GENERAL CONCEPTS

Participating in the FY10 Conversion Project is voluntary with the understanding, based on the FY09 and FY10 budgeting experiences, that choosing not to convert non-Medicaid funds to Medicaid reimbursable programs could make their funding more vulnerable to budget reductions. Providers and individuals must make their own decisions, given the current environment, as to whether they want to convert programs. If a provider makes the choice to convert, the individuals served must determine how they wish to proceed in light of the new circumstances.

The preferences of individuals regarding types of services will be an important factor in the conversion plans.

Individuals who agree to participate in the conversion process must apply for and be approved for Medicaid and cooperate with the clinical eligibility determination process.

Conversions cannot result in expenditures that are greater than those that currently exist under the non-Medicaid programs.

All conversions proposals must be approved by the Division prior to implementation.

Recognizing that cash flow will be a concern, especially given the State’s current payment delays, for conversions to Community Integrated Living Arrangements (CILA) or Developmental Training (DT), the advance and reconcile mechanism developed for FY05 conversions will be available upon the provider’s request. We will explore the possibility of offering this for other programs, such as Supported Employment, as well. The use of transition grants where warranted may also be employed where it is determined the short-term investment will allow providers to make a reasonable transition from grant to Medicaid eligible services.

Only those individuals for whom there is a reasonable basis for the PAS agency to believe the individual will be found Medicaid Waiver eligible will be assessed as part of this project.

The Division will not enroll individuals served under another Medicaid Waiver, e.g., physical disabilities, aging, etc. Such enrollments would not produce federal match.
Once an individual is enrolled in the Medicaid Waiver, the funding for their services is portable. Individuals may choose among qualified providers. It is the job of the Individual Service and Support Advocacy organization to assist the individual with such issues.

Portions of a non-Medicaid program may be converted. A provider may choose to convert part of a grant, for example, to a Medicaid program and leave the remaining portion in the grant program. Or, a provider may choose to convert part of a grant to one Medicaid program and the other part to another Medicaid program.

Programs may be combined to form the basis of a conversion plan. For example, an individual may be receiving services under both a Supported Employment Program grant and a Client and Family Support grant. In that case, the two funding sources could be combined to support a conversion to the Home-Based Support Services Program.

Existing service definitions and rate structures will be used.

TIME LINES

Proposals for program conversions are to be submitted in the Division’s template (see attached) and are due to the Division via e-mail (dhs.ddconversion@illinois.gov) on or by October 30, 2009. Conversion activity will continue throughout FY10 and beyond, as long as funds are available.

PROGRAMS

The majority of grant and non-Medicaid fee-for-service programs will be included in the voluntary conversion project opportunity. Attached is a list of those programs.

The Division will consider proposals from any of the programs on the list in part or in whole. We will not be prioritizing one program area (e.g., Supported Employment, Code 390) over another (e.g., Client and Family Support, Code 160).

The remaining programs are those listed below. Their conversion potential, time lines (if applicable), and activity is as follows:

Respite. It is the policy decision of the Division that it would not be cost effective or practical to convert respite programs to Medicaid. The administration, service planning, and quality assurance costs typically associated with Waivers would outweigh the financial benefits of capturing federal match for these services delivered to families and other care-givers on a low intensity basis.
Pre-Admission Screening (PAS). The PAS grants currently receive 75% match from the federal Medicaid program under OBRA ‘87. The Division will review the current funding mechanism to determine whether a fee-for-service mechanism would be more effective; however, this will be deferred until after the direct service conversions for two reasons: (1) the State already receives matching funds for this program, and (2) the PAS agencies will be an integral part of the conversion project and will need to focus resources on that. If changes are made, they would be on a program-wide basis, rather than voluntary on the part of the provider. Access to Medicaid services must be consistent statewide.

Bogard Independent Service Coordination. The federal government has already indicated it will not provide matching funds for this program under OBRA ‘87.

Independent Service Coordination. One of the major components of this grant is the intake work for the Prioritization of Urgency of Need for Services (PUNS), the Division’s waiting list for the Medicaid Waiver programs. While the State is not currently receiving matching funds for these grants, it could be if modifications were made. It is the Division’s intent to convert these grants to Medicaid coverage; however, this will require additional review and research and will occur after the main conversion plan. Changes would be program-wide rather than voluntary on the part of the provider. Access to Medicaid Waiver services must be consistent statewide.

Dental. Dental services can be covered as an extended plan service under the Waivers. Further review is required to determine possibilities involving these specific grants. Cost containment will be an issue. Only five providers have this grant. We will be discussing current grant practices with them.

Family Assistance Program. Families will be given opportunities to convert to the Children’s Support Waiver. This will produce little financial benefit for the State, since the allocation for each family would double in the conversion. Any conversions would be voluntary on the part of the family. This activity will be underway at the same time as the main conversion project.

Home Individual Placements. There are currently 10 individuals served under this program with 3 providers. Division staff will review each case and determine whether conversions are possible. This activity will be underway at the same time as the main conversion project.

ELIGIBILITY DETERMINATIONS

A special assessment tool will be used by PAS agencies in determining eligibility. The tool is an updated version of the one used for the DT conversions effective in FY05 and the instructions for the children program conversions effective in FY08. Since individuals will not be moving from one residence to another, and they are already receiving the developmental disabilities services from the provider, a full Level II per the
PAS manual is not necessary. This tool includes the components of the Level II necessary to determine eligibility.

Providers will identify individuals who are believed to be Medicaid eligible for each conversion program. These individuals will be referred for assessments.

Providers will be given a list of items to have ready for the PAS agencies’ use in completing determinations. This list is incorporated into the template used for providers’ proposals.

It is possible that an individual is receiving grant-funded services and is enrolled in the Waiver. Should such an individual be involved in a program conversion, a new assessment will not be necessary. The individual will have already been assessed for Waiver eligibility and would be participating in annual re-determinations of that eligibility.

**TEMPLATE**

A template has been developed by the Division for use by providers in submitting their conversion proposals. Providers will be asked to indicate their intentions for all of their non-Medicaid programs that are covered under this plan. A copy of the template is attached.

Complete proposals will be reviewed in the order they are received by network staff. If the Division has additional questions, contacts will be made. If the proposal is incomplete, it will be returned to the provider for completion.

**OVERVIEW OF CONVERSION PROCESS**

In summary, the overall process among the individuals, providers, and Department is as follows:

- The provider makes the decision to explore conversion from a State-funded program to a Medicaid program. This decision should be based on the following factors:
  - The number of individuals served by the current programs who are believed to be Medicaid eligible,
  - The ability to serve or transition individuals who are believed to be ineligible for the conversion,
  - The amount of the grant(s),
  - The similarity with or adaptability to Waiver services of the current programs, and
  - The ability to meet provider and site qualifications.
• The provider informs the Division of Developmental Disabilities of its intentions regarding conversions during the fiscal year, including submitting a proposal to the Division outlining any plans for conversion using the template developed by the Division.

• The Division responds to the provider with an approval or denial of the proposal. It may request additional information if needed.

• Once the provider has approval from the Division for the conversion, it identifies people currently receiving non-Medicaid, Division-funded services who appear to be eligible for conversion based on the following factors. The individual:
  o Meets the clinical eligibility requirements,
  o Meets the financial Medicaid eligibility requirements,
  o Has support needs that match service definitions in the Medicaid program, and
  o Agrees to participate in the conversion.

• Should the provider find that it is serving more potentially eligible individuals than can be accommodated through the conversion, it will develop an objective mechanism for determining who will continue to receive services and who will not. The decision making process should be transparent and include the PAS agency. The provider must not consider donations or private fundraising by the individual or family in determining who remains in services. The provider may consider a variety of other factors, such as the following:
  o Length of time in the program being converted,
  o Clinical needs of the individual,
  o Family circumstances,
  o Other available supports,
  o Division priority population criteria, especially in the absence of State-only funds,
  o Etc.

• Should the provider find that it is serving fewer individuals than can be accommodated through the conversion, it may, with prior approval from the Division, elect to enroll additional individuals from its waiting list prior to the final conversion. If it is unable to do so, the Division may provide referrals or use the funds for others in need of services.

• The provider notifies the appropriate number of identified individuals that their services are being converted and provides specific information about any changes that will occur, e.g.:
  o Change in levels of services,
  o Availability of new services,
  o Discontinuation of any services that are no longer available, and
  o New administrative and documentation requirements under the Waiver, e.g., service planning, medication administration, Individual Service and Support Advocacy, etc.

• The individual (family/guardian) decides whether he or she wishes to participate in the conversion and informs the provider of his or her decision.

• The provider notifies the appropriate PAS agency of its conversion plans and gives it the list of individuals it considers to be eligible for the conversion.
- The provider gathers documentation necessary for the PAS agency to complete the eligibility determinations.
- The PAS agency completes the eligibility determinations using the special assessment tool designed for the FY10 Conversion Project and informs the provider and individuals of the results.
- The provider also identifies individuals who it believes are ineligible for the conversion process and takes actions to continue to serve or transition these individuals.
- The provider and PAS agency communicate continually with the individuals to inform them of the status of the conversion and of the changes impacting them.
- The provider and the Division communicate continually during the process regarding progress with the plan and time lines for reallocating funding from one program to another.
- The provider and PAS agency submit applications for service authorizations for the individuals involved in the conversion. Applications should be marked prior to submission as “FY10 Conversion Project”.
- The Division processes the applications and issues award letters as appropriate.
- The PAS agency meets with individuals whose services have been converted, explains to them what they may expect under the Waiver, and begins Individual Service and Support Advocacy.
- The Division terminates payments under the program(s) being converted and puts system authorizations in place for the new programs.
- The Division produces necessary contract adjustments.