**Section 240.260 Care Coordination Service**

Care coordination service is defined as the provision of a comprehensive needs assessment and service coordination by CCUs to assist an older person to gain access to and receive needed services. The participant/authorized representative is provided the opportunity to lead the person-centered planning process.

a) Service Components

Specific components of care coordination service include the following:

1) Review of all inquiries to determine if a request for CCP services is desired, and maintenance of a referral request log.

2) Distribution and assistance with completion of CCP applications for charitable, private, and public benefits provided by federal, State and local agencies, including assistance with the initial application and redetermination for Medicaid benefits.

3) Performance of determinations/redeterminations of eligibility, including a comprehensive needs assessment, the development of a person-centered plan of care and authorization/referral of CCP services.

4) Completion of a minimum of 1 face-to-face contact with the participant in between initial assessment and annual reassessment. The face-to-face visit is to occur between 4 and 8 months after the last determination or redetermination of eligibility.

5) Reporting of critical events includes critical incidents, service improvement program complaints, and requests for change of status in the Department's automated reporting system. Completing initial critical event reports will occur within 7 days after the date the event occurred or was identified to have occurred. All critical event reports will be closed to reflect mandatory follow-up with CCP participants within 60 days after the date the event occurred or was identified to have occurred. Critical event report closure will occur through completion of the 60-day review summary housed in the Department's automated reporting system.

6) Availability to receive inquiries and requests for services and supports, by telephone or in person, and respond to those inquiries and requests.

7) Choices for Care prescreenings and postscreenings (see Section 240.1010).

8) Department of Healthcare and Family Services (HFS) OBRA-1 (Level I ID Screen).

9) Provide referrals to other needed services.

10) Implementation of services and participant transfers.

11) Authorization of all actions related to the disposition of CCP services as required by this Part.

b) Comprehensive Assessments

1) A comprehensive assessment is required when a participant needs services to remain living independently in the community or is at imminent risk of nursing facility placement.

2) A comprehensive assessment is not warranted when a participant only requires a referral to services (e.g., providing contact information for a vendor).

3) Conditions triggering a comprehensive assessment may include, but are not limited to:

A) multiple or complex health problems which are often chronic in nature, and may affect the ability of the participant to live independently, such as musculoskeletal disorders, strokes, heart disorders, or mental health issues (e.g., Alzheimer's disease, major depression, or organic brain syndrome).

B) lack of sufficient formal or informal supports; or

C) sudden and permanent loss of a primary caregiver.

4) The Care Coordinator will appropriately complete the comprehensive assessment tool authorized by the Department, or any successor assessment tool, used to determine need for community-based or long-term services and supports, that is relevant to the participant in a manner consistent with the responsibilities set forth under Section 240.1420.

c) Goals of Care

1) Each participant/authorized representative is provided the opportunity to lead the person-centered planning process where possible. The participant's authorized representative should have a participatory role, as needed and defined by the participant, unless State law confers decision-making authority to the legal representative.

2) If a participant's Goals of Care cannot be developed to create an adequate person-centered plan of care, the Care Coordinator is required to discuss the risks associated with the preferences and selections made regarding one or more specific goals by the participant/authorized representative and suggest any alternative options and/or referrals that might be available to mitigate risk.

3) Each participant will be advised by the Care Coordinator of his/her right to accept or refuse some or all offered services developed in participants' Goals of Care.

d) Reassessments

1) A reassessment will be conducted face-to-face on at least an annual basis to determine if the participant remains eligible for the program or if changes in the participant's services under the person-centered plan of care are needed and/or the Goals of Care need to be revised.

2) A reassessment will also be conducted when requested by a participant/authorized representative or when a participant may have experienced a change in his/her needs.

3) The participant/authorized representative develops his/her own revised Goals of Care with input from the Care Coordinator consistent with the responsibilities set forth in Section 240.1420.

e) Unit of Service

Several different types of assessments constitute a care coordination unit of service for which reimbursement is made.

1) Completion of 1 initial eligibility determination for CCP services constitutes 1 unit.

2) Completion of 1 required continuous eligibility redetermination of CCP eligibility constitutes 1 unit. A redetermination shall be completed at least annually.

3) Completion of either 1 face-to-face prescreening or postscreen of a participant constitutes 1 unit.

4) Completion of 1 HFS Interagency Certification of Screening Results form constitutes 1 unit.

5) Availability to receive participant inquiries and requests, by telephone or in person, and to respond to those inquiries and requests for each active participant per month constitutes 1 unit.

(Source: Amended at 42 Ill. Reg. 20653, effective January 1, 2019)