Member, representing the MCE, will be called the Care Coordinator.

As required by Medicaid policies and procedures, an eligibility determination for a Medicaid waiver or State Plan mental health service may be involved. These frequently require the involvement of an organization such as a Care Coordination Unit (CCU) visiting a Class Member or conducting a review to determine eligibility. Even when these organizations are used, the Care Coordinator will be responsible for interfacing with providers and coordinating care and assistance for Class Members.

11.2. Initial Contact and Engagement

In addition to the ability to work effectively with Class Members, family members, significant others, friends, guardians and nursing home staff (including nurses, doctors, discharge planners and advocates), the Care Coordinators must be good listeners. Class Members will be encouraged to share life goals with

Care Coordinators as one of the means to begin to identify interest in community transition and begin the informal process of assessing the strengths and risks of the Class Member.

11.3. Multi-Disciplinary Teams of Qualified Professionals

The MCEs will initially conduct outreach and Evaluation by the Qualified Professionals. These teams will visit Nursing Facility residents, initiate engagement of the Class Members, and make contact with each Class Member regardless of age or status of disability.

11.4. Review of Nursing Home Medical Records

At the initial Nursing Facility visit and prior to a face-to-face conversation with a Class Member, the Care Coordinator and team will review the Nursing Facility medical records and begin to evaluate the Class Member's strengths and needs relative to planning for community transition. This review will determine whether a face-to-face meeting with the Class Member should take place. An example of a reason not to conduct a face-to-face preassessment is advanced dementia or current care for the end-stage of an illness.

If a Class Member's medical record indicates a significant mental illness, his/her last Resident Review and scores on the LOCUS (Level of Care Utilization System) will be reviewed. If a Resident Review has not occurred recently, either a member of the Qualified Professional team or another professional that is skilled at administering the LOCUS will administer the tool. A time frame will be established to review Class Members who are determined to meet the criteria identified for a follow-up assessment.

11.5. Face-to-Face Contact in the Initial Evaluation by a Care Coordinator

Class Members who have resided in an institutional setting for an extended period of time may not have considered returning to community residency. The Care Coordinator will meet the Class Member to engage him/her in a conversation to consider transition to the community.

The meetings will have several objectives:

- To learn where the Class Member hopes to be in the short-term and long-term;
- To learn why the Class Member is a nursing home resident;
- To understand what strengths and needs the Class Member may possess; and
- To begin a conversation regarding transition to community residency.

Class Members may need to talk with significant others or guardians in the community regarding transition to community residency. In addition, the conversation may lead the Care Coordinator to determine that transition to the community residency is premature, for example, due to preparation for a future surgery. In this instance, the Care Coordinator would document this outcome and plan for a future follow-up visit.

12. Evaluation/Assessment, Services and Service Plan of Care

Assessment and Evaluation involves speaking with the Class Member and those who he/she identifies as persons who should be involved in transition planning and in the development of a Service Plan of Care. The process not only involves the administration of assessment instruments, but also requires obtaining clarifications on current treatment protocols. While Nursing Facility medical records and discussions with Nursing Facility personnel can be valuable to create a comprehensive picture of the Class Member, further medical evaluations and consultations may be necessary.

As a result of an Evaluation and Assessment, the Qualified Professionals and Class Member will develop a Service Plan of Care to help meet the Class Member's identified needs. The Evaluation and assessment will provide a picture of what a person needs to be successful in the community. Needs will not be defined as a particular service; rather services will be identified that meet the Class Member's needs. The Qualified Professionals will evaluate all areas necessary to transition a Class Member successfully, including physical and behavioral health, nutrition, ability to perform activities of daily living and instrumental activities of daily living, social, recreational and spiritual, finances, informal supports, environment and housing requirements. The services necessary to meet the Class Member's needs will be contained in the Service Plan of Care and, subject to Section 12.5, will be those resources existing in the State's current service taxonomy for which the Class Member is eligible and which will meet the Class Member's needs.

12.1. Evaluation, Assessment and Assessment Tools

No single tool has been identified to assess or Evaluate a Class Member. A statewide effort is currently underway by the Defendants to identify such a resource that would assess cross-disability. Current tools may include the Illinois Determination of Need (DON), the Comprehensive Assessment Instrument used by IDoA, the MDS Home Care, the LOCUS and tools that the MCEs may select. Additional tools will include those designed to assess mental health and substance abuse. No one tool gives the Qualified Professionals a definitive picture of the Class Member. Putting the assessments together from an array of instruments, one-on-one conversations with the Class Member and his/her support system, and consultations with other professionals should provide enough information to give the Class Member the ability to make decisions for a successful Service Plan of Care.

12.2. Access to Medicaid Home and Community-Based Service Options

HFS is exploring options with the Federal CMS to enhance the benefits under the Pathways to Community Living/MFP initiative. The enhanced benefits may include demonstration services for a population for the first year post transition to community residency for those that qualify for MFP. Subject to Federal CMS approval a Class Member will be eligible for participation in an enhanced MFP program and make use of its benefits.

If a Class Member does not consent to participation in MFP, eligibility for other HCBS programs will be determined. The Qualified Professionals will use current standards to determine eligibility for HCBS waiver services. While the linkage with the actual providers of services is the responsibility of the Qualified Professionals, the eligibility determination for the HCBS waiver services is conducted according to the policies, procedures and rules of State agencies and as applicable by the Federal CMS.

The majority of Class Members may qualify and benefit from the array of HCBS options based upon his/her need. For example, persons who have physical disabilities between the ages of 18 to 59 may qualify for the Persons with Disabilities Waiver and/or State Plan services. Persons over the age of 60 may qualify for the Community Care Program under the Illinois Department on Aging and State Plan services. Persons 22 years of age and over may qualify for the Supportive Living Facility Waiver. Persons with SMI may qualify for various State plan services. There are a number of other waiver options depending upon meeting established criteria such as diagnosis of a brain injury or HIV/AIDS. Subject to Federal approval, Class Members may also have an enhanced MFP set of services.

To be eligible for waiver services, no new eligibility determination will be conducted for Class Members unless the last eligibility determination is more than one year old. A Service Plan of Care that utilizes the current eligibility determination will be used to establish waiver services. If the Class Member has not

received an eligibility determination for Nursing Facility or Community-Based Waiver Services in more than one year, the authorized entities will be called in to conduct the assessment of eligibility.

The current tool used in Illinois to access waiver services for persons with physical disabilities beginning at age 18 is the DON. The DON "score is derived from the Mini-Mental State Examination (MMSE), six activities of daily living (ADLs), nine instrumental activities of daily living (IADLs) including the ability to perform routine health and special health tasks and the ability to recognize and respond to danger when left alone. Each ADL, IADL and special factor is rated by level of impairment (0-3) and unmet need (0-3). Scores for each area are totaled and weighted toward people with moderate or severe dementia. The process is designed to target services to people with high levels of impairment who may have informal supports, and to people with lower levels of impairment without informal supports." (Mollica and Reinhard (2005), p. 2-3.)

The entities responsible for eligibility determination for the waiver services will determine eligibility in a timely manner. The Care Coordinator working with the Class Member will also ensure that a timely eligibility determination is made.

12.3. Access to Rule 132 – Medicaid Community Mental Health Services Program

The Care Coordinator will collaborate with the community mental health provider to determine eligibility for the Rule 132 – Medicaid Community Mental Health Services Program. The Division of Mental Health uses the LOCUS tool. The LOCUS determines the level of care needs across six domains. The Care Coordinator will identify and collaborate with mental health service providers in their networks to determine and further establish a comprehensive Service Plan. The strength of the cross-discipline integrated approach is the ability of the professionals to coordinate the Service Plan of Care and develop an integrated Service Plan of Care.

12.4. Social History and Service Plan of Care

All conversations with Class Members are opportunities to learn something relevant to the development of the Service Plan of Care. In addition to the various assessment tools that are used, a social history will be created as a cohesive narrative for each Class Member. A social history to explore the Class Member's past and future goals and aspirations will be useful for linkages to home and community-based resources, including mental health services, necessary for success in the community.

The last section of the Social History will be the Service Plan of Care. This section will present what services are to be arranged for and on behalf of the Class Member. This Service Plan of Care is expected to address those needs that were identified in the Evaluation and Assessment.

12.5 Data Gathering of Waiver Services Necessary for a Successful Transition to Community-Based Settings

Counsel for Class Plaintiffs and Counsel for Defendants have a disagreement over whether "Community-Based Services," as defined in the Consent Decree, include any and all services under any Illinois Medicaid Waiver[1] or only those services available under the particular Illinois Medicaid Waiver (Waiver) for which the individual Class Member is currently eligible. Although the Parties are agreeing to collect

[1] For purposes of the data gathering set forth in this section only, "any Illinois Medicaid Waiver" does not include the following waivers: Children and Young Adults with Developmental Disabilities-Support Waiver; Children and Young Adults with Developmental Disabilities-Residential Waiver; Waiver for Children that are Technology Dependent/Medically Fragile; or the Waiver for Adults with Developmental Disabilities.

and analyze certain data, as described herein, the Parties also disagree regarding the focus of the data analysis – *i.e.*, whether the focus of the data analysis is limited to the extent to which Class Members' ineligibility for services beyond the particular Waiver for which they are eligible is a barrier to successful transition to a Community-Based Setting or otherwise. Counsel for the Parties have agreed to defer Court resolution of this disagreement over the definition of "Community-Based Services," pending the completion of the data gathering and the Parties' analysis of the data described in this section.

Data will be gathered during the year following the first Evaluation on Class Members who fall into two categories: (A) Class Members who would need, in the opinion of the Qualified Professionals, one or more Waiver services not available under the particular Waiver for which the Class Member is currently eligible in order to transition successfully to a Community-Based Setting; and (B) Class Members who are eligible for a particular Waiver but who, in order to transition successfully, would need one of the eligible services in a quantity greater than the Waiver permits or a service that is not included within a service definition. The services described for categories (A) and (B) are collectively referred to as "Transition Necessary Services."[2] Transition Necessary Services are services vital to the Class Member's health or safety post-transition and, if they are unavailable, prevent the Class Member from transitioning to a Community-Based Setting.

As part of the Evaluation of those Class Members in categories (A) and (B), the Qualified Professionals will gather data and complete a survey as set forth below:

1. Evaluate, determine and document a Class Member's needs to transition without regard to the Class Member's eligibility for any Waiver.

2. Determine either (a) those needs can be met by the services available under an applicable Waiver for which the Class Member is eligible and that the Class Member is able to transition successfully; or (b) those needs cannot be met because the Class Member falls in either category (A) or (B) above, and Transition Necessary Services are unavailable, and thus the Class Member cannot transition to a Community-Based Setting.

3. If the Class Member is determined able to transition to a Community-Based Setting, the Qualified Professionals will develop one Service Plan of Care with those services available to the Class Member under an applicable Waiver for which the Class Member is eligible. The Qualified Professionals will not be required to develop any alternative Service Plan of Care for any transitioning Class Member. If the Class Member is determined unable to transition to a Community-Based Setting, the Qualified Professional will complete a survey (See Appendix 21.4) that includes a checklist of Transition Necessary Services.

4. The data gathered will not include data regarding:

    - Any Class Member or Guardian who has declined to take part in the Evaluation.

[2] For illustrative purposes, an example for category (A) would be a Class Member who is eligible for the Aging Waiver but would need the personal assistant service provided under the Disability Waiver in order to transition successfully. An example for category (B) would be a Class Member who is eligible for the Disability Waiver but would need more hours per day of the personal assistant service that are permitted under the Disability Waiver program as implemented by Defendants' rules and policies and as approved by the federal government in order to transition successfully. A second example for category (B) would be a Class Member who is eligible for the Aging Waiver and the adult day service under the Aging Waiver but would need a service component (*e.g.*, personal assistant service) that is not included in the definition of adult day service.

- Any Class Member identified in Section 10.2 of this Implementation Plan as one whose physical or mental health status places him/her at too much risk to transition even if all Waiver services were available at the time of the Evaluation.

5. The data gathered will include data regarding any Class Member who participated in an Evaluation and was offered a Community-Based Setting, but declined to transition. For such Class Members, the Qualified Professionals shall complete the survey indicating the reasons stated by the Class Member and/or Guardian for declining to transition.

The data will be made available to the Defendants, the Court Monitor and Counsel for the Class Plaintiffs no later than 90 days following the first Evaluation and quarterly thereafter. The collection of data will cease 12 months following the first Evaluation, unless the Parties and the Court Monitor agree that the collection of data will continue for an additional period of time. Counsel for the Class Plaintiffs and Defendants and the Court Monitor may each conduct their own analysis of the data. Each party shall be responsible for the costs of their analyses, which costs shall not be included for purposes of the development of a Cost Neutral Plan. The Court Monitor, Counsel for the Class Plaintiffs and Counsel for Defendants shall discuss what actions, if any, should be taken on this disagreement. Unless the Parties agree otherwise, no sooner than 120 days after the completion of data collection, the Parties may take whatever actions they deem appropriate on the disagreement set forth in this section and in the Consent Decree.

12.6. Pathways to Community Living/MFP Requirements

The goal is to utilize the resources, policies and procedures identified in the MFP Operational Protocol for Class Members under the Consent Decree. Care Coordinators working on behalf of Class Members who meet Pathways to Community Living/MFP requirements are required to fulfill the requirements of MFP. These requirements include the completion of a Risk Inventory, a Risk Mitigation Plan, a 24-Hour Back-up Plan and the Quality of Life Survey.

12.6.1. Risk Inventory and Mitigation Plan

MFP has developed an Inventory of Risk document. The Inventory of Risks and the Risk Mitigation Plan further define elements for successful transition and are additional tools in the development of a holistic evaluation of the Class Member. The Inventory of Risk document re-frames needs identified in the Evaluation into identified risks. The Risk Mitigation Plan subsequently identifies specific strategies, tasks and services that should reduce each risk. For example, a Class Member that has difficulty preparing meals or may have a history of non-compliance to a prescribed diet could have a notable nutritional risk. Risks will emerge from the review of all face-to-face meetings and assessment tools. The risks will be documented in the MFP Risk Inventory and will be linked with mitigation strategies through the computer software program. These strategies define actions that the Care Coordinator, working in conjunction with the Class Member, should address in a Service Plan of Care.

12.6.2. 24-Hour Back-Up Planning

MFP requires the completion of a 24-hour Back-up Plan. The development of this 24-Hour Back-up Plan, prepared in conjunction with the Care Coordinator, Class Member, his/her identified significant others and guardian, if applicable, is expected to be a valuable resource once the Class Member resides in the community. This document is one of the critical pieces and tools in sustaining a successful transition. The best intended plans often experience unanticipated challenges. Persons who agreed to provide assistance to Class Members may fail to live up to expectations. In addition, the Class Members may have physical and/or mental health issues that require emergency or alternative assistance. A 24-hour

Back-up Plan is not synonymous with calling 911. While reaching out to emergency services may be required, alternative resources should be put into action if plans fail to meet expectations.

12.6.3. Quality of Life Survey

The Pathways to Community Living/MFP requires the administration of the MFP Quality of Life Survey to measure the individual who is transitioning and his/her perceptions relating to quality of life in seven domains. These domains are living situation, choice and control, access to personal care, respect/dignity, community integration/inclusion, overall life satisfaction and health status. The survey is to be administered to all participants at three points in time, just prior to transition, about 11 months after transition and about 24 months after transition.

12.7. Care Coordination and Service Plan Conferences

Care Coordinators and service providers within their networks are to work collaboratively to ensure that all of the Class Members' needs are addressed. A minimum of one care conference will take place prior to transition to community residency. The care conference will include the Class Member and any significant others he/she chooses, the Care Coordinator, the guardian, if applicable, and other professionals affiliated with the MCE, home and community-based service providers and mental health providers. HFS staff will participate from time-to-time in these care transition conferences to ensure all processes and identifiable needs are being adequately addressed. The other participants in this care conference may include Nursing Facility staff knowledgeable about the care and care giving that is presently being provided in the Nursing Facility on behalf of the Class Member.

12.8. Quality Assurance Resources Available through Pathways to Community Living/Money Follows the Person

The Pathways to Community Living/MFP Initiative has as part of its Operational Protocol a quality assurance team led by a nurse who reviews the service plan of care. This quality assurance activity takes place via a conference call and is an additional assurance that all medical needs are sufficiently addressed. This conference, prior to discharge, will further ensure quality to the plan development by the MCE and fulfill the expectations set-forth in the MFP Operational Protocols.

13. Class Member Finances

A comprehensive assessment of each Class Member will include understanding his/her finances. A Class Member may require income to transition successfully into a Community-Based Setting, such as a private residence or permanent supportive housing. Depending upon the unit in which the Class Member seeks to live, he/she may need to meet income eligibility requirements for any Federal or State housing assistance program.

Class Members may receive income from many sources and will be required to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled, including, but not limited to, Veterans' compensation and pensions, benefits from the Old Age, Survivors, and Disability Insurance program (OASDI) of the Social Security Administration (which includes common Social Security retirement benefits, survivor benefits, and Social Security Disability Insurance (SSDI) benefits), railroad retirement benefits, unemployment compensation, and/or income from Supplemental Security Income benefits (SSI). The Care Coordinator will link the Class Member to resources and/or legal advocates for the applicable population to assist with the applications for any sources of income and for any appeals of eligibility denials for such income. Each Class Member's financial picture should be

reviewed as early as possible in order to avoid delays in transitioning to the community due to a lack of necessary income.

14. Housing

The Consent Decree states that Class Members should transition to Community-Based Settings that promote "independence in daily living and ability to interact with persons without disabilities to the fullest extent possible." These settings include "a private residence, a Supportive Living Facility, Permanent Supportive Housing, or other appropriate supported or supervised residential settings that are specifically chosen by the Class Member." Class Member preferences, availability and type of setting will be factors for the Class Member to consider when making his/her choice.

14.6. Identification of Housing

14.6.1. State Housing Coordinators

The Governor's Office currently employs two Housing Coordinators to identify means of enhancing housing opportunities for special needs populations including Class Members. One Housing Coordinator is focused on housing opportunities in Cook County and the other Housing Coordinator has State-wide Housing responsibilities. The Housing Coordinators are to expand networking opportunities, partnerships and relationships thereby facilitating the expansion of housing resources including PSH, access for Pathways to Community Living/MFP, housing opportunities for Class Members of the Consent Decrees and management of the referral flow to IHDA's Low Income Housing Tax Credit Units. A portion of IHDA's Low Income Housing Tax Credit units are targeted to persons with disabilities and referred through a State referral network that includes, but is not limited to, Class Members of the Consent Decrees.

14.6.2. Care Coordinator Responsibilities for the Identification of Housing

The Care Coordinator will work in conjunction with the Housing Coordinators and the Class Members to identify housing. The Care Coordinator will work with each Class Member to determine the best options. The Housing Coordinators will help in identifying the properties that meet these options.

Care Coordinators will work with each Class Member to explore all options including family, guardians, friends, significant others, newspaper advertisements and options identified through an on-line State funded housing search inventory. The Illinois Housing Search web based search engine is an available resource that contains thousands of units landlords have available to rent in the private market place. This website contains a caseworker portal that allows Care Coordinators to search a subset of housing options wherein landlords have expressed a specific willingness to rent apartments to persons with disabilities. Class Members, as part of their goal to be independent and invested in the transition, need to be active participants in the housing search.

14.6.3. State-funded Internet On-Line Housing Locator

The primary on-line State funded housing search inventory is the Illinois Housing Locator, www.ILHousingSearch.org. Class Members and Care Coordinators can access this site which lists housing by location, features, vacancy, and other criteria. Care Coordinators will have secure access to a web portal that enables them to search for housing options that may be targeted to populations represented by the various Consent Decrees and the Pathways to Community Living/Money Follows the Person initiative. This option further advances the ability to access additional and more detailed housing information relevant to the populations whom they service. Once a unit or housing option is located, the

Care Coordinators will assist in making arrangements for the Class Member to visit the property. A factor in the decision to choose the property may relate to assuring accessibility.

14.7. Assessment and Guidelines for Home Modification

Housing units that appear to require home modification to meet the needs of the Class Member will be referred to an assistive technology program and/or any other available programs. The Assistive Technology program will be under contract with one or more of the Defendants and will work with the MCEs to provide:

- An onsite assessment and production of a field sketch, specifications and scaled drawings of what needs to be done:
- Bid Solicitation, review contractor's proposal and review with Care Coordinator; and
- Project Management of selected contractor and authorize payment to contractor

The goal of the modification is for the Class Member to perform independently his/her ADLs, have a decreased need for assistance from another individual in the completion of his/her ADLS, prevent an anticipated increase in service costs, or improve the safety of the Class Member during the completion of his/her ADLs.

The modifications are limited as follows:

- Will be granted if there are no other public resources that will provide the modification;
- Will be reviewed after determination of private resources (the availability of private resources is not a barrier to eligibility for housing modification); and
- Home accessibility adaptation costs, including but not limited to the cost for home evaluation, purchase of all modifications and assistive equipment purchases, rentals and repairs does not exceed $5,000 in accordance with the terms of the Consent Decree.

14.8. Housing Assistance

The Consent Decree states that following a review of the finances of a Class Member, financial assistance for housing may be required. The Consent Decree also establishes specific limitations to access financial assistance. The specific criteria can be found on pages 7-9 of the Consent Decree. The housing assistance is calculated by the difference of the actual or Fair Market Rent less any government funded housing subsidy and 30% of the Class Member's income. Class Members are to seek alternative arrangements or financing that may include accessing Section 8 HUD Vouchers or other public or privately supported housing programs.

At the point of transition and the development of the Service Plan of Care, the Care Coordinator will arrange for a home inspection by an identified home inspection agent. This agent has responsibilities separate from those previously described as relating to accessibility and home modification. All identified properties where the future Class Member tenant requires financial assistance to help pay rent must be inspected in order that it meet the United States Housing and Urban Development (HUD) approved Housing Quality Standards. Based upon the inspection, properties may require corrective actions for needed repairs. These repairs will be subject to the establishment of a timeline for the completion. The correction of deficiencies will require re-inspection before a property can be occupied and its future tenant is eligible for the State-funded housing subsidy.

The Care Coordinator will work in collaboration with the Fiscal Agent, (described in Section 14.6) and has the responsibility for the monthly disbursement of housing subsidy funds. The establishment of the exact subsidy amount is formula-based.

14.9. Identification of Long-term Rental Subsidy Supports

The various rental subsidy support programs are listed in Section 21.3 of this Implementation Plan. The State has made and will continue to make efforts to increase access to and availability of rental assistance to Class Members.

14.9.1. Collaboration with Local Public Housing Authorities

The Housing Coordinators and IHDA are working with local Public Housing Authorities to increase the availability of access by Class Members to their rental assistance programs and units. This collaboration is developing methodologies within the context of existing HUD policy guidance for both tenant-based assistance and project-based units. Examples include enhancing the availability of Housing Choice Vouchers for the elderly and persons with disabilities, as well as obtaining access for Class Members to vacant public housing units that exist within certain public housing authorities in the State.

14.10. Guidelines for Costs Associated with Moving and the Establishment of Household

Financial resources are available to provide a Class Member with the necessary items and services to transition to community residency. One-time transition costs fall under five broad categories as defined on page 12 of the Consent Decree. On page 13 of the Consent Decree, there are defined costs that may not be counted as expenses associated with moving and the establishment of a household. The Care Coordinator will coordinate the needs of a transitioning Class Member and make the necessary arrangements to secure these items. These transition costs may not exceed $4,000.

14.11. Fiscal Agent

The Fiscal Agent, under contract with one or more of the Defendants, will be a single independent entity responsible for working with all of the MCEs. These authorized funds may include a housing rental subsidy, rent for any temporary stay in a hospital or long-term care facility, and approved costs associated with the establishment of a household as defined in the Consent Decree and not to exceed $4,000 for the lifetime of the Class Member.

Housing units that are selected and meet the needs of the Class Member will be referred to the Fiscal Agent to handle all aspects of the Housing Assistance Benefits that are identified under the Service Plan of Care. The specific services of the Fiscal Agent include:

- Coordinate with HFS and the MCEs regarding the Assistive Technology Assessments and Home Modifications to secure landlord resources;
- Conduct site visits to ensure HUD Quality Standards inspection are met in every case and document inspections annually thereafter;
- Process housing assistance;
- Coordinate with the Care Coordinator regarding the enrollment process for permanent rental subsidies with HUD or the Illinois Housing Development Authority for Class Members in the Housing Assistance program;

- Inform and work with the Qualified Professionals of Class Members receiving Housing Assistance on housing stabilization skills;
- Assist, as needed, with terminations of Class Member lease agreements in the event of failure on the part of the landlord to comply with provisions in the Class Member's individual lease agreements and/or a decision on the Class Member to move to another residence in the community because of acceptance into another rental subsidy option or in the event of reinstitutionalization in a long-term care facility; and
- Manage a system of payment of expenses regarding moving and setting-up the household.

15. Relationship of Colbert Implementation Plan with Various State Agencies

Many of the programs and services that Class Members will receive once transitioned to community residency are part of the various Medicaid waivers and State Plan services. As Illinois moves and advances the inclusion of these programs and services to a managed care environment, the Defendants are engaged in an on-going process of redefining the relationships of the service providers to current and future MCEs. Many of these same service providers may be members of the networks organized by the MCEs, having the same, modified or new roles. Class Members will be part of this transformation to care coordination and managed care. Through established monthly meetings addressing long-term care reform and other on-going discussions among the Defendants, processes are in place for ongoing collaboration in relationship to the Implementation Plan.

16. Training and Supervision of Qualified Professionals

MCEs contracted by HFS for the Consent Decree will be required to have procedures in place for retaining, training and supervising their respective staffs. Evidence of such protocols will be required under the terms of their contracts. HFS has required and will continue to require all of the MCEs to have quality assurance procedures in place to show that they are able to demonstrate adherence to various Federal rules and laws related to managed care.

With recognition of a changing environment for service provision, delivery and a new model of care coordination bringing medical and non-medical resources together using an integrated care approach, education will be beneficial. MCEs will be required to provide a plan for on-going training of its staff and encourage their staff to attend State and local conferences and workshops. Also, Defendants will periodically provide training specific to the MCEs to insure a well-informed staff working with each Class Member.

16.6. Training Components

The MCEs will provide a training program. This training will be provided by academics, practitioners and professional staff from the MCEs and HFS and its sister Defendant agencies. Members of the Qualified Professionals, because of previous clinical training, experience and acquired degrees and certifications, may not need to participate in certain topics of the training. Qualified Professional members may provide some of the training. In addition, all MCEs will be required to submit a training schedule annually beginning with the implementation of this Plan and at the beginning of Year 2 and Year 3 of the Implementation Plan. At a minimum, the training for all members of the multi-disciplinary integrative teams will include all topics that are identified in the list below.

Training will include:

- Background to the Consent Decree;
- The Holistic Approach to care coordination using a Multi-Disciplinary Integrative Approach;
- Building Positive Relations with Nursing Facilities;
- Engagement of a Class Member Regarding the Consideration of Community Transition;
- Multicultural Competence;
- Philosophical Approaches to Meeting the Needs of Various Populations with Disabilities;
- Social Work Methods of Person Centered Practice, Strengths Perspective, Person in Environment;
- Health and Disease Management;
- Physical and Behavioral Health Management and Treatment Options;
- Motivational Interviewing;
- Substance Abuse Management and Treatment Options;
- Nutrition;
- Caregiver Supports;
- Safety in Relationship to One's Environment:
- Evaluation and Assessment Processes;
- Assessment Tools, Expectations of Evaluation and Assessment and the Development of the Service Plan of Care and Budget Plan;
- Training on all MFP forms:
- Financial Assistance and Insurance Programs – OASDI, SSDI, SSI:
- Medical Assistance Benefits:
- Long-term Services and Supports (LTSS); Waiver options;
- Rule 132 Mental Health;
- Older Americans Act Programs;
- Legal Issues that include POAs and Guardianships;
- Informal Supports;
- Housing Resources; and
- Professional Ethics.

16.7. Contractual Expectations of MCEs in Regards to Retention and Training

All MCEs are required to meet expectations set forth in contracts between the individual MCE and HFS. These contracts require that MCEs, at the request of HFS, secure documentation of compliance that Qualified Professional members meet or exceed the definitions of a Qualified Professional as stated in Section 10 of this Implementation Plan.

17. Quality Assurance Activities and Actions to Comply with Obligations Under the Decree

Quality Assurance activities are designed to ensure that services, supports, processes and successful maintenance in all phases of implementation and stages of care coordination beginning with Evaluation through transition to community residency, meet appropriate standards of quality.

17.1. Monitoring of Outreach and Education

Defendants will monitor the activities of providers engaged in Outreach and Education. In addition, Defendants will report, document and affirm the value of these Outreach and Education activities. While it is expected that those provider entities will provide Outreach and Education in a professional and

quality manner, State agencies will measure the effectiveness by tracking the number of transitions attributed to the Outreach and Education activities. Currently, there are processes in place that record the number of referrals generated by ADRC/ADRNs. The on-line self-referral system for Pathways to Community Living/MFP will record all self-referrals. Class Members and the providers will be instructed to use these current systems so that effectiveness is measured.

17.2. Compliance, Communication and Reporting with MCEs

The lead Colbert staff person from HFS will be meeting and speaking with the identified and assigned staff from each of the MCEs on a regular and consistent basis. A schedule of these meetings will be developed beginning in the Year 1 and continuing through the full implementation of this Plan. The lead Colbert staff person from HFS will periodically attend Qualified Professionals meetings of preassessment, evaluation and care planning sessions of Class Members through the pre and post-transition process to ensure that MCEs are in compliance with expectations and to hear the progress and issues that emerge. Most of the pretransition sessions will take place at the Nursing Facilities and involve Class Members. The lead Colbert staff person from HFS will also make on-site visits and observe the Qualified Professionals in operation and also shadow the Care Coordinators on occasion to ensure that the needs of Class Members are being adequately addressed and that professionalism and quality are the hallmark of all Colbert related activities.

MCEs will provide weekly progress reports. These reports will include success stories, problems encountered, service planning needs and nursing home relations. Statistical data will report the number of contacts and the outcomes of initial reviews, number of persons engaged in transition planning, and the number of Class Members who have successfully transitioned. In addition, MCEs will need to provide a status report of how Class Members are doing post transition. For Class Members who are enrolled in the MFP Initiative, MCEs are required to adhere to all MFP Operational Protocols and procedures.

17.3. Ensuring Cultural Competence of Qualified Professionals

In addition to assuring that Qualified Professionals are trained and sensitive to working with Class Members of different ethnicities and cultures, MCEs will provide appropriate language translators for Class Members whose primary language is not English and ensure the ability to communicate with Class Members with special needs. MCEs will have various assistive technologies available to conduct Evaluations and to assess, develop and implement a Service Plan of Care.

17.4. MCEs' Internal Quality Assurance Activities

Internal processes for monitoring the quality of all activities will be required by all MCE contracts. The MCEs will incorporate accepted practice guidelines that are based on valid and reliable clinical evidence and consider the needs of their enrollees. As the contractors develop the work of assessment, pre and post transition planning and care coordination, they will be provided a written description of a Quality Assurance Plan (QAP) that includes medical and nonmedical related services, care coordination, care management, disease management and behavioral health services. This QAP must include: goals and objectives, scope, methodology, activities, provider review, a focus on outcomes, processes of quality assessment and improvement and consumer input. A more detailed description of these requirements will be found in the contracts with these entities. The contract will give HFS oversight authority over these QAP measures. A uniform method of reporting outcomes will be developed with each contract entity. HFS staff will also be making on-site visits to the nursing homes as assessment activities are performed, and randomly participate in pretransition and post-care coordination conferences.

17.5. Ensuring Quality Performance and Network Adequacy

The Defendants plan to have their own multi-disciplinary team representing HFS, DRS, DMH and IDoA to serve as an Oversight Committee. This committee will conduct random sample reviews of individual Class Member's Service Plans of Care to affirm that Class Members' needs are being adequately addressed. The knowledge and experience of State staff serving on this Oversight Committee will be valuable in assuring that MCEs are utilizing all available LTSS, in addition to medical treatment protocols. This Oversight Committee will also conduct random samples and reviews of all other contracted providers engaged in this Implementation Plan. This Oversight Committee will also allow the Defendants to review reports from the MCEs and address service and program gaps and capacity issues that may emerge. The Oversight Committee will affirm that individual Class Member's rights are respected and the key philosophical principles identified in the Consent Decree and Implementation Plan occur in all activities.

17.6. Corrective Action Steps

In the event HFS believes corrective actions need to be taken, written notification will be provided to that entity. The entity will be required to develop and implement a corrective action plan in accordance with the terms their contract.

18. Information Systems

During the drafting of this Implementation Plan, HFS has begun to explore what options are available to build upon existing IT systems. There are no current plans to develop another IT system specifically for the Consent Decree.

While the IT system issues are being identified, a system to provide information pertaining to the following will be required of the MCEs. This information includes: (1) File Review/Screening; (2) Initial Face-to-Face; (3) Assessment(s); (4) Social History and Service Plan of Care including housing; (5) Referrals to Community Resources; (6) Referral for Fiscal Agent and Information regarding Class Member finances and Home Inspection; (7) Referral Form for Home Modifications; and (8) Study of Services. In addition, regardless of whether a person is enrolled in MFP, the Care Coordinator will complete the MFP Risk Inventory, Risk Mitigation Plan, and a 24-Hour Back-up Plan as these are current and future requirements of all Medicaid waiver programs.

The system will provide information to track all Class Members as they progress from a medical record file review and screening to transition to community residency. The use of this information will enable the Defendants to report accurately the status of Class Members and provide data on the progression in reaching the Consent Decree benchmarks.

19. Appeals

The Consent Decree provides that Class Members have the right to appeal disputed decisions through the Defendants' existing fair hearing processes and may also avail themselves of any informal review or appeal process that currently exists. The appeal process will be outlined in a fact sheet (and include contact information) to be given to each Class Member. This fact sheet will explain rights, responsibilities and expectations of a participant who initially agrees to explore transition to community residency under the terms of the Consent Decree. This fact sheet will be given to the Class Member and reviewed by the Care Coordinator upon a verbal affirmation made by the Class Member that he/she wishes to pursue transition to community residency.

20. Finances

Each year of the Consent Decree, the Defendants will prepare and submit to the Governor's Office of Management and Budget (GOMB) budget proposals for inclusion in the Governor's Introduced Budget. These proposals will describe the programmatic purpose, amount of funding, and appropriation authority, if necessary, to ensure that provisions of the Decree are carried out. Elsewhere in this Implementation Plan, the specific tasks, timetables and goals necessary to carry out the provisions of the Decree are set forth. These comprehensive proposals will be coordinated across all Defendant agencies and will strive to ensure that funding for purposes, timetables and goals associated with the Decree are justified and included in the Introduced Budget. Based on the Implementation Plan, the known resource needs include:

- Court Monitor Compensation and Reimbursement
- Outreach/Education
    - ADRC/ADRN Contracts
    - Peer Registry
    - Tracking Outcomes of Outreach and Education Activities
    - Informational Materials
    - Methods for Class Member Self-Identification
- Implementation
    - MCE Evaluation and Transition Coordination Contracts
        - Includes services of Qualified Professionals for Evaluation, Service Plan of Care development and implementation, utilization of assessment tools, meeting requirements of Community-Based Services such as the quality assurance MFP requirements, identifying housing and on-going care coordination in the community.
        - Training of Qualified Professionals (may be included as part of fee paid to MCE)
    - Enhanced rates paid to MCEs for transitions and Care Coordination in fully capitated models.
- Illinois Client Enrollment Broker Contract
- Community-Based Services (after first year of implementation, may be included as part of MCE fee)
- Quality Assurance Activities and Actions
- Home Accessibility Adaptation Costs (including project management, development and review of specifications for modification and contractor fees)
- Housing
    - Housing assistance
    - Transition Costs
    - Fiscal Agent
- Administrative costs specific to the Implementation Plan
- Information/IT Services specific to the Implementation Plan

21. Appendices

21.1. Chart Showing Current Breakdown of Class Members

Chart shows the breakdown of current Class Members by age and whether or not there is a diagnosis of a Serious Mental Illness (SMI). Data also shows how many of the Class Members enrolled in Medicaid are also enrolled in Medicare as indicated by the term "Dual."

< 60	< 60	60 – 64	60 – 64	65 +	65 +	Total	
SMI	No SMI	SMI	No SMI	SMI	No SMI	Medicaid	Dual
3225	1691	928	836	2803	7983	17466	14094

21.2. Timetable and Nursing Home Selection for Colbert Implementation Plan

Timetable and Nursing Home Selection for Colbert Implementation Plan

Year	Target Date to Begin Process	Strategy using Qualified Professionals	Target # of nursing homes for each year	Quarter in which Initial Review and Evaluation process begins and becomes ongoing	Target # of Class Members for Initial Review and Evaluation	Anticipated # of Class Members Choosing Community Residency
Year 1/First Quarter	01/15/2013+	Integrated Care Program in Suburban Cook County -- Seniors and Persons with Disabilities (SPD) Medicaid clients only	Up to 31 NHs * ** Will serve their own members	Year 1/First Quarter	1175	117
Year 1/First Quarter	01/01/2013	Year 1 Transition Plan: Care Coordination services contracted with ICP vendors, for persons who self-identify (not already in ICP Plans -- Duals in Suburban Cook; any SPD in Chicago)		First Quarter/Year 1; Process will be evaluated if needed to continue in Year 2	Unknown	30
Year 1/ Second Quarter	03/01/2013+	Year 1 Transition Plan: Care Coordination services contracted with ICP vendors to cover residents who are Duals in Suburban Cook or any SPD in NHs in Chicago	Up to 30 additional NHs for a total of 61 NHs * ** Each vendor to be assigned 1/2 half of NHs	Year 1/ Second Quarter	1530	153
Year 1/ Second Quarter	05/05/2013	Within 180 days following the finalization of the Implementation Plan, at least 500 Class members residing in a Nursing Facility shall receive an Evaluation by Qualified Professionals.				
Year 1/Third Quarter	10/01/2013+	Year 1 Transition Plan: As Class Members are ready to transition to community, they will have full array of MCE options across Cook County, including CCEs, MCCN, Medicare and Medicaid Alignment Initiative for Duals				

Year 1/ Fourth Quarter	First Year Benchmark of Transitions – November 5, 2013			Year 1/ Fourth Quarter		300
Year 2	11/05/2013+	Choice of full complement of MCEs providing all needs	Up to an additional 72 NHs for a total of 133 NHs ***	Year 2/ First Quarter	5000	500
Year 2	05/05/2014	A total of at least 2,000 Class Members then residing in a Nursing Facility shall have received an Evaluation		Year 2/ Second Quarter		
Year 2/ Fourth Quarter	Second Year Benchmark of Transitions – November 5, 2014			Year 2/ Fourth Quarter		800
Year 3 (2 yrs. & 5 mos.)	02/20/2015+	Choice of full complement of MCEs providing all needs	All 185 NHs in Cook Co.	Year 3/ Second Quarter	3000	300
Year 3 (2 yrs. & 5 mos.)	End of Third Year Benchmark of Transitions – May 5, 2015			Year 3/ Second Quarter		1100

\+ Dates in this table as they relate to the future availability of MCE options are tentative and conditioned on Federal approval. HFS will continue to contract for Care Coordination services beyond Year 1 of the Implementation Plan as necessary until MCEs are approved by the Federal government and become available.

* More nursing homes will be targeted if necessary to reach required benchmark by end of year.

** Demographics of Class Members may be found in separate charts.

*** Additional nursing homes to be determined.

21.3. Colbert Housing Options – Summary for Transition Planning

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
State Administered Housing Finance Programs				
1. IHDA Tax Credit Targeting Program (LIHTC Targeting Program)	Participating Developers set aside 10%-20% of units for PSH at rents that do not exceed payment of 30% of adjusted household income for households with extremely low incomes at or below 30% of HUD Area Median Income. Supportive services providers refer consumers to the State Lead Referral Agent for referral and processing of rental applications by the property manager, as available.	IHDA Low Income Housing Tax Credit Program	575 units developed since 2008. Approximately 175 units added annually. Units in program are available for 30 years on turnover basis after being made initially available at project opening for a 90 day marketing period	1. Because rents are already established at a lower level for 30%of AMI households (Average $400 in Chicago for 1 BR), cost of rental subsidy is low relative to subsidy levels at HUD Fair Market Rent of $853 for 1BR. Successful placement of class members in targeted units with Bridge Subsidy or other rental assistance will increase the number of units that can be provided with the available resources
2. Build Illinois Bond Program	Provides Capital Grants for new construction/rehab of PSH	Governor's Office Allocation to IHDA	$17 million allocated to finance 122 units under Demonstration Program in 2011; $40 million in additional bond proceeds to be provided as part of a PSH Request for Applications, which were due on 9/24/12	1. Includes HomeFirst Illinois/Access Living Initiative, Thresholds scattered site initiative, and other PSH Initiatives; 2. With 2012 funding round PSH is receiving 54% of $130 million in total commitment of Build Illinois Bonds for Affordable Housing under the State Capital Authorization

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
State Administered Rental Assistance Programs				
3.Rental Housing Support Program (RHSP)/(LTOS)	State of Illinois provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent	Mortgage document filing fee at County Recorder of Deeds. IHDA Receives $9 of every $10 per recorded document to fund RHSP	$10 million in funding announced in 2012, which will provide for the availability of approximately 150 units for persons with disabilities	1. Original RHSP Authorizing Statute precludes preference for persons with disabilities 2. Illinois Legislature adopted, and Governor just signed P.A. 97-0892 which allows IHDA and its Local Administering Agencies to grant a preference for persons with disabilities under the RHSP. IHDA just announced the availability of RHSP dollars for a new round of Long Term Operating Support (LTOS), with applications due on 10/24/2012. Recipients must be at 30% AMI, with 50% targeted at 15% of AMI or below.
4. Bridge Subsidy Program("BSP")	Provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent	IDHS – Division of Mental Health receives funding from Hospital Lockbox and GRF per Governor's FY 13 Budget	700 units currently subsidized under BSP; program is expanding to provide housing subsidy for Williams and Colbert class members	1. Current BSP administered for the State by Catholic Charities for persons with Mental Illness 2. Program model can be replicated for Colbert Class 3. Program has reputation for efficiency and excellent administration/payment cycles and inspection protocol 4. Out of 700 Bridge Subsidies to date only five evictions 5. Transition Coordinators experienced in use of BSP to house persons with disabilities; State Housing Coordinators and Divisions are working to expand the supply of landlords accepting BSP 6. Caseworker Portal on Illinois Housing Search housing search engine provides supportive service providers with access to database of landlords who have expressed a specific preference to house persons with disabilities

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
5. HUD Section 811 Project Rental Assistance Program	Allows State agencies to competitively apply to HUD for rental assistance for a 20 year term to allocate to non elderly disabled households with preferences for members of Olmstead classes; Authorized by Frank Melville Act to reform Section 811 as a community integrated program	HUD, to be administered by IHDA, if funded.	Maximum of $12 million per state; maximum for Illinois approximately 825 units	1. State of Illinois application submitted by August 7, 2012 deadline 2. NOFA grants scoring preferences to States that have entered Consent Decrees to address the Olmstead case 3. NOFA Grants scoring preference to States that obtain commitments from PHA's for Housing Choice Vouchers or public housing units as leverage to increase the supply of assisted housing for persons with disabilities; 4. Must be under 62 to initially qualify for assistance but participants may age in place under the program beyond the age of 62 and so applications demonstrating strong programs for independent elderly households will be highly competitive; Illinois application met all of these criteria; HUD to announce grant awards by late 2012.
6. Public Housing Authority (PHA) Programs	Includes: - Project basing of Housing Choice Vouchers - Public Housing units - Housing Choice Vouchers			
7. PHA Units and Housing Choice Vouchers	Tenants pay 30% of Income; PHA Pays difference in rent up to HUD Fair Market Rent or an "exception rent" if justified by market conditions	HUD via Public Housing Authorities	TBD	1. CHA willing to match names of class members with waiting list to determine who is eligible for a voucher preference under CHA Administrative Plan; CHA has executed Protective Orders and the State is preparing class lists in format to protect privacy of class members and will submit to CHA shortly for list comparisons ; 2. State in ongoing discussions with CHA regarding additional Voucher commitments consistent with HUD notices, and commitment of Project Based Rental Assistance("PRA") under State preference in CHA Administrative Plan; 3. State in ongoing discussions with Housing

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
				Authority of Cook County to negotiate a Demonstration Program for an allocation of Housing Choice Vouchers and public housing units for Money Follows the Person and Consent Decree Class Members; 4. State has received list from HUD of hard unit vacancies in public housing authorities in State if Illinois and is following up with each PHA with vacancies to determine if units that are vacant may be viable opportunities for MFP Participants and Consent Decree Class members; 5. IHDA has received a commitment of 50 Housing Choice Vouchers and 30 Public Housing Units from Rockford Housing Authority for Consent Decree members and MFP enrollees (as part of State's HUD Section 811 application).
8. Public Housing Authority Waiting List Preferences for Housing Choice Voucher Program for MFP enrollees	Provides rental subsidy to allow tenants to pay 30% of income in rent	HUD PIH Notice 12-31 issued June 29, 2012 encompasses a wide variety of HUD policy to encourage PHA's to prioritize rental resources for Olmstead class members, including specific guidance that PHA's may establish "Olmstead" waiting lists separate and distinct from their existing waiting lists	TBD	1. PHA's have authority to grant preference on waiting lists to MFP Enrollees and Olmstead class members; 2. See paragraph 2 above for further detail on State actions in this area; 3. State invited to present on Consent Decrees and housing needs to Illinois Association of Housing Authorities in September, 2012; 4. HUD has offered to reach out to PHAs to encourage their participation in Olmstead compliance initiatives 5. State also speaking to Illinois Chapter of NAHRO at its Annual Meeting on August 16, 2012, where HUD Regional Administrator Antonio Riley will encourage Olmstead initiatives.

HOUSING PROGRAM OPTIONS (IN FORMATION)	Program Description	Funding Source	Number of Units	Notes
9. Non Elderly Disabled (NED) Housing Choice Vouchers	Provides Rental Subsidy to allow tenants to pay 30% of Income in Rent and PHA pays difference up to Fair Market Rent	HUD awards competitively to PHAs	Under NED 1 Illinois has 445 NED 1 Vouchers allocated to 6 PHA's that are in place and can be utilized for non-elderly disabled households on voucher turnover; Under NED 2 Illinois received 25 NED 2 Vouchers; 15 to the Oak Park PHA and 10 to the Springfield PHA that are currently in lease up	Must express support to HUD/Congress for continued and increased annual allocations of NED Vouchers. No new NED vouchers proposed for FY13.

10. Project Based Rental Assistance Program(PRA)	Provides 15 year Rental Subsidy contract for up to 25% of units for PSH in a market project or 100% PSH for developments that serve a 100% PSH tenant population	PHA Award to Developers on rolling application basis. This program is specific to CHA and Cook County Housing Authority	CHA has 2500-3000 PRA units for both PSH and non PSH developments; Housing Authority of Cook County has approximately 260 PRA units	CHA providing PRA in support of Home First Illinois acquisition of accessible units with proceeds from Build Illinois Bond Program; for Thresholds scattered site initiative and for the Diplomat Hotel under IHDA PSH Demonstration Program; State in dialogue with PHA's regarding set aside of percentage of PRA units for MFP enrollees or Consent Decree Class members
City of Chicago Programs				
11. City of Chicago Low Income Housing Trust Fund (CLIHTF)	Provides rental subsidy to allow extremely low income tenants to pay 30% of income in rent	City receives $10 per recorded document in City of Chicago	TBD Based on Next Funding Round and $$ available per funding source	Need for Discussion with City on Availability of funding for PSH; meeting scheduled with City of Chicago Department of Housing and Economic Development in August, 2012.

21.4. Survey - Waiver Services Necessary for a Successful Transition to Community-Based Settings

Survey of Transition Necessary Services											
RIN#:	Date of Birth:		DON Score (if administered):								
Circle outcome of initial Contact &/or Evaluation of Class Member	Class Member refused to consider transition	Guardian refused to consider transition	Evaluated & determined ineligible based on Section 10.2	Evaluated & declined transition	Evaluated, found eligible & waiver issue identified (*complete section(s) below*)						
Circle the Illinois Waiver for which the Class Member is eligible:								Aging	Disability		
Zip Code for Nursing Home:								HIV/AIDS	TBI		
Zip Code for Community in which the Class Member desires to live											
	Waiver Service needs	Gaps in Waiver Service: Class Member would need one or more of these services in a quantity greater than the Waiver for which the Class Member is currently eligible permits or as defined in order to successfully transition (*Check each applicable service*)									
Waiver Service	Class Member would need one or more of these services under a Waiver for which he/she is NOT currently eligible in order to successfully transition (*Check each applicable service)*	Hours of Waiver Service					Waiver Service Definition				
		Class Member is eligible for the Waiver, but the hours of service were determined to be a barrier to transition (*Complete for only those services that are provided on an hourly basis*)					Class Member is eligible for the Waiver service but, because of the scope of the service definition, the service definition is the barrier to transition (*Indicate all that are applicable*)				
		Based upon eligibility, the Class Member qualified for the following number of total hours for this service	Based upon need, the following number of hours for this service is a necessity to transition				Check if "Yes"	Write in the specific task(s) that, if included in the definition, the Class Member would have been able to transition			
Adult day service (TBI, Disability, Aging, HIV/AIDS)											
Adult day service transportation (TBI, Disability, Aging)											
Behavioral/cognitive services (TBI) Day habilitation (TBI)											
Environmental modifications (TBI, Disability)											
Home delivered meals (TBI, Disability)											
Home health aide (TBI, Disability, HIV/AIDS)											
Homemaker (TBI, Disability, Aging, HIV/AIDS)											
Nursing (TBI, Disability, HIV/AIDS)											
Occupational therapy (TBI, Disability, HIV/AIDS)											
Personal assistant (TBI, Disability, HIV/AIDS)											
Personal emergency response system (TBI, Disability, Aging, HIV/AIDS)											
Physical therapy (Disability, HIV/AIDS)											
Respite care (TBI, Disability, HIV/AIDS)											
Specialized medical equipment and supplies (TBI, Disability, HIV/AIDS)											
Speech therapy (TBI, Disability, HIV/AIDS)											
Supported employment (TBI)											
Supported Living Facility (SLF)											
Transportation for employment (HIV/AIDS)											
Comments:											

21.5. Acronyms and Abbreviations

Coordinated Care Entity (CCE): A CCE is a collaboration of providers and community agencies, governed by a lead entity that receives a care coordination payment in order to provide care coordination services for its enrollees.

Integrated Care Program (ICP): The program under which HFS contracted with HMOs to provide the full spectrum of Medicaid covered services through a risk-based integrated care delivery system to seniors and adults with disabilities who are eligible for Medicaid but are not eligible for Medicare.

Illinois Client Enrollment Broker (ICEB): The entity contracted by HFS to conduct enrollment activities for potential enrollees, including providing impartial education on health care delivery choices, ICPs, CCEs, MCCNs and all other managed care entities (MCE) that may become available, providing enrollment materials assisting with the selection of a PCP and CCE or MCCN, and processing request to change CCEs or MCCNs.

Local Contact Agency (LCA): The entity is a Community-Based agency, according to Federal CMS expectations, that responds to Nursing Facility referrals by providing information to residents about available Community-Based long-term care supports and services, works with Nursing Facility staff to engage the resident in their discharge and transition plan and works collaboratively to arrange for all of the necessary Community-Based long-term care services.

Managed Care Community Network (MCCN): A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with HFS exclusively to persons participating in programs administered by HFS.

Managed Care Entity (MCE): MCE is the term referring to any number of options that is currently or planned to be offered to a Medicaid beneficiary in Illinois. MCEs include Integrated Care Program (ICPs), Coordinated Care Entities (CCEs), Managed Care Community Networks (MCCNs), and the Medicare and Medicaid Alignment Initiative, including the care coordination provided by these organizations. All Colbert Class Members will either currently be in a MCE or be enrolled in a MCE.

22. References

Lidz, Charles W., and Meisel, Alan. 1982. “Informed Consent and the Structure of Medical Care.” In vol. 2 of *Making Health Care Decisions,* pp. 317–410. Washington, D.C.: U.S. President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

Mollica, R. & Reinhard, S. (2005). *Community Living Exchange, Establishing Nursing Home Level of Care: How States Vary*, New Brunswick, NJ: Rutgers Center for State Health Policy.

UIC National Research and Training Center on Psychiatric Disability and the UIC NRTC Self-Determination Knowledge Development Workgroup. (2002) Self-Determination Framework for People with Psychiatric disabilities. Chicago, IL: Author. Retrieved on June 14, 2012 from: http://www.psych.uic.edu/uicnrtc/sdframework.pdf.