

## Request for a Renewal to a §1915(c) Home and Community-Based Services Waiver

### 1. Major Changes

---

Describe any significant changes to the approved waiver that are being made in this renewal application:  
This 1915 (c) Waiver for Adults with Developmental Disabilities renewal includes:

1) Inclusion of Performance Measures to be consistent with federal changes in assurances and sub-assurances. Performance measures are also being modified to be consistent with changes made as part of the renewals of the two DD Children's Waivers operated in Illinois.

2) Inclusion of language described in our Statewide Transition Plan for Compliance with HCBS settings as required by the Centers for Medicare and Medicaid Services (CMS) and published final regulations that pertain to Home and Community-Based Services (HCBS) programs, including 1915 (c), 1915 (i) and 1915(k) as described in 42 CFR 441.301(c) (4) (5) and 441.710(a) (1) (2). Illinois' Transition Plan was submitted on March 16, 2015. Subsequent revisions to the Transition Plan have been submitted on February 29, 2016 and February 1, 2017.

3) Modifications to processes related to Participant Centered Planning in accordance with HCBS final rules (2249-F and 2296-F) published on January 16, 2014 impacting this 1915c Medicaid waiver and enable waiver participants to direct the planning process. This would allow a representative(s) whom the individual has freely chosen and would result in a person-centered plan with individually identified goals and preferences. The PCP would also have promote outcomes in the most integrated community setting, and the delivery of services in a manner that reflects personal preferences and choices and assurances of health and welfare.

4) The Information and Assistance in Support of Participant Direction (formerly Service Facilitation) definition in Appendix C for the Home-Based Support Services option is being modified to remove the requirement that everyone in this option receive two hours of this service per month. This service is now optional and focused on assistance to participants and their families in managing their self-directed services.

5) The day habilitation and supported employment definitions in Appendix C are being modified to provide more integration for site-based services and enhance access to supported employment. Further, a new day option is being added in Appendix C that will afford participants the opportunity to receive services in small groups in community environments during the day.

6) Program capacity is being increased as part of the renewal.

A waiver renewal notice was sent to the tribal government on February 10, 2017.

In accordance with these substantive changes, this waiver was posted on February 9, 2017 at the website of the Illinois Department of Healthcare and Family Services (HFS), <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>. The posting for public comment ran until March 10, 2017. A second public comment period was held from May 31, 2017 to June 30, 2017.

### Application for a §1915(c) Home and Community-Based Services Waiver

#### 1. Request Information (1 of 3)

---

- A.** The State of Illinois requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).
- B. Program Title** (*optional - this title will be used to locate this waiver in the finder*):  
**HCBS Waiver for Adults with Developmental Disabilities**
- C. Type of Request:** renewal

**Requested Approval Period:** (*For new waivers requesting five year approval periods, the waiver must serve individuals who are dually eligible for Medicaid and Medicare.*)

3 years  5 years

Original Base Waiver Number: IL.0350  
Waiver Number: IL.0350.R04.00  
Draft ID: IL.026.04.00

D. Type of Waiver (select only one):  
Regular Waiver

E. Proposed Effective Date: (mm/dd/yy)  
07/01/17

Approved Effective Date: 12/11/17

1. Request Information (2 of 3)

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

Hospital

Select applicable level of care

Hospital as defined in 42 CFR §440.10

If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:

[Empty text box for hospital subcategories]

Inpatient psychiatric facility for individuals age 21 and under as provided in 42 CFR §440.160

Nursing Facility

Select applicable level of care

Nursing Facility as defined in 42 CFR §440.40 and 42 CFR §440.155

If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:

[Empty text box for nursing facility subcategories]

Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) (as defined in 42 CFR §440.150)

If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/IID level of care:

Not applicable.

1. Request Information (3 of 3)

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities

Select one:

Not applicable

Applicable

Check the applicable authority or authorities:

Services furnished under the provisions of §1915(a)(1)(a) of the Act and described in Appendix I

Waiver(s) authorized under §1915(b) of the Act.

Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:

[Empty text box for waiver program details]

Specify the §1915(b) authorities under which this program operates (check each that applies):

§1915(b)(1) (mandated enrollment to managed care)

- §1915(b)(2) (central broker)
- §1915(b)(3) (employ cost savings to furnish additional services)
- §1915(b)(4) (selective contracting/limit number of providers)
- A program operated under §1932(a) of the Act.

Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved:

- A program authorized under §1915(i) of the Act.
- A program authorized under §1915(j) of the Act.
- A program authorized under §1115 of the Act.

Specify the program:

#### H. Dual Eligibility for Medicaid and Medicare.

Check if applicable:

- This waiver provides services for individuals who are eligible for both Medicare and Medicaid.

## 2. Brief Waiver Description

---

**Brief Waiver Description.** *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Waiver for Adults with Developmental Disabilities provides supports to eligible adults with developmental disabilities ages 18 and over. The supports provided are designed to prevent or delay out-of-home residential services for participants or to provide residential services in the least restrictive community setting for participants who would otherwise need ICF/IID level of care.

The Waiver affords participants the choice between participant direction, including both budget and employer authority and more traditional service delivery, or a combination of the two options. The number of participants served each year is based on available State appropriation levels.

Participants who choose home-based supports may select from a menu of services based on their individual needs within an overall monthly services cost maximum. Typical services chosen by participants may include day programs as well as personal support services provided by domestic employees or by employees of direct service providers. When participants exercise employer authority and hire domestic employees, the services of a Financial Management Services (FMS) entity are available. Participants also have a variety of therapies and other services available to them.

Residential service participants are provided with residential services and supports from the qualified provider of their choice. These participants may also select day programs and have a variety of therapies and other services available to them.

All participants receive assistance in directing service delivery options from Independent Service Coordination (ISC) entities under contract with the Operating Agency.

Independent Service Coordination (ISC) entities under contract with the Operating Agency serve as the local point of access for adults with developmental disabilities.

In cooperation with the Illinois Department of Healthcare and Family Services (the State Medicaid Agency), the Illinois Department of Human Services, Division of Developmental Disabilities, functions as the Operating Agency (OA) for the administer of the Waiver for Adults with Developmental Disabilities.

## 3. Components of the Waiver Request

---

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):
- Yes.** This waiver provides participant direction opportunities. *Appendix E is required.*

**No.** This waiver does not provide participant direction opportunities. *Appendix E is not required.*
- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Improvement Strategy.** Appendix H contains the Quality Improvement Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

#### 4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):
- Not Applicable
- No
- Yes
- C. Statewideness.** Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act (*select one*):
- No
- Yes

If yes, specify the waiver of statewideness that is requested (*check each that applies*):

- Geographic Limitation.** A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State.

*Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:*

- **Limited Implementation of Participant-Direction.** A waiver of statewideness is requested in order to make *participant-direction of services* as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State.
- Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:*

## 5. Assurances

---

In accordance with 42 CFR §41.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
  2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
  3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.
- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
  2. Given the choice of either institutional or home and community-based waiver services. **Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Act (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) age 21 and under and the State has not included the optional Medicaid benefit cited in 42 CFR § 440.160.

## 6. Additional Requirements

---

*Note: Item 6-I must be completed.*

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected frequency and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.
- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/IID.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.151, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s)

of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

**H. Quality Improvement.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Improvement Strategy specified in **Appendix H**.

**I. Public Input.** Describe how the State secures public input into the development of the waiver:

Illinois secured public input into the development of this waiver through 2 separate statements of public notice and input. One form of public notice was electronic through a posting on the HFS website; <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Pages/default.aspx>; and on the website of the Operating Agency, the Illinois Division of Developmental Disabilities found at: <http://www.dhs.state.il.us/page.aspx?item=45915>. For persons that may not have access to the website, a second, non-electronic publication of the waiver renewal was made available. This non-electronic publication is the Illinois Register issued on May 29, 2015. In the 2 methods of public notification, the dates of the 30 day public input period were identified. The 30 day public period is from 5/29/15 - 6/28/15.

In addition to these 2 methods of notification, the OA sent an e-mail blast with the same language found in the Illinois Register and on the website to its stakeholders which includes provider agencies and care coordination entities. These entities were asked to inform the public of the opportunities as described in the public notice to access a copy of the waiver application from the HFS or DHS - DD websites described above, or to review a copy at the Independent Service Coordination (ISC) agencies across the State. To locate the closest ISC agency or see a listing of all ISC agencies, persons were instructed to use the Office Locator on the DHS website at <http://www.dhs.state.il.us/page.aspx?module=12&officetype=3&county>.

The public interested in providing input was asked to e-mail their feedback to the HFS web portal e-mail address: [HFS.SWTransitionPlan@illinois.gov](mailto:HFS.SWTransitionPlan@illinois.gov); or mail their input to the Illinois Department of Healthcare and Family Services, Attn: Waiver Management, 201 South Grand Ave East, 2nd FL, Springfield, IL 62763.

As discussed above, the public notification indicates that all stakeholders have the opportunity to provide the State input either electronically through the website or non-electronically through the U.S. mail. In addition, the full waiver renewal application is available to the public to review and comment and Illinois has provided multiple levels of contact with our stakeholders.

A summary of the public notice and comments has been incorporated into the renewal prior to submission to federal CMS. This summary includes modifications to the initial waiver renewal and reasons why the State is not adopting specific comments or recommendations.

In addition, Illinois informed via U.S. Mail and e-mail and sought feedback from our representative of the Tribal Authority or First Nation of Illinois' intent to renew this waiver on January 9, 2015. On May 26, 2015, a second letter was sent via U.S. Mail and e-mail informing of the extension of this waiver and its' posting for public comment. In all letters to the Authority, HFS has offered to meet and discuss the waiver.

Specific to Statewide Transition Plan:

Illinois established a LTSS Inter-Agency workgroup in April, 2014 to address the Statewide Transition Plan (STP) in response to the HCBS new regulations. This workgroup continues to meet throughout the implementation of the STP.

In accordance with CMS-2249-F/2296-F, (iii), Illinois provided a 32-day public notice and comment period with two statements of public notice, one non-electronic and one electronic with several methods to inform and engage the public in providing the State with feedback on the draft Statewide Transition Plan. In addition, Illinois informed and sought feedback from our representative of the Tribal Authority or First Nation. The Plan reflects input received and has been modified accordingly.

Illinois' strategies to comply with public notice and input are detailed in Illinois Statewide Transition Plan to Comply with the Department of Health and Human Services Centers for Medicare and Medicaid (CMS) 2249-F and 2296-F Regarding Home and Community-Based Services (HCBS) Settings Rules in Illinois' 1915c Waivers which was submitted to federal CMS on March 16, 2015 and can be found at: <http://www2.illinois.gov/hfs/MedicalPrograms/HCBS/Transition/Pages/default.aspx>.

In addition, Illinois hosted six public listening forums at which 175 stakeholders signed attendance sheets and a webinar in which 265 individuals participated.

The input that was received was incorporated into the Transition Plan or there was indication in the Plan of either the inability of the State to respond or how the State intends to respond to comment in the future.

The State gathered public input for this Waiver Renewal in several ways. The public comment period started on Tuesday, February 9, 2017, and concluded on Thursday, March 10, 2017. Second, on February 9, 2017 the Medicaid Agency posted on its public website a draft of the proposed Waiver Renewal. The draft Waiver Renewal will stay on the public website until final approval of the Renewal from CMS.

Finally, the State issued notice to allow for tribal notification on February 10, 2017.

The State received 119 public comments during the public comment period with 8 additional comments received after the end of the comment period. The State did not receive any comments during the tribal notice period. The State received 149 comments during the comment period with 7 additional comments being received after the end of the second comment period.

The Waiver Renewal applications are located at the following active link:

<https://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx>. In addition, the Illinois Department of Healthcare and Family Services (HFS) posts all Waiver Renewals on its website. Lastly, anyone can request a hard copy of the entire waiver by calling a number listed on the notice. The public notice invited comments via email or mail.

For additional public comments please see section: Main B. Optional

**J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date is provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

**K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

**7. Contact Person(s)**

---

**A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

Last Name:

Holden

First Name:

Dan

Title:

Senior Public Service Administrator

Agency:

Department of Healthcare and Family Services

Address:

201 South Grand Avenue East - 2nd Floor

Address 2:

City:

Springfield, IL

State:

Illinois

Zip:

62763

Phone:

(217) 557-0997 Ext:   TTY

Fax:

(217) 557-4497

E-mail:

dan.holden@illinois.gov

**B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:**

Last Name:

Leach

First Name:

Stephanie

Title:

Senior Public Service Administrator

Agency:

Department of Human Services

Address:

Division of Developmental Disabilities

Address 2:

600 East Ash Street, Bldg. 400

City:

Springfield

State:

Illinois

Zip:

62703

Phone:

(217) 552-4139 Ext:   TTY

Fax:

(217) 558-2799

E-mail:

Stephanie.Leach@illinois.gov

**8. Authorizing Signature**

---

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are *readily* available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: Kelly Cunningham

State Medicaid Director or Designee

Submission Date: Dec 7, 2017

Note: The Signature and Submission Date fields will be automatically completed when the State Medicaid Director submits the application.

Last Name: Hursey

First Name: Teresa

Title: Acting Medicaid Director

Agency: Healthcare and Family Services

Address: 201 South Grand Avenue East

Address 2:

City: Springfield

State: Illinois

Zip: 62763

Phone: (217) 782-5672 Ext: TTY

Fax: (217) 782-5672

E-mail: Attachments teresa.hursey@illinois.gov

Attachment #1: Transition Plan

Check the box next to any of the following changes from the current approved waiver. Check all boxes that apply.

- Replacing an approved waiver with this waiver.
Combining waivers.
Splitting one waiver into two waivers.
Eliminating a service.
Adding or decreasing an individual cost limit pertaining to eligibility.
Adding or decreasing limits to a service or a set of services, as specified in Appendix C.
Reducing the unduplicated count of participants (Factor C).
Adding new, or decreasing, a limitation on the number of participants served at any point in time.
Making any changes that could result in some participants losing eligibility or being transferred to another waiver under 1915(c) or another Medicaid authority.

☐ **Making any changes that could result in reduced services to participants.**

Specify the transition plan for the waiver:

As a condition of approval for the Adults with Developmental Disabilities waiver (effective date of July 1, 2017), it was determined that a CAP should be implemented for Administrative Authority and Health and Welfare. The CAP was approved 12/06/2017 and expected to be fully implemented by 12/31/18.

**Attachment #2: Home and Community-Based Settings Waiver Transition Plan**

Specify the state's process to bring this waiver into compliance with federal home and community-based (HCB) settings requirements at 42 CFR 441.301(c)(4)-(5), and associated CMS guidance.

*Consult with CMS for instructions before completing this item. This field describes the status of a transition process at the point in time of submission. Relevant information in the planning phase will differ from information required to describe attainment of milestones.*

*To the extent that the state has submitted a statewide HCB settings transition plan to CMS, the description in this field may reference that statewide plan. The narrative in this field must include enough information to demonstrate that this waiver complies with federal HCB settings requirements, including the compliance and transition requirements at 42 CFR 441.301(c)(6), and that this submission is consistent with the portions of the statewide HCB settings transition plan that are germane to this waiver. Quote or summarize germane portions of the statewide HCB settings transition plan as required.*

*Note that Appendix C-5 HCB Settings describes settings that do not require transition; the settings listed there meet federal HCB setting requirements as of the date of submission. Do not duplicate that information here.*

*Update this field and Appendix C-5 when submitting a renewal or amendment to this waiver for other purposes. It is not necessary for the state to amend the waiver solely for the purpose of updating this field and Appendix C-5. At the end of the state's HCB settings transition process for this waiver, when all waiver settings meet federal HCB setting requirements, enter "Completed" in this field, and include in Section C-5 the information on all HCB settings in the waiver.*

Illinois assures that the settings transition plan included with this waiver renewal will be subject to any provisions or requirements included in the state's approved Statewide Transition Plan. The State will implement any required changes upon approval of the Statewide Transition Plan and will make conforming changes to its waiver when it submits the next amendment or renewal.

The following represent key components of the Statewide Transition Plan and represent language taken directly from the Plan.

The HCBS regulations require States to ensure that individuals receiving Long-Term Services and Supports (LTSS) have full access to the benefits of community living and the opportunity to receive services in the most-integrated setting appropriate and that those rights and privileges are comparable to those afforded to Non-Waiver participants in the community.

In the spring of 2014, the Illinois Department of Healthcare & Family Services (HFS) convened an LTSS Inter-Agency workgroup consisting of representatives of: HFS as the State Medicaid Authority responsible to federal CMS for oversight of the State's nine 1915(c) Waivers; the Illinois Department of Human Services (DHS) and its Divisions of Developmental Disabilities (DDD), Mental Health (DMH), Alcoholism and Substance Abuse (DASA), Rehabilitation Services (DRS); the University of Illinois at Chicago Division of Specialized Care for Children (DSCC); and the Illinois Department on Aging (IDoA).

Illinois' Statewide Transition Plan included an assessment of existing State statutes, regulations, standards, policies, licensing requirements, and other provider requirements, including whether waiver settings' comply with the regulations as outlined at 42 CFR 441.301(c)(4)(5) and 42 CFR 441.710(a)(1)(2). Furthermore, the Statewide Transition Plan describes the remediation steps Illinois plans to implement to assure full and on-going compliance with the HCBS settings requirements, with specific timeframes for already-identified actions and deliverables.

Based upon follow-up site validation visits to provider settings, the State agencies under whose jurisdiction these settings operate along with HFS, are in the process of notifying providers who are not in compliance with the new regulations. Specific explanations are to be presented to the providers regarding areas of their service setting and practice which do not comply with the new regulations.

The State has made recommendations as to whether certain Illinois' HCBS settings qualify for "Heightened Scrutiny".

The State is working with HCBS waiver providers to bring their settings into compliance with the new regulations. When remediation actions have failed, it will become necessary to inform participants and their families, guardians or representatives that an alternate compliant setting will need to be selected.

The development of the Illinois Statewide Transition Plan was subject to public input, as required at 42 CFR 441.301(6)(B) (iii) and 42 CFR 441.710(3)(iii) and describes the process Illinois utilized for obtaining initial stakeholder input as well as plans to maintain stakeholder dialogue as the Transition Plan is modified.

The first Statewide Transition Plan was submitted to federal CMS on March 16, 2015. After receiving guidance from CMS, subsequent revisions to the plan have been submitted on February 29, 2016 and February 1, 2017.

### Additional Needed Information (Optional)

---

Provide additional needed information for the waiver (optional):

In accordance with federal regulations, the Medicaid and Operating agencies sought public comment on the proposed renewal application. The draft application was posted on February 9, 2017, at the website of the Medicaid Agency, the Illinois Department of Healthcare and Family Services (HFS), at <https://www.illinois.gov/hfs/SiteCollectionDocuments/ADULTDDrenewal02092017.pdf>. The posting for public comment ran through March 10, 2017. Additional comments were received through March 16, 2017 and those comments were included for response. A second public notice period was conducted from May 31, 2017 to June 30, 2017.

Interested parties were given two means through which to submit public comments: Comments could be submitted via e-mail to [HFS.HCBSWaiver@illinois.gov](mailto:HFS.HCBSWaiver@illinois.gov), or in writing to:

Illinois Department of Healthcare and Family Services  
Attention: Waiver Manager  
201 S. Grand Avenue East, 2nd Floor  
Springfield, IL 62763

The Operating Agency also posted the draft on its website at <http://www.dhs.state.il.us/page.aspx?item=45915>. In addition, it shared the link and an overview of significant changes with its major trade and advocacy organizations, encouraging them to review the draft and participate in the public comment period. These organizations in turn shared the information with their members. The Operating Agency also included an item about the draft application and public comment period in the February 17, 2017, edition of its newsletter to stakeholders.

A total of 119 commenters responded with input during the public comment period and 8 additional comments were received after the comment period had ended for a total of 127 separate comments. The key points and the State's response to each are listed below. Please note that many individual comments that were received had multiple points and that numerous people responded multiple times.

Issue: One contact per year by the Independent Service Coordination (ISC) agency is not enough. This issue was noted on 25 received public comments.

Response: The State modified language in the Waiver to clarify a minimum of two separate direct, in-person contacts are required for the ISC per year. One is for plan development; the other is to monitor the plan's implementation. Additional contacts will be made based on the needs and preferences of the Waiver participant.

Issue: ISC agencies indicate the proposed plan template and processes take more hours than are supported by the current fee-for-service payment structure for this administrative activity. This issue was noted on 16 received public comments.

Response: The draft template and processes have been tested by ISC agencies. A workgroup is now revising the documents based on the feedback received to ensure compliance with Federal and State regulations and to provide for as much efficiency as possible. The new format and processes will be finalized and implemented by July 1, 2017. The current Waiver indicates that ISC agencies will have contact with all Waiver Participants a minimum of four times per year. The renewal application changes that to a minimum of one visit per year in the home in addition to the time spent with the individual and guardian during the assessment and planning processes, for a total minimum contact of two per

year. Additional contact will be determined by the needs of the individual, per guidelines issued by the Operating Agency. We believe this change will give ISC agencies the flexibility to direct their resources based on the needs of the Participants at a given point in time.

Issue: The current Waiver states the maximum number of billable hours for Employment and Day services is 1,100 per year. This maximum is based on the requirement that Developmental Training sites be open for services a minimum of five hours per day for 240 days per year, or a total of 1,200 per year. The State then calculated the hourly rate with an absentee factor so that the 1,200 per year could be billed in 1,100 hours. The State proposes changing the methodology to allow for billing of 1,200 hours per year. Some providers objected to this change indicating they would lose funding due to absenteeism and others identified a potential loss of revenue to the system due to a rounding issue. This issue was noted on 61 received public comments.

Response: The State intends to follow through with this proposed change. While this practice has been in place for decades now, it continues to cause confusion for stakeholders as to the number of service hours that are actually calculated into the annual funding amount. While the hourly rate will be reduced to accommodate this change, the annual amount of funding will remain constant, but providers' revenue will reflect actual attendance. In addition to simplifying the methodology, we believe this change will make it easier for Participants to develop Plans that incorporate multiple types of Employment and Day services. The full 1200 hours must be available to Participants so they can choose among all types of day programs, including employment related services. The State has addressed the rounding issue and will ensure no funds are lost to the system.

Issue: Commenters indicate that the rates paid under the Waiver programs are too low, specifically citing provider wages for Direct Support Persons. This issue was noted on 97 received public comments.

Response: The State is aware of stakeholder concerns regarding wages for Direct Support Persons in residential and day programs. This issue continues to be discussed as part of the State's budgetary negotiations. The renewal application reflects estimated average costs to the State as allowed by current spending authority. Current spending levels have been sufficient to sustain growth in the Waiver, as reflected by the requested increase in capacity, and development of new residential sites.

Issue: Commenters liked the addition of the new Community Access/Pathways to Employment Service. This issue was noted on 34 received public comments.

Response: No response needed.

Issue: The State is undergoing a change in its case management functions for the self-directed Home-Based Support Services Program. Commenters asked questions regarding the role of the ISCs compared to the functions of the Information and Assistance in Support of Participant Direction service (formerly called Service Facilitation). This issue was noted on 10 received public comments.

Response: The State is in the midst of sharing information about the changes, making documents available on its website and informing families through the Independent Service Coordination agencies.

Issue: The State is proposing to add a new service to assist providers serving Participants with exceptionally challenging behavior issues regarding property destruction. The State proposed the new service be limited to individuals with two previous psychiatric administrations. Commenters felt this was too limiting. This issues was noted on 30 received public comments.

Response: The State has modified the language to indicate the service would be limited to individuals who have extreme behavior issues as evidenced by a functional analysis of property destruction by a qualified behavior therapist under this Waiver per guidelines issued by the OA. Prior approval must coincide with the development of a behavior intervention strategy to address this behavior.

Issue: Family members providing comment on the revised definition of Supported Employment-Individual reviewed the language as limiting their options for providers of service. This issue was noted on 4 public comments.

Response: In C-1/C-3, the State modified the definition of Individualized Supported Employment to remove language restricting and discouraging providers of Supported Employment services from also being the employer of record. We have

maintained the Medicaid free-choice-of-provider requirement to be able to choose a different provider of Supported Employment-Individual services without jeopardizing their continued employment.

Issue: In C-1/C-3, family members providing comment on the revised definition of site-based Developmental Supports thought that language in the last paragraph was confusing as to whether individuals are required to participate in other types of day programs.

This issue was noted on 3 public comments.

Response: The word "expected" was changed to "encouraged". The phrase, "consistent with individual's informed choice" was added to the end of the last sentence for clarity.

Issue: A commenter indicated that some quality assurance review findings are corrected immediately rather than through a plan of correction.

This issue was noted on 1 public comment.

Response: The State added clarifying language to reflect that some findings are corrected immediately while reviewers are on site rather than through a plan of correction.

Issue: A commenter identified a few remaining references to mental retardation and suggested the requirement of the need for active treatment be removed from the eligibility criteria.

This issue was noted on 1 public comment.

Response: The references to mental retardation have been corrected. The need for active treatment under the eligibility criteria has been replaced with the need for ICF/IDD level of care.

Issue: Several commenters noted confusion in the language as to the entity responsible for conducting risk assessments. This issue was noted on 6 public comments.

Response: The State clarified this language.

Issue: Commenters pointed out the need for various technical corrections.

This issue was noted on 30 public comments.

Response: The State has made the needed changes.

During the second Public Notice period (May 31, 2017 to June 30, 2017), A total of 149 commenters responded with input during the public comment period and 7 additional comments were received after the comment period had ended for a total of 156 separate comments. The key points and the State's response to each are listed below. Please note that many individual comments that were received had multiple points and that numerous people responded multiple times.

Issue: Commenters proposed utilizing people with IDD to expand the DSP workforce. (14 Comments)

Response: Currently, there is nothing in the Waiver that prevents this as long as the individual is able to meet the provider qualifications.

Issue: Commenters proposed that there are not enough contacts by the ISC and that they had concerns with the roles and functions of the ISC's. (3 Comments)

Response: The Waiver indicates that one ISC contact is for plan development and the other is to monitor the plan's implementation. Additional contact will be made based on the needs and preferences of the Waiver participants. In addition, ISC case management functions are aligned with federal CMS expectations.

Issue: Commenter showed concern about implementing the Person Centered Plan and concerns of the provider's role. (10 comments)

Response: The State asks that the agencies do their best that they can as we look at identified needs or lack of needs during the transition period to person centered planning. The providers can contact the State and the State will track and assist. Participants need to be able to explore their options using person centered planning.

Issue: Commenters proposed more flexible and supportive housing as an option. (14 comments)

Response: The State currently has Waiver participants who are in supportive housing and supports it as an option for Wavier participants to consider.

Issue: Commenters indicated that the rates paid under the Waiver are too low, specifically citing provider wages for Direct Support Persons. (54 Comments)

Response: The State is aware of stakeholder concerns regarding wages for DSP's in residential and day programs. The State has implemented a \$.75 wage increase and has reflected those rates in the current re renewal application.

Issue: Commenters showed concern over the sit-based DT rate going from \$10.39 in the approved Waiver to \$9.53 in the pending application. (126 comments)

Response: The State has changed the pending renewal application addressing the rate issue by combining the Site-based DT and Community Access into Community Day Services. The 10.39 rate will be paid for Community Day Services (that is not including the increase which brings it to \$10.88)

Issue: Commenters showed concern over the State giving individuals who wish to be in Day Programs the flexibility of using 1200 hours combined for the Day Program options instead of having 1100 hours as in the currently approved Waiver. (27 comments)

Response: The State has adjusted the Application back to 1100 hours as a cap for all Day Programs.