Illinois Department on Aging

Bi-Annual CCU Performance Report
Period ending December 31, 2025

Illinois Department on Aging Mission

The mission of the Illinois Department on Aging is to serve and advocate for older Illinoisans and their caregivers by administering quality and culturally appropriate programs that promote partnerships and encourage independence, dignity, and quality of life.

Illinois Act on Aging

This Care Coordination Unit performance report is produced to fulfill requirements detailed in the Illinois Act on Aging (20 ILCS 105). The Act provides that the *Department shall conduct bi-annual review of Care Coordination Unit performance and adherence to service guidelines. The bi-annual review shall be reported to the Speaker of the House of Representatives, the Minority Leader of the House of Representatives, the President of the Senate, and the Minority Leader of the Senate. The Department shall collect and report longitudinal data on the performance of each care coordination unit. Nothing in this paragraph shall be construed to require the Department to identify specific care coordination units.*

Community Care Program Overview

The Illinois Department on Aging (IDoA) is the Operating Agency for the Persons Who are Elderly 1915(c) Medicaid waiver, commonly referred to as the Community Care Program (CCP). CCP provides services to 130,841 older persons through Managed Care Organizations (57,541), Medicaid fee-for-service (54,724), and non-Medicaid (18,576). Services are provided statewide through 34 Care Coordination Units (CCUs) in 59 contracted service areas, 332 In-Home (INH) providers, 49 Adult Day Service (ADS) providers, 9 Emergency Home Response Services (EHRS) providers and 6 Automated Medication Dispenser (AMD) providers. The program serves as an alternative to nursing facility placement by supporting older adults with comprehensive care coordination and the development of person-centered plans of care for eligible individuals, allowing older adults to continue to live and thrive in their home and community with the supports and services they require.

The CCP is one cornerstone of the "Aging Network" that provides a coordinated system of long-term supports and services encompassing programs such as Older Americans Act Services (including nutrition, evidence-based programs tailored to older adults and their caregivers, senior centers, information and assistance, respite, and outreach), the Benefits Access Program (discounted transit and license plates), assistive technology, Emergency Senior Services, and Adult Protective Services. CCUs play a vital role as case managers for older adults, providing referrals to ensure they are connected with the full spectrum of services available to them through the Aging Network.

General Overview

CCUs are contracted with IDoA and serve as the front door for individuals and their families, to learn how to access CCP services and/or other Aging Network services. At the initial in-person meeting, an IDoA-certified CCP Care Coordinator conducts an eligibility assessment and Determination of Need (DON). Individuals must score a minimum of 29 on the DON and meet financial requirements to be eligible for CCP services. The Care Coordinator works with the CCP eligible older adult, and their family, friends or other ''authorized representative(s)" to develop a person-centered plan of care (PCPOC) based on the participant's strengths, needs, and preferences. Additionally, participants are required to apply for, and if eligible, enroll in Medicaid which allows the State to claim Federal Financial Participation (FFP) or Medicaid matching funds on the CCP services provided. Frequently, Care Coordinators assist older adults with navigating the Medicaid application process, serving as their point of contact with the Department of Human Services.

The Care Coordinator uses the PCPOC to facilitate participant connections with providers of services and supports including INH (homecare aides assist with dressing, meal preparation, cleaning, laundry and taking participants to appointments), ADS, EHRS, and/or AMD. In developing the PCPOC, the participant has the option to choose their preferred service provider. The Care Coordinator authorizes services to begin within a maximum of fifteen (15) calendar days.

Six months after the initial assessment and at the time of annual redetermination, the CCU is required to conduct an in-person visit. An update to the PCPOC may be necessary if the participant is presenting with increased or decreased difficulties or needs.

The CCU must redetermine all CCP participants' eligibility and level of need at least annually. At the initial and annual redetermination, the Care Coordinator will conduct the full CCP assessment as well as check for financial eligibility which requires verification of income, assets, and related financial documents.

Under the Choices for Care Program, CCUs screen older people to determine eligibility and educate individuals in hospitals, nursing facilities, and in the community about all long-term care options, including home and community-based service (HCBS) options. This equips individuals with the information needed to make an informed choice about their options for long-term services and supports to prevent and/or reduce unnecessary institutionalization. Even when an individual chooses to receive care in a nursing facility, the CCU asks the individual if they would like to schedule follow-up with a Care Coordinator within a certain number of days to discuss their possible return to the community and HCBS options. Following person-centered practices, the individual/authorized representative drives this process and has the full authority to accept or decline follow-up.

Successes

- **Multi-Sector Plan for Aging**. In August 2024, Governor JB Pritzker signed an Executive Order to establish a cross-sector planning process to create a strategic blueprint to address the comprehensive needs of older adults, people with disabilities, and caregivers over the next decade. He charged the Illinois Department on Aging, and a Chief Planning Officer to drive this effort with the participation of 15 state agencies and a 25-member Community Advisory Council. Care Coordinators participated in public hearings and roundtables to share their feedback and input on the MPA's development.
- **Framing the Future IDoA Conference.** In the fall of 2025, IDoA held its annual conference that garnered well over 600 participants from the Aging Network. As part of the conference, IDoA sought speakers to share their innovative ideas, technology updates, and new models of care. CCU representatives presented on leadership and coordination in the Aging Network, increasing visibility and awareness of services, and successful practices in partnering with health care entities.
- **Increase Medicaid Enrollment of CCP Participants.** The overall Medicaid population supported through the Persons who are Elderly Waiver (Medicaid fee-for-service and MCO) increased from 111,126 in December 2024, to 112,265 as of December 18, 2025. The increase in Medicaid-covered participants from 2023 to 2024 was due in part to the State's increase in allowable assets from $2,000 to $17,500 for Medicaid eligibility effective May 12, 2023, and CCUs focusing on ensuring the eligible individuals become enrolled in Medicaid. Since August 2019 when IDoA was mandated to work with the CCUs to enroll eligible participants in Medicaid, the percentage has increased from 69% to 86% as of December 2025. This percentage includes the Medicaid fee-for-service and MCO participants.

Data as of December 18, 2025

PSA	Waiver Services provided by an MCO (all Medicaid)	Community Care Program (CCP)			Total CCP and MCO Participants
		Medicaid FFS	Non-Medicaid	Total CCP Participants	
01	1,852	2,477	681	3,158	5,010
02	8,966	7,836	2,304	10,140	19,106
03	1,167	1,324	547	1,871	3,038
04	1,031	1,039	234	1,273	2,304
05	2,286	2,731	636	3,367	5,653
06	290	403	43	446	736
07	1,334	1,847	477	2,324	3,658
08	1,851	2,206	509	2,715	4,566
09	442	582	17	599	1,041
10	372	520	28	548	920
11	1,297	1,341	115	1,456	2,753
12	23,580	19,350	7,849	27,199	50,779
13	13,073	13,068	5,136	18,204	31,277
Total	57,541	54,724	18,576	73,300	130,841

Totals from 1 year ago*

Total	55,290	55,836	22,103	77,939	133,229

Data as of 12/23/2024

Totals from 2 years ago*

Total	56,840	49,730	27,431	77,161	134,001

Data as of 12/21/2023

Totals from 3 years ago*

Total	54,351	46,538	30,686	77,224	131,575

Data as of 12/22/2022

Totals from 4 years ago*

Total	50,994	43,017	29,699	72,716	123,710

Data as of 12/21/2021

Totals from 1st Enrollment Report (8/29/2019)

Total	40,735	36,085	34,559	70,644	111,379

Data as of August 29, 2019.

Data Source: Authorized participants listed in IDoA Billing System compared to daily eligibility file from HFS.

- **Six-month Review.** In 2022, to fulfill the requirement of the six-month review under the Persons Who Are Elderly Waiver, IDoA, as the Operating Agency, implemented this mid-year formal touch base with participants to ensure services are meeting participant needs. As of December 22, 2025, 84% of participants received their six-month review. IDoA monitoring staff continue to work with the CCUs who are behind in meeting the requirement.
- **Choices for Care.** The CCUs play a pivotal role in ensuring older adults know their community care options when being discharged from hospitals, admitted to nursing facilities, and discharged from nursing facilities. As of December 26, 2025, 61,061 pre-screens and 2,605 post-screens have been completed across the State for FY26.

PSA	Pre-Screens FY25	Pre-Screens FY26 YTD (July 2025 through December 18, 2025)	Post-Screens FY25	Post-Screens FY26 YTD (July 2025 through December 18, 2025)
1	9,965	3,648	601	150
2	36,530	14,752	1,606	815
3	5,768	2,066	561	195
4	5,606	2,389	110	74
5	9,853	4,304	226	75
6	1,514	690	50	19
7	5,986	2,411	254	96
8	7,205	2,793	525	225
9	2,187	1,153	304	159
10	966	463	259	107
11	3,025	1,622	571	267
12	24,523	9,574	416	161
13	37,441	15,196	981	262
Total	150,569	61,061	6,464	2,605

- **CCU Participation in PACE.** The Program of All-Inclusive Care for the Elderly (PACE) is a comprehensive and integrated Medicare and Medicaid program administered by the Department of Healthcare and Family Services (HFS) which gives people age 55+ additional choice in how they access health care as needs change with age, allowing more older adults to continue living at home safely, for longer. CCUs have a critical role in PACE as they complete the federal CMS mandated Determination of Eligibility prior to PACE enrollment and serve as a referring source to older adults who are candidates for the PACE program. There are currently 157 people served through the 4 PACE sites currently in operation with 9 CCUs collaborating with the PACE sites to complete the Determination of Eligibility.
- **Money Follows the Person (MFP).** This demonstration initiative led by the State's Medicaid Agency (HFS) was originally approved by federal CMS to launch in Illinois in 2008. HFS recently submitted an updated Operational Protocol version MFP 2.0 to be approved by federal CMS. As a former lead on MFP, IDoA and CCUs are well versed in strategies to support HFS in a re-launch. MFP targets Medicaid eligible individuals who have been residing in qualified institutions such as skilled nursing facilities for at least 90 days and includes an enhanced federal matching rate (FMAP) for a 12-month period following transition to the community. The Money Follows the Person initiative reimburses the state 75 percent of the eligible costs for the first year. CCUs will conduct

outreach, provide intensive case management, and provide data to evaluate program outcomes. IDoA anticipates 4 CCUs in Planning and Service Areas (PSAs) 03, 04, 09, and 11 will participate in MFP 2.0. Although HFS launched the program initially for participants with Intellectual/Developmental Disabilities, the CCUs will engage in MFP activities related to older adults beginning in July 2026.

- **Collaborative Retreats.** IDoA, the CCUs and their representative organization the Care Coordination Alliance (CCA) held two retreats in 2025 to identify goals, objectives, and strategies to address challenges while also planning for growth in case management. Topics of common interest include workforce shortages, competitive compensation, innovation and technology, and systems changes. It is anticipated additional retreats will be held in 2026 including those to bring Aging Network partners together as we continue to ensure a system of long-term care services and supports is prepared to meet the growth in the older population.
- **Aging Cares.** Aging Cares, a new case management system developed by IDoA with the assistance of the Department of Innovation and Technology was launched in December of 2024. During calendar year 2025 four CCUs participated in Phase 1 of go-live. Aging Cares will use innovation and technology to transition a paper-based system to electronic based, facilitating real-time communication between the CCUs, in-home providers, and other stakeholders. Importantly, the system will also serve to collect additional data for CCP that can be leveraged to inform policy changes, improve quality of care, and reduce administrative burden. Well in advance of the phase 1 launch, several CCUs engaged with IDoA to shape the system to ensure future phases when additional CCUs and in-home providers are brough online will be as seamless as possible.
- **Agents of Change.** In 2025, several CCUs including Catholic Charities and CCSI advanced high-quality care through innovation and systems changes. Catholic Charities developed a strategic plan to address workforce shortages, increase efficiencies, and transform their operations. These changes have led to an increase in productivity, compliance with re-determinations, and workforce retention. Similarly, CCSI worked collaboratively with IDoA to take over care coordination in two areas of the state where workforce challenges jeopardized continuity of services to older adults and their caregivers. By establishing offices, entering into a demonstration grant to trial workforce retention strategies, and their commitment to the Aging Network, significant strides have been made in these areas.
- **Comprehensive Rate Study.** In the fall of 2025, IDoA contracted with a highly experienced vendor to conduct a comprehensive rate study of waiver services. While not required under the Persons Who Are Elderly Waiver, IDoA is seeking a comparable analysis of rates paid to CCUs to ensure wages are competitive and able to attract and retain new Care Coordinators to the field. As part of the rate study, all providers and the Care Coordinators will provide valuable feedback to the vendor.

Challenges

As discussed previously in this report, there have been numerous successes during the last year. However, there is no shortage of challenges facing the Aging Network and the CCUs in the future. These include changes to Medicaid eligibility, new quality metrics under recently implemented federal rules, continued growth in home and community-based services, implementation of new systems, and budgetary constraints.

- **Aging Cares.** In 2026, IDoA will implement planned phases of Aging Cares to onboard additional CCUs and providers. As a significant systems change, this will require CCUs to stand up new processes, train staff, and transition all records from paper to electronic. Several CCUs will serve as mentors to new CCUs during the transition process.
- **Annual Redetermination Rate.** The annual redetermination rate is determined by the number of participants who are reassessed within twelve months of the last assessment. The chart below shows the annual redetermination rates for FY16 - FY26 YTD. During the public health emergency (PHE), for a short period of time, CCUs were able to complete remote assessments. This led to an increased redetermination rate for FY21, the highest in the lookback period cited below. Since FY21, the CCUs moved back to in person assessments in

the participant's home and in the community. Upon the lifting of the PHE flexibilities, the CCUs were flooded with redeterminations in the face of significant workforce challenges, along with the incorporation of the new asset limit for Medicaid increasing the number of Medicaid-eligible participants and Medicaid applications. Currently, the CCUs are at 68.6% for FY26 YTD. This represents a 22% increase in compliance over FY 24. In discussions with CCUs, workforce challenges are the cited as the persistent barrier to meeting the goal. Currently, IDoA monitoring staff are working with the CCUs with redetermination rates below 86% to develop corrective action steps to meet current performance measures through ensuring delinquent redeterminations are completed, data clean-up, and filling Care Coordinator vacancies.

Fiscal Year	Percentage of Assessments completed timely annually
FY16	70.2%
FY17	71.3%
FY18	69.8%
FY19	73.5%
FY20	76.6%
FY21	82.7%
FY22	73.3%
FY23	65.1%
FY24	61.1%
FY25	70.0%
FY26 YTD	75.0%

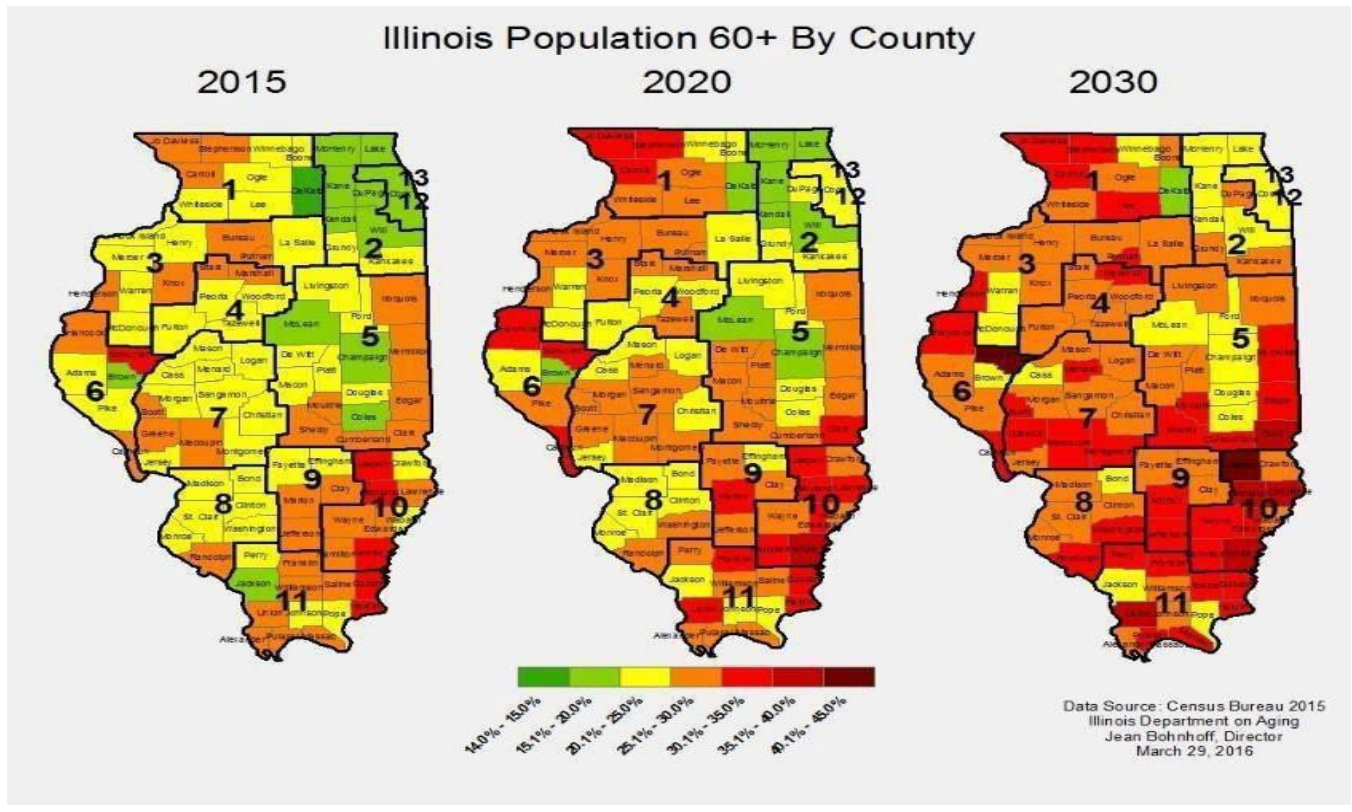
- **Care Coordination Unit Workforce Shortages.** Care Coordination Unit (CCU) workforce shortages continue to impact CCUs across the State with the southern part and some urban areas of the State demonstrating significant challenges recruiting and retaining Care Coordinators. To address these issues, IDoA continues to utilize several strategies including a demonstration grant aimed at understanding the challenges associated with serving clients in the most remote and rural areas of the state. In FY 25, the Rural Service Demonstration grant was developed to help the CCU staff a portion of PSA 10 that has experienced historic workforce challenges due to low population and increased travel demand for Care Coordinators due to the rural landscape. This demonstration grant will help IDoA determine if bundling travel into a daily rate would satisfy CCU workforce needs in other rural areas of the State. Recent data suggests the demonstration grant has been successful in attracting new Care Coordinators to serve extremely rural areas through aggressive hiring campaigns, higher than average rate and benefit package, bundling client visits whenever possible, the CCU establishing a local office, and other strategies employed by the CCU.

Summary

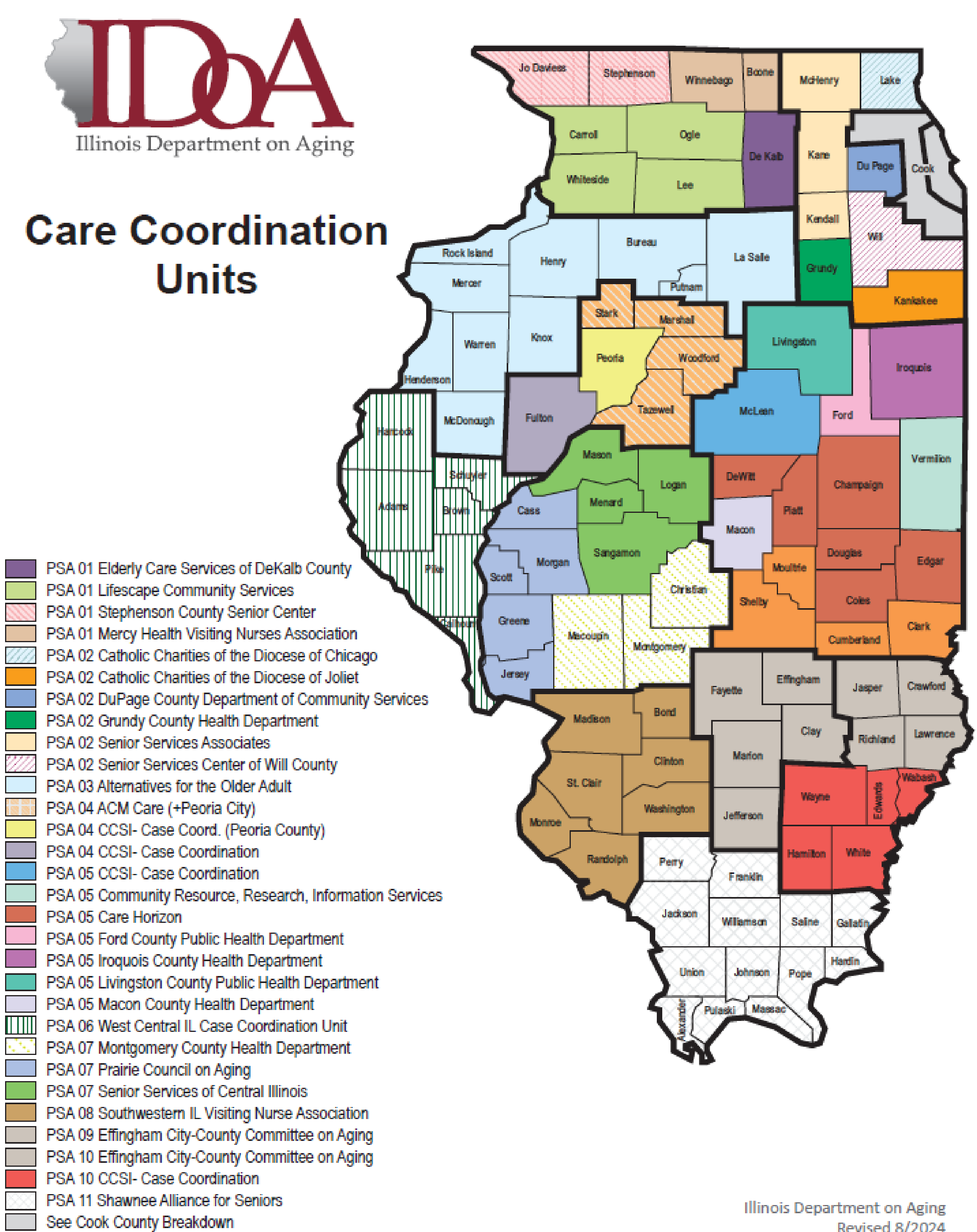
The CCUs continue to meet the needs of tens of thousands of older Illinoisans through assessment for services, development of a person-centered plan of care, and comprehensive care coordination. A 3% increase in CCP enrollment is anticipated for FY26.

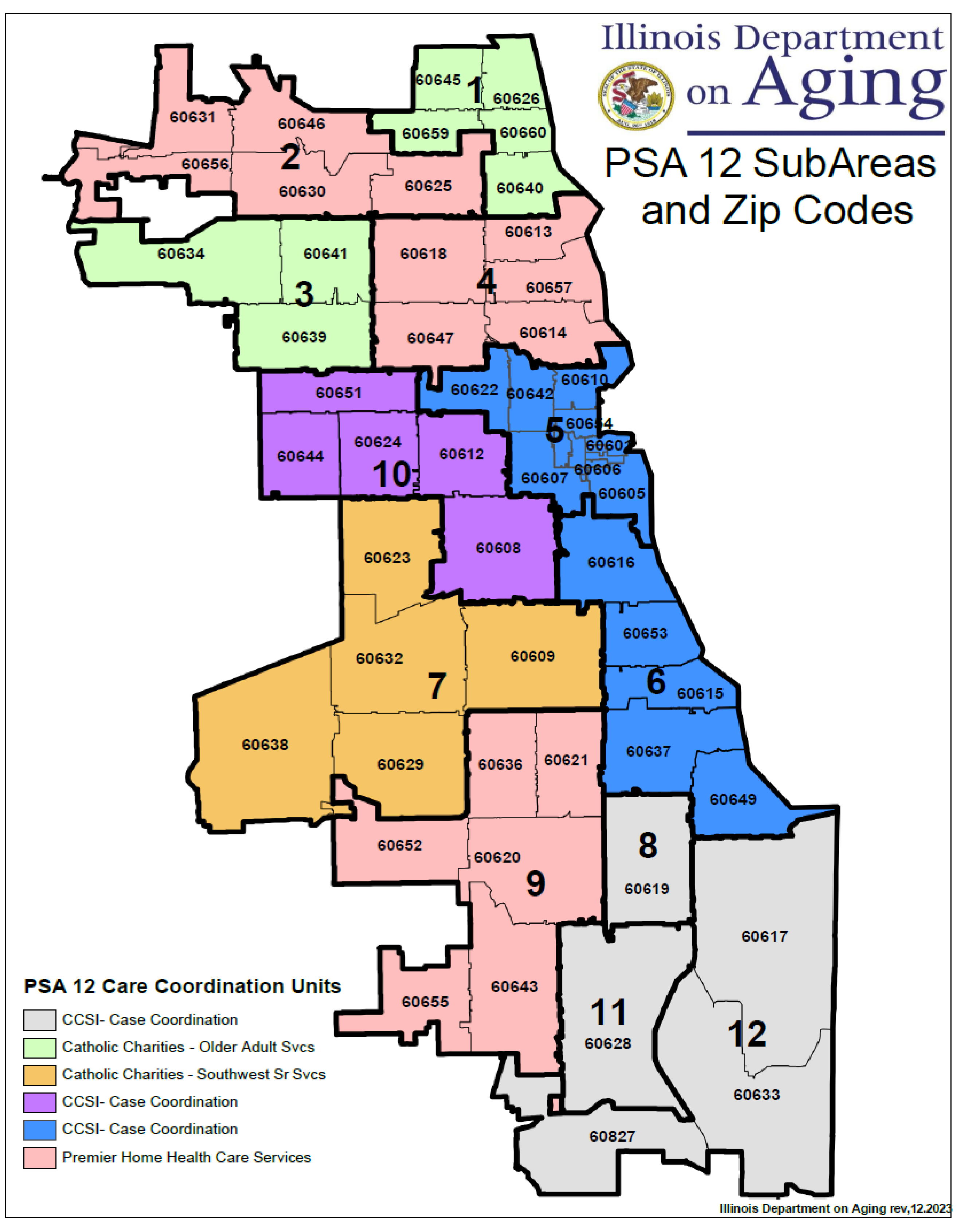
Workforce shortages along with the sustained increase in need for CCP will continue to be a challenge for the CCUs. The Department looks forward to working with the CCUs, the State Medicaid Agency, and national leaders

to continue to identify successful recruitment and retention strategies.



CCU Maps:





Illinois Department on Aging
PSA 12 SubAreas and Zip Codes
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PSA 12 Care Coordination Units
CCSI- Case Coordination
Catholic Charities - Older Adult Svcs
Catholic Charities - Southwest Sr Svcs
CCSI- Case Coordination
CCSI- Case Coordination
Premier Home Health Care Services
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PSA13 CCUs

- Aging Care Connections
- Catholic Charities - Northwest Senior Services
- Kenneth Young Center
- North Shore Senior Center
- Solutions for Care
- Stickney Township
- Pathlights Human Services
- Oak Park Township
- Catholic Charities - South Suburban
- North Proviso - Solutions for Care, South Proviso - Aging Care Connections

BARRINGTON
PALATINE
WHEELING
NORTHFIELD
NEW TRIER
HANOVER
SCHAUMBURG
ELK GROVE
MAINE
NILES
EVANSTON
NORWOOD PARK
LEYDEN
RIVER FOREST
OAK PARK
PROVISO
BERWYN
CICERO
RIVERSIDE
STICKNEY
LYONS
WORTH
CALUMET
PALOS
LEMONT
ORLAND
BREMEN
THORNTON
RICH
BLOOM

PSA 13

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Springfield, Illinois 62702-1271

Senior HelpLine: 1-800-252-8966, 711 (TRS)
8:30 a.m. to 5:00 p.m. Monday through Friday
24-Hour Adult Protective Services Hotline: 1-866-800-1409, 711 (TRS)
ilaging.illinois.gov

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