

Illinois' Plan to Comply with New Federal Home and Community-Based Services Requirements

Provider Questions and Answers

This Question and Answer document provides an overview of the requirements from the final regulations for Home and Community-Based Services (HCBS), published by the federal Centers for Medicare and Medicaid Services (CMS). The final regulations require HCBS Waiver settings to comply with them by March 17, 2019. The new regulations are located at 42 CFR 441.301(c)(4), (5) and 441.710(a)(1), (2). Illinois' plan for complying with these regulations and supporting materials are available at <http://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx>.

1. What are the new federal HCBS rules, and what is the Statewide Transition Plan?

The new federal HCBS rules apply to Medicaid HCBS Waiver settings. The rules are designed to enhance the quality of home and community-based services, provide additional protections to HCBS program participants, and ensure that individuals receiving services through HCBS programs have full access to the benefits of community living. (The rules state requirements for HCBS settings, and they grant states and settings until March 17, 2019, to comply.) Sites that do not comply by that date would be barred by federal law from participating in an HCBS Medicaid waiver program.

In response to these new federal rules, Illinois developed a Statewide Transition Plan, available at the above link, to show how Illinois will help providers meet the new federal HCBS rules. The state kicked off the plan by trying to get a better understanding of where the sites stand in relation to the new rules through a self-assessment survey. Illinois then evaluated and categorized each site based on the survey results, as explained in Question 3 below. After categorization, some sites will receive an on-site validation visit and a remediation plan, if needed, to reach full compliance. This is explained further in Questions 4 and Question 5. Generally, sites can expect this on-site process to be similar to their existing regular reviews. After the on-site visit, many sites may need to make some changes in order to reach full compliance. The State plans to continue working with providers during the transition period to help them reach compliance by March 17, 2019. The new federal rules will become one of the things the State looks for in its routine monitoring checks.

2. To whom do the rules apply?

This rule applies to all sites, residential and non-residential, that provide Medicaid services under any of Illinois' nine 1915(c) HCBS Waiver programs:

1. HCBS Waiver for Adults with Developmental Disabilities (Operated by DHS)
2. Residential Services for Children and Young Adults with Developmental Disabilities (DHS)
3. Support Waiver for Children and Young Adults with Developmental Disabilities (DHS)
4. HCBS Waiver for Children Who Are Medically-Fragile, Technology-Dependent (DSCC)
5. HCBS Waiver for Persons who are Elderly (IDoA)
6. HCBS Waiver for Persons with HIV or AIDS (DHS)
7. HCBS Waiver for Persons with Brain Injury (DHS)
8. Persons with Disabilities (DHS)
9. Illinois Supportive Living Program (HFS)

3. I have heard that the State has divided its providers into categories. What does the category classification mean to me?

In order to determine whether waiver providers already comply with the federal rule or whether they need to make changes, Illinois asked its waiver providers to complete a self-assessment survey. These surveys helped divide all providers into four different categories:

1. Settings that fully align with the federal requirements;
2. Settings that do not comply with the federal requirements but may comply with modifications;
3. Settings that are at risk of being unable to meet the federal requirements and require removal from the HCBS program and relocation of individuals; and
4. Settings that are presumably not home and community-based (i.e., are presumed to be institutional), but for which the State may provide justification/evidence through the federal heightened scrutiny process to show that the settings do not have the characteristics of an institution and do have the qualities of home and community-based settings.

The categorization itself will not lead to any action or decision on whether a setting complies with the federal rule; it will help establish the method the State will use to determine whether a setting meets the federal rule.

Category 1 or 2 settings will be asked to be sure they comply by the March 17, 2019 deadline. Those settings are likely to have to make minor changes (or no changes at all for Category 1) to show that they are compliant. Those sites may be asked to send the State a letter or other documentation so that the State knows they have made any changes needed for compliance (or to let the State know that they cannot comply), as explained in Question 7. Also, some of these sites may be part of the sample of Category 1 and 2 settings that receive an on-site visit, as explained in Questions 4 and 5.

Category 3 settings will receive an on-site visit, and may receive a compliance plan. Classification into Category 3 does not mean a site will be shut down or that HCBS participants will be moved from that setting. However, a site in Category 3 will need to make changes – probably more changes than Category 1 or 2 settings – to comply with the federal rule.

Category 4 settings presumed to be institutional. As with Category 3, settings that fall into Category 4 will not be shut down automatically. Instead, Category 4 settings must be approved through the federal heightened scrutiny process (described in Question 8) in order to continue to participate in Illinois Medicaid’s HCBS programs.

4. Will I receive an on-site visit as part of the assessment process?

Federal CMS requires the State to “validate” the results of its provider surveys by having on-site visits. The State expects to begin this process by publishing a list of the sites it has placed in Category 3 and Category 4 (to the extent it can do so without violating clients’ privacy interests) to get public comment on how those settings were categorized. The State’s on-site reviewers will use any public input to help create the results for on-site visits.

For Category 1 and 2 settings, federal CMS requires the State to do on-site visits to a “statistically valid sample” of settings. These visits will be conducted in the same manner as the visits to the Category 3 and Category 4 visits. That is, if your setting is informed ahead of time of normal monitoring visits, it will be notified ahead of time of the visits for this plan. Also, as much as possible, State reviewers will make their work, interviews, and inspections for this plan fit into the work they normally do to monitor settings.

All settings that have been categorized as Category 3 or Category 4 can expect an on-site visit. This process will be similar to existing visits, and will be conducted by the normal oversight agency the setting already works with (see Question 2). This process is further explained in Question 5.

This survey validation process will happen only one time. Once the surveys have been validated, settings’ compliance with the new federal rule will be monitored on an ongoing basis as part of the State’s normal review process.

5. What can I expect in an on-site visit?

Each setting that will receive an on-site visit, can expect this visit to be conducted by its normal oversight agency (for example, HFS will conduct Supportive Living Provider visits; DHS will conduct Community Integrated Living Arrangement visits). The State will make this on-site visit align as much as possible with existing monitoring. The State intends most of the HCBS on-site visits to take place at the same time as other, already planned on-site monitoring visits. The on-site visits will include interaction with individual clients, record reviews, meetings with key setting staff, and reviews of individual service plans, all by the agencies and personnel most qualified to conduct the reviews for the setting in question. All on-site reviews will be conducted using a tool the State developed based on published CMS guidance and revised based on stakeholder input. This tool appears in Appendix I of the Statewide Transition Plan, available at the link on Page 1 of this document.

6. What types of actions should I take to prepare for an on-site visit?

Sites should prepare for the on-site visit in the same way they prepare for their existing regular reviews. In order to minimize the burden on providers, the State will try to combine the HCBS Plan on-site visit with existing State visits.

7. What types of changes will I be required to make to comply with the federal HCBS rules?

The State will begin the remediation process by publishing a provider Informational Notice listing all of the measures its HCBS settings are required to meet under the new federal rules.

For sites whose assessment survey and validation show only small areas of non-compliance, the setting will be asked to (1) submit documentation such as a letter describing the changes made to achieve full compliance; and (2) demonstrate full compliance with both the claims in the letter and with the HCBS requirements during the next visit it receives during the ongoing monitoring process.

For sites with more substantial non-compliance with the rule, the State will require the setting to submit a corrective action plan for achieving full compliance before the effective date of the federal rule, March 17, 2019.

8. What is the “Heightened Scrutiny” process?

The new federal rule says that certain types of settings, such as those that are attached to an institution or that are part of a campus, must be presumed to be institutional. That is, the federal rule requires Illinois to assume these sites do not comply. Those sites will be placed in Category 4, described in Question 3. However, the federal rule provides a process that lets the State argue that a Category 4 site should be able to stay on as a Medicaid waiver provider. This process is called the “heightened scrutiny process.”

Under that process, the State may present evidence to federal CMS that a site that has been presumed to be institutional is actually home- or community-based. The federal government has the final authority to decide whether a provider is a community or institutional setting. The State makes the initial determination on whether to challenge the presumption and seek federal heightened scrutiny review. To make this determination, the State will use public comments, consultation with the affected settings, and information already available.

The State understands that many successful settings may currently exhibit features that make them appear at first look to be institutional under the federal rules. Because the State recognizes the important role many of these settings hold in the social service system, it will work with the settings to present evidence to the federal government that they are well-integrated programs.

9. If necessary, how will waiver participants be relocated?

If the State believes that a site cannot be compliant by the March 17, 2019 federal deadline, it will begin transitioning the site’s waiver participants as appropriate. The State will notify affected participants and their families, guardians, and representatives as soon as possible of the need to relocate. The State will work within existing structures to afford participants an informed choice of available options and will make every effort to relocate affected participants to the most integrated setting appropriate to their needs and close to family and friends. These efforts will be led by the state agency that operates the waiver program of the affected participants. Participants or their legal guardian will have the final say regarding where they relocate.

10. What is the timeline for this project?

The State has already taken several steps towards complying with the new federal rule, including development of a transition plan, an assessment of settings, and the survey process of HCBS settings. The State expects to complete all of the on-site visits as well as initial Heightened Scrutiny recommendations for this process by the end of calendar year 2016. Additionally, the State will be reviewing and modifying waiver documents, Illinois Administrative rules, and provider agreements, to

be completed by July 2018. While the State will be working towards several important deadlines, everything must be completed by March 17, 2019.

For a complete timetable and more detailed information, please refer to Appendix G located in the Statewide HCBS Transition Plan available at the following location

<http://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx>.

11. Where can I find more information?

HCBS Training by CMS: <https://www.medicare.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/home-and-community-based-services/hcbs-training.html>

Regulatory Requirements for Home and Community-Based Settings:

<https://www.medicare.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Home-and-Community-Based-Services/Home-and-Community-Based-Services.html>

Healthcare and Family Services Home and Community Based Services Waiver Programs:

<http://www.illinois.gov/hfs/MedicalClients/HCBS/Pages/default.aspx>