Assessing the Feasibility of Implementing the Community First Choice Option in Illinois

Estimating the Potential for Additional Federal Funds and Identifying Implementation Issues

HCBS STRATEGIES INCORPORATED

HCBS.INFO

February 11, 2014

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Executive Summary

The report provides a high level study to determine the feasibility for implementing the Community First Choice (CFC) option in Illinois. CFC is a Medicaid option that allows individuals who need long term supports and services (LTSS) to receive attendant care in their homes or to access alternatives that reduce reliance on human assistance for meeting needs.

The effort developed estimates on the potential for additional federal funding and/or requirements for additional State General Revenue Funding (GRF) if CFC is implemented. The project scope also included the identification of operational issues necessary to implement CFC and a determination about whether implementing CFC appears consistent with other State initiatives. The report provides background information on the CFC option, a description of the report approach, presentation of findings and options, a discussion of possible next steps and conclusions drawn from this set of high level analyses.

Our analysis compared current services covered under existing 1915(c) home and community based services (HCBS) waiver against definitions of allowable services included in the Centers for Medicare & Medicaid Services (CMS) regulations and actual services included in two approved CFC applications (California and Oregon). This analysis suggests that almost all existing Medicaid HCBS could be covered under CFC. Based on State Fiscal Year (SFY) 2010 data, we estimate that CFC could have brought in approximately $200 million in additional federal dollars. Of this, personal care services account for approximately half of these additional federal dollars. Residential services were the next biggest category, accounting for approximately $65 million in additional federal funding.

Unlike the current 1915(c) Waivers, CFC is an entitlement and, therefore, the State will not be able to cap enrollment in the program. Because CFC is an entitlement, some or all of the individuals currently on the Developmental Disabilities (DD) waitlist will likely be served. The extent to which these individuals shift to CFC will depend upon the design of the program. We describe five different implementation scenarios for which two are projected to require no additional GRF required, two require modest additional outlays of GRF ($1 to $9 million), and one would require a substantial increase in GRF ($125 million).

This study used a relatively simple approach for estimating potential costs. The actual costs will be influenced by a variety of additional factors that could not be accounted for as part of this study.

EXECUTIVE SUMMARY

Illinois will need to carefully consider the implications of CFC for its proposed 1115 demonstration waiver. Because the 1115 also proposes to restructure the delivery of HCBS, the State will need to consider whether the initiatives are compatible.

Purpose and Background

The State of Illinois requested HCBS Strategies, Inc., a small consulting firm with extensive experience in home and community based services (HCBS) delivery systems, to complete a high level study to determine the feasibility for implementing the Community First Choice (CFC) option. CFC is a Medicaid option that allows individuals who need long term supports and services (LTSS) to receive attendant care in their homes or to access alternatives that reduce reliance on human assistance for meeting needs.

The effort developed estimates on the potential for additional federal funding and/or requirements for additional State General Revenue Funding (GRF) if CFC is implemented. The project scope also included the identification of operational issues necessary to implement CFC and a determination about whether implementing CFC appears consistent with other State initiatives. The report will be used to inform members of the executive branch and agency leaders in making decisions about the future of publicly funded home and community LTSS in Illinois.

The report provides background information on the CFC option, a description of the report approach, presentation of findings and options, a discussion of possible next steps and conclusions drawn from this set of high level analyses. It is important to note that Illinois is currently implementing other initiatives, such as Balancing Incentive Program (BIP) and Money Follows the Person (MFP). These initiatives contain work plan components that are complementary to CFC requirements. Illinois is also developing other options that may impact the adoption of CFC, such as using the 1115 demonstration waiver authority to administer LTSS. We discuss the relationship of CFC to other major initiatives in key areas in order to facilitate decisions.

BACKGROUND ON CFC

CFC is a Medicaid state plan option introduced in Section 2401 of ACA and signed into law as section 1915(k) of the Social Security Act. The legislation allows a state option to provide "person-centered" home and community-based attendant services and supports. CMS issued proposed rules for this program on February 25, 2011 and published final rules on May 7, 2012.

The option creates another means to fund HCBS under the Medicaid state plan, similar to the 1915(c) HCBS waiver, the authority under which Illinois currently provides most of its HCBS. The following are the major differences between the CFC and 1915(c) waiver authorities:

- **Enhanced match:** CFC provides an enhanced 6 percent federal match above the current Federal Medical Assistance Percentage (FMAP). 1915(c) waivers do not offer any enhanced match. Given Illinois' current FMAP in which 50% of the costs of services are matched by the federal government, the federal government would cover 56% of the CFC service costs.
- **Entitlement:** CFC is an entitlement. Unlike a under a 1915(c) waiver, a state cannot places caps on the number of slots or place individuals on a waitlist.
- **Approval process:** Approval for CFC is obtained through a State Plan amendment and does not have to be renewed. 1915(c) waivers must be renewed three years after the initial application and every five years thereafter.
- **Services:** The range of services that can be offered under CFC is somewhat narrower than under a 1915(c) waiver. CFC is limited to providing supports relating to activities of daily living (ADLs) (e.g., bathing, dressing), instrumental activities of daily living (IADLs) (e.g., shopping, managing money) or health related tasks. These flexible benefits include personal attendant services and an expanded service set, including options to pay for goods that substitute for personal assistance, emergency response systems, skills training, training for participants regarding hiring/firing staff, and transition costs related to moving from a nursing facility to a community setting. In addition to these services, the 1915(c) authority has also been used to provide support for achieving other goals, such as stronger community integration and support for employment.
- **Service models:** CFC explicitly permits states to provide supports through an agency model, a self-directed budget model[1], cash model, or voucher model. The 1915(c) waiver authority traditional funds services provided by an agency, however, it has been used for other models, notably self-directed models.
- **Eligibility criteria:** Both CFC and 1915(c) waivers require that participants must meet an institutional level care (LOC). Under a 1915(c) waiver, a state can determine which of the following three LOC criteria it wishes to apply: 1) nursing facility, 2) intermediate

[1] Under a self-directed model, also called participant-directed or consumer-directed, individuals are given greater control over services. Types of control include the ability to hire and fire staff (e.g., the model for personal attendants offered under the Division of Rehabilitation Services (DRS) waivers, the ability to set rates (which is allowed under the Division of Developmental Disabilities (DDD) waivers), and the ability to use a flexible budget to pay for goods and services that substitute for hands-on care.

care facility for individuals with an intellectual disability (ICF/ID)[2], or 3) hospital. Under CFC, states must consider all of these LOC criteria.[3]

- **Service Availability**: Under CFC, services must be available statewide and to any individual meeting the functional and income eligibility criteria for the CFC program option. A 1915(c) waiver can be limited to certain sections of a state and may target specific populations, such as older adults or individuals with developmental disabilities.
- **Maintenance of Effort:** During the first year of operation of CFC, the state must maintain or exceed its level of financial effort across home and community based services for individuals with disabilities. There is no comparable requirement for a 1915(c) waiver.
- **Implementation Council:** The state must establish an implementation council for CFC. The majority of members must be individuals with disabilities or their representatives. There is no comparable requirement for a 1915(c) waiver.
- **Person Centered Assessment and Planning:** CFC requires a person centered approaches into processes for assessing needs and developing individual plans. There is no comparable requirement for a 1915(c) waiver.
- **Conflict Free Planning:** Under CFC, individuals conducting eligibility assessments and leading the development of individual support plans with the development of individual plans may not have any direct or indirect financial interest in decisions (e.g., they may not be a direct service provider). There is no comparable requirement for a 1915(c) waiver.
- **Quality Systems and Data:** Under CFC, states must adopt quality systems that collect and use consumer feedback and include measures of service outcome. The major differences between these requirements and those required for 1915(c) waivers are that while 1915(c) waivers do not explicitly requirement consumer feedback, the waiver application identifies a broader range of assurance that must be met.

CMS recently provided guidance that the enhanced match available for CFC would not be available if the program were implemented as part of an existing 1115 demonstration waiver. The rationale for this decision appears to be that CFC only applies to the Medicaid State Plan

[2] Federal regulations still refer to this as an intermediate care facility-mental retardation (ICF/MR)

[3] CFC also requires considering LOCs for an institution that provides psychiatric services for individuals under age 21and an institution for mental diseases for individuals age 65 or over, if they are included in the State plan. However, our interviews with State staff indicated that Illinois does not pay for these under the State plan, therefore, they appear not to be applicable.

and an 1115 is, by definition, not part of the State Plan. However, to our knowledge, CMS has not made a ruling regarding whether an existing CFC program for which enhanced match is already being received could be used as part of the baseline and alternate budget projections used for a new 1115.

The Kaiser Family Foundation reports that as of August 2013, eight states had implemented or are planning to implement CFC. California was the first state receiving approval for implementation of CFC, followed by Oregon (the first state to actually implement). Maryland and Arizona submitted state plan amendments. Arizona later withdrew its SPA based on CMS determination that CFC could not be approved under states with existing 1115 demonstration waivers. According to Kaiser, other states indicating intent to implement CFC include Arkansas, Minnesota, Montana, and New York.

We provide brief summaries of the California and Oregon plans below.

California

California's approved state plan offers CFC to individuals through both an agency model and a consumer directed budget or direct cash model. County social workers perform assessment and assist with the development of the person-centered plan. County social workers also provide information regarding service options. Individuals must meet institutional level of care and reside in a community based setting specified in California's State Plan Amendment as follows: *CFCO services are available and provided to individuals residing in settings that meet the federal regulatory requirements for a home and community-based setting and include, but are not limited to, single-family homes, duplexes, apartments, congregate independent living communities, and settings which provide room and board.*

California's CFC program covers a range of services including the following.

- Personal assistance services covering individual ADL/IADL activities, yard abatement work, paramedical tasks (delegated health tasks performed by an attendant), domestic services, and protective supervision.
- Skill acquisition services that are time limited (up to three months). These services are referred to as Teaching and Demonstration services. If skills are not acquired within three months, they may be re-authorized as needed through the planning process.
- Back-up systems include a risk assessment and mitigation plan. The state is NOT claiming federal match for these supports but include the service in its CFC state plan description.

- Voluntary training for managing CFC services is offered and performed by social workers during the initial assessment and reassessments. Materials such as handbooks are also made available.
- A Restaurant Meal Allowance serves in lieu of human assistance for meal preparation, clean-up and shopping for food.

For individuals receiving cash payments, the prospective payment may be made for individuals electing to receive the 1) Restaurant Meal Allowance option, and 2) for individuals using the Direct Cash (Advanced Pay) option. The Advance Pay option covers the costs of personal care/assistance, meal preparation and clean up, and paramedical services. Payment is managed through a Fiscal Management Service.

Individual budgets are established based on assessed needs and the services identified in the person-centered plan. As indicated above, providers may be obtained through an agency model or individuals may hire their own workers under a consumer directed model. Agency rates are negotiated by the state and published in a fee schedule.

Similar to Illinois, California's personal attendant workers have a collective bargaining agreement. Participants in CFC who hire workers under the consumer directed option must pay wages consistent with the collective bargaining agreement. Because the rates vary among counties, individuals are instructed to obtain information about wage rates from their social worker.

Oregon

Oregon's CFC plan is structured to allow a broad scope of activities within the service CFC categories. Additionally, Oregon is able to capture most of its licensed settings and providers within its definition of where services can be delivered. These are discussed below.

Settings for CFC Service in Oregon

The Oregon CFC program offers only an agency based option. Attendant services may be provided in the individual's home or in a licensed, certified or endorsed community program/setting of the person's choice. Programs and services must meet Oregon standards for home and community based services. The following characteristics define a home and community based setting in Oregon.

- The setting is integrated in and facilitates the individual's full access to the greater community, including opportunities to seek employment in competitive integrated

settings, engage in community life, control personal resources, and receive services in the community in the same manner as individuals without disabilities;

- The setting is selected by the individual from among all available alternatives and is identified in the person-centered service plan;
- An individual's essential personal rights of privacy, dignity and respect, and freedom from coercion and restraint are protected;
- Individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact are optimized and not regimented;
- Individual choice regarding services and supports, and who provides them, is facilitated.
    - The unit or room is a specific physical place that can be owned, rented or occupied under another legally enforceable agreement by the individual receiving services, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the State's landlord tenant law of the State, county, city or other designated entity.
    - Each individual has privacy in their sleeping or living unit unless the person centered plan identifies a risk to such privacy.
    - Units have lockable entrance doors, with appropriate staff having keys to doors.
    - Individuals share units only at the individual's choice.
    - Individuals have the freedom to furnish and decorate their sleeping or living units.
    - Individuals have the freedom and support to control their own schedules and activities, and have access to food at any time.
    - Individuals are able to have visitors of their choosing at any time.
    - The setting is physically accessible to the individual.
        - Not located in building with inpatient or institutional services.
        - Not adjacent to public institution or disability specific housing.

Given the above definitions and consistent with Oregon licensing regulations, the settings in which CFC may be provided include:

- Licensed, Certified or Endorsed Community-based settings include-
- Assisted Living Facility (ALF)
- Adult Foster Care (AFC)
- Adult Day Center
- Day Habilitation Provider

- Residential Care Facilities (RCF)
- Residential Treatment Facility/Home for Mentally or Emotionally Disturbed
- Persons
- Supported Living Providers
- Adult Group Home (GCH)
- Group Care Homes for Children (GCH)
- Developmental Disabilities Adult Foster Care
- Children's Developmental Disability Foster Care

Services and Covered Activities in Oregon's CFC Program

As mentioned above, Oregon's CFC covers a broad range of activities within each of the CFC service categories. If Illinois elected a similar approach, many of the current waiver services would operate under CFC. Below we provide a summary of the activities defined within each of the service categories to illustrate the flexibility within Oregon's approved CFC plan.

Assistance with ADLs, IADLs and Health-Related Tasks Through Hands-On Assistance, Supervision, and/or Cueing

The State covers services and supports related to core activities of daily living including: assistance with bathing/personal hygiene, dressing, eating, mobility (ambulation, transferring and positioning), bowel care and bladder care, stand-by support, cognition, memory care and behavior supports. IADL activities cover light housekeeping, laundry, meal preparation, shopping, and chore services.

Of particular note, Oregon also includes in its definition the provision of Community Nursing Services to support health related tasks. Community Nursing Services do not include direct nursing services and are not covered by other Medicaid authorities. Examples of the activities performed include chronic disease management, medication reviews, evaluation and identification of supports to minimize health risks, and delegation of nursing tasks.

Oregon allows Community Nursing Services to be provided under CFC only for individuals living in their own homes or foster care. Payment is not allowed for Community Nursing Services when a person lives in other residential settings.

Acquisition, Maintenance, and Enhancement of Skills Necessary for the Individual to Accomplish Activities of Daily Living, Instrumental Activities of Daily Living, and Health Related Tasks

Services provided under this category include skill training and maintenance related to functional skills and health related tasks. To be approved, the service must be tied to functional needs identified in the assessment and approved as part of the planning process. It is worth noting that the definition captures Community Nursing Services that incorporate training and maintenance activities. It does not include professional therapy or skilled nursing services, but can include activities that complement professional therapy services.

Back-up Systems to Ensure Continuity of Services and Supports

Covered services include electronic systems (including personal emergency response systems and mobile electronic systems), assistive technology (including motion and sound sensors, two-way communication systems, automatic faucet and soap dispensers, toilet flush sensors, incontinent sensors and fall sensors), relief care, and behavioral support services.

Voluntary Training on How to Hire and Dismiss Attendants

This service covers both individual and group based training.

Support System

Local, state or contracted case management entities perform support activities, including assessment and counseling prior to enrollment in CFC and plan development through person centered planning.

Permissible/Optional Services

These services include environmental modifications, assistive devices, community transportation, home delivered meals, and transition costs.

Service budgets are established on the basis of functional needs not otherwise met by state plan services in areas of ADLs and IADLs and the availability of a live-in provider on a 24 hour basis. Natural supports are considered when developing the individual plan for support. Some individual services, such as equipment or modifications, have individual cost maximums or other limitations based on factors such as type of residence.

POTENTIAL IMPLICATIONS FOR CFC IMPLEMENTATION

Illinois will need to consider the potential implications of CFC when making a decision whether or not to move forward to implement. Below we briefly describe four critical factors.

Entitlement: States with approved CFC plans previously had Personal Care Services as part of their Medicaid state plans. Thus, CFC does not create a new entitlement for these states. In Illinois has sizeable waitlists for its 1915(c) waivers targeting individuals with DD. Some or all

of these individuals on the waitlist would potentially be served under CFC depending upon how the program is structured. This study develops estimates of the costs of serving these individuals on the wait list under several potential scenarios.

Single Program: Current Illinois' waivers operate as individual programs. CFC would replace many (potentially almost all) current waiver services with a single program. While CFC might be structured to accommodate some of the population specific infrastructure used within the waivers (such as assessment tools, case management and provider networks), the majority of operations would need to be standardized. For example, self-directed services that now operate differently across the waivers would operate the same for every individual in CFC using a consumer directed option. Similarly, rates, service costs maximums and individualized budgets would be set under a common CFC approach.

Person Centered Planning and Participant Control: CFC emphasizes person centered planning and facilitation of participant control. Some of the existing processes used for comprehensive assessment and support planning, informed choice and options counseling would need enhancement and/or modifications. New approaches and tools for facilitating participant control would also likely be needed. Examples of new tools include consumer handbooks, training, and counseling resources to help individuals manage their own budgets and services.

Opportunity for Refinancing Existing Services: Based on the review of California and Oregon state plans for CFC, there appears to be significant opportunities to refinance existing waiver services under CFC to capture the enhanced FMAP. For example, it appears that Supportive Living Facilities (SLFs) and other residential services could be defined under the CFC umbrella. Some modifications in the process used to access SLF services may be required to meet the CFC standards for choice and conflict free planning, however, this could be accomplished through a high level planning process that ensures individuals select from a full range of other choices and identifying broad service goals prior to SLF referral.

Other examples of services likely to qualify under CFC include personal attendant services, assistive technology, environmental modifications and personal emergency response systems. Our analysis includes an evaluation of how likely refinancing would be for each of the waiver services.

Current Medicaid HCBS Options in Illinois

To remain consistent with the requirements for CFC, the study focuses on current Illinois programs having the greatest overlap with CFC. Two main criteria were used: 1) program eligibility requires individuals to meet institutional level of care; and, 2) individuals receive services in a community based setting. Additionally, for purposes of the study, we used a fairly broad definition of "community based". This latter item was based on the definitions used and approved for inclusion in the Oregon plan discussed above.

This section briefly describes the current Illinois Medicaid funded HCB LTSS options that presented the greatest overlap with CFC. Findings related to CFC and these existing programs are discussed in greater detail in later sections of the report.

HOME SERVICES PROGRAM

The Home Services Program consists of three waivers serving individuals with physical disabilities, brain injury or HIV/AIDS. These waivers are administered by the Department of Human Services, Division of Rehabilitation Services (DRS). For purposes of this report we reviewed the following two waivers.

Waiver for Individuals with Disabilities

This waiver serves individuals with physical disabilities who meet the NF level of care and live in their own home. This waiver serves individuals under the age of 60. It also serves individuals who elect to remain in the program if entry to the program occurred prior to their 60th birthday. The Determination of Need (DON) tool is used to establish functional eligibility for institutional level of care. A comprehensive assessment in addition to the DON is used to identify specific service goals and service needs.

Services provided under this waiver include adult day health/care, home health aide, homemaker, personal assistant, respite, environmental adaptations, home delivered meals, nursing, occupational therapy, personal emergency response systems, physical therapy, specialized medical equipment, and speech therapy services. Some services, such as personal assistant services, include the option to arrange services under a consumer directed model.

Waiver for Individuals with Brain Injury

This waiver serves children and adults with brain injury who meet the NF level of care as determined by a DRS counselor using the DON. Reevaluation occurs every six months.

Individual costs cannot exceed the amount that would otherwise be paid for NF care. Individuals with exceptional need may have monthly costs which exceed monthly NF costs on a temporary basis, so long as the total annual cost does not exceed what would otherwise be paid in a NF.

Services provided under this waiver include adult day care, day habilitation, homemaker services, personal assistance, prevocational services, respite, supported employment, home health aide, intermittent nursing, occupational/physical/speech therapies, cognitive behavioral therapy, environmental accessibility adaptations, home delivered meals, in-home shift nursing, personal emergency response, and specialized medical equipment. Some services, such as personal assistance services, include a consumer directed option.

COMMUNITY CARE PROGRAM

The Community Care Program (CCP) serves older adults, age 60 and older, living in their own home who meet NF level of care as determined by a care coordinator working with one of the independent Care Coordination Units (CCU) contracted by the state. Illinois offers CCP to individuals meeting Medicaid financial eligibility and individuals above Medicaid financial thresholds, so long as they meet level of care requirements for the program. Reevaluation occurs at least annually or when it is determined there has been a change in status. CCP is overseen and operated by the Department on Aging (IDoA).

CCP provides support services including adult day services, in home services and personal emergency response services. CCP does not provide a consumer-directed option. Service cost maximums are established and published for each service.

MEDICALLY FRAGILE-TECHNOLOGY DEPENDENT (MFTD) CHILDREN'S WAIVER

The MFTD waiver serves children up to age 21 with a wide variety of complex medical needs who would otherwise need care in a NF or hospital. LOC eligibility is determined through the use of a standardized screening tool that focuses on medical and technology needs consistent with this group. MFTD complements other medical services offered through Medicaid, including services provided under EPSDT. MFTD services include nurse training, family training, special medical equipment and supplies, environmental modifications, respite care in the child's home, respite care center services, medically supervised day care and placement maintenance counseling.

DEVELOPMENTAL DISABILITIES (DD) WAIVERS

The DD waivers are operated by the Department of Human Services, Developmental Disabilities Division. At the present time these waivers are the only ones in Illinois with a waiting list for access to an open slot. People on the waiting list have not had LOC established and will still need to be screened and assessed for waiver eligibility. Approximately 23,000 individuals are currently on the waitlist for services.

Adult Waiver

The Adult Waiver serves individuals, 18 and older determined to have a diagnosis of mental retardation or a related condition and meet the LOC criteria for admission to an ICF/MR using the ICAP. The state contracts with agencies employing Qualified Mental Retardation Professionals (QMRPs) to complete the screening and assessment. This waiver is organized around three main service groupings: 1) **home based support** services including service facilitation (support for consumer directed services), emergency home response services, home accessibility modifications, personal support, temporary assistance, training and counseling for unpaid caregivers, vehicle modifications, skilled nursing, non-medical transportation, and adaptive equipment; 2) **community based support** that includes residential habilitation (e.g., group home), adult day care, developmental training and supported employment; 3) **other support services** including behavior intervention and treatment, occupational/speech/physical therapy, behavioral services.

Support Waiver for Children and Young Adults with DD

This waiver serves individuals with DD up to age 21 who live at home with their families and meet ICF/MR LOC. The state contracts with agencies employing QMRPs to determine eligibility, using special protocols established by the state for individuals under the age of 22. Individuals aging-out of this waiver are given priority for slots in the Adult Waiver. The state contracts with independent advocates to assist transitioning adults.

The services offered through this waiver include adaptive equipment (extended state plan services), service facilitation (support for consumer-directed services), assistive technology, behavior intervention and treatment, home accessibility modifications, personal support, temporary assistance, training and counseling for unpaid caregivers and vehicle modifications.

Residential Waiver for Children and Young Adults with DD

This waiver provides 24 hour residential support to children and young adults, ages 3 to 21, with mental retardation or a related condition who meet ICF/MR LOC. The state contracts with

agencies employing QMRPs to determine eligibility, using state protocols designed for children and adults under the age of 22. Individuals aging-out of this waiver are given priority for slots in the Adult Waiver. The state contracts with independent advocates to assist transitioning adults.

The services offered under this waiver include child group home, adaptive equipment (extended state plan service), assistive technology and behavioral intervention and treatment.

Approach

This section of the report describes the approach taken to complete the feasibility study and discusses the considerations and limitations of the study approach.

STUDY DESIGN AND DESCRIPTION OF ESSENTIAL INFORMATION

The study approach called for the gathering of program and financial information through specific reports (e.g. 372 reports), staff interviews, and written program information provided by staff or available on the state agencies' websites. The information was then categorized and organized into several tables as a way to facilitate our analyses. Below we describe the activities and tools involved in the study approach.

Staff Interviews

In a site visit to Springfield during the week of November 4th – November 7th, we interviewed key staff from each of the agencies operating the 1915(c) waivers and staff from the mental health division. An interview protocol was developed that covered key components of CFC and critical issues specific to Illinois LTSS programs (e.g., consent decrees, state initiatives such as BIP). The main protocol areas and questions are described below.

Eligibility

CFC requires individuals to meet institution Level of Care (LOC). The eligibility discussion covered areas to help us understand the current LOC determination processes and tools, financial eligibility criteria, waiting list information (if applicable), and other operational processes in place to facilitate access to services. Particular attention was given to the DD waiver waiting list because of the potential financial implications for implementing a new entitlement service.

Services

CFC could potentially be used to refinance a broad spectrum of services currently covered under 1915(c) waivers. The analysis needed to identify which services may be shifted to CFC and what changes would need to occur under a CFC program. This area of discussion included clarifying current waiver service descriptions, limitations and conditions, existing provider networks and qualifications. Additionally we explored unique program conditions for service delivery, such as where services may be provided, whether the service was offered under a consumer directed model, collective bargaining, and service monitoring.

Functional Assessment and Service Planning

CFC emphasizes person-centered assessment and service planning and active engagement of the individual in the planning and service selection process. This portion of the protocol focused on the extent to which the existing program operations currently or could be made to comply with the regulatory requirements for CFC.

Conflict of Interest Standards

CFC requires that the parties involved in assessment and plan development have no direct or indirect financial interest in decisions made by the individual. We explored the extent to which this is currently the case and, in cases where conflict occurs, how the conflict is mitigated and how the agency intends to meet the BIP requirements for conflict free case management.

Budget Setting

The State must adopt a valid methodology based on cost data to be applied consistently across CFC participants. The protocol explored current approaches to help determine if they might provide potential models for the new approach. In addition, we wanted to have a better understanding of the changes a unified approach across the State would require when the unified approach replaces an existing budget assignment method.

State Assurances

Under CFC, State HCBS spending must be maintained for at least one year. The protocol included questions about anticipated or planned reductions in caseloads, rates or services that would result in changes to HCBS expenditures.

Quality Assurance

Under CFC, the State will need to have a single quality assurance system that meets the requirements listed in the regulations. The protocol design helped us to understand the extent to which these systems exist. Specifically we explored the existence of critical incident systems and processes, systems for collecting information about consumer outcomes and satisfaction, and how existing programs perform risk assessment and mitigation planning.

Fiscal Impact Analysis

The fiscal impact analysis used existing reports that were easily obtainable, supplemented by program knowledge from staff. The reports used for the study included the 372 reports for each of the 1915(c) waivers and the most recent PUNS reports about the DD waiting list. We developed a modeling file that documented reported service costs for each service in each waiver. This modeling file contained information about expenditures, number of participants receiving the services during the time period, total participants receiving services under the

specific waiver, the estimated percentage of service recipients likely living in a residential setting (not own home), the likelihood of the specific service being covered under CFC, and potential funds from CFC for those services most likely to be included under a CFC program.

We also analyzed the DD waiting list, identifying individuals indicating they want services similar to those that would be available under CFC. We obtained supplemental information from DD staff regarding individuals on waiting lists, such as the percentage of people typically found to already be in services (e.g. PD waiver) and other patterns that would provide guidance to making estimates about the number of people likely to select a CFC service.

More information about the approach and the actual estimates are included in the Findings section of the report.

Findings

We break our findings into two broad categories; estimated fiscal impact and potential operations issues.

POTENTIAL ADDITIONAL FEDERAL DOLLARS

Because CFC offers enhanced match with the caveat that the state's overall spending on HCBS must not decrease for the first 12 months following implementation, we discuss the potential for additional federal dollars and the potential for savings. ***Exhibit 1*** summarizes the potential for additional federal dollars by shifting existing services to CFC. We have broken these estimates down by the agencies that oversee the existing programs. We report separate numbers for the two waivers that HFS oversees because these waivers differ dramatically from each other in terms of supports provided and populations served.

For the analysis, we broke the waiver services into the following categories:

- **Services for which there is precedent to cover under CFC:** These include services that are clearly identified in the CFC regulations or are being covered in a CFC plan that is approved for another state.
    - **Personal care services provided in the community**: This includes a wide range of services, notably personal attendants and homemaker services.
    - **Emergency Backup or Habilitation Services**: These services are identified as required services in the CFC regulations.
    - **Other services that provide or substitute for ADL/IADL assistance:** This category included a broad range of services such as home modifications, adult day care, nursing services, home health aides, and behavioral counseling. If these services could be provided to someone in a residential setting, we obtained an estimate from State staff about the portion of provided to individuals in these settings. We present both the costs for in-home and residential settings in the exhibit. This breakdown was necessary to build different implementation scenarios.
    - **Residential services:** This includes supported living facilities and group homes covered as residential habilitation.
- **Services that may not be covered under CFC:** The only services that we classified as potentially not eligible were prevocational and supported employment supports. It may be possible to cover some of the costs for these services. However, because the CFC

regulations require that services provide or substitute for assistance with ADLs or IADLs and the primary purpose of these services are to foster employment and community integration, we excluded them from the estimated cost savings.

EXHIBIT 1: SUMMARY OF ESTIMATED ADDITIONAL FEDERAL DOLLARS UNDER CFC

(IN MILLIONS – 2010 DOLLARS)

	Personal Care Provided in Community	Emergency Backup/ Habilitation	Other services that provide or substitute for ADL/IADL assistance –Home-based	*Subtotal – All Home-based*	Other services that provide or substitute for ADL/IADL assistance –Residential	Residential	*Subtotal- Residential*	**Total**	Services that may not be covered
DDD	$8.3	$-	$8.4	*$16.7*	$12.4	$47.3	*$59.7*	**$76.4**	$1.0
DRS	$50.6	$1.7	$1.1	*$53.5*	$-	$-	*$-*	**$53.5**	$0.0
HFS-MFTD	$0.3	$-	$9.2	*$9.5*	$-	$-	*$-*	**$9.5**	$-
HFS-SLF	$ -	$-	$-	*$-*	$-	$17.6	*$17.6*	**$17.6**	$-
IDoA	$40.7	$0.8	$1.5	*$43.1*	$-	$-	*$-*	**$43.1**	$-
Total	$100.0	$2.6	$20.2	*$122.7*	$12.4	$64.9	*$77.3*	**$199.9**	$1.0

These estimates are based on State spending in State fiscal year 2010.[4] Our methodology suggests that CFC could have brought in approximately $200 million in additional federal

[4] The time frames for some of the waivers differed by up to three months depending upon when the operating agency filed it 372 report.

dollars. Of this, personal care services account for approximately half of these additional federal dollars. Residential services were the next biggest category, accounting for approximately $65 million in additional federal funding.

Dollars associated with services provided to individuals in non-residential settings accounted for $123 million in additional federal dollars. Only the DD and SLF offer residential services.

ESTIMATED FISCAL IMPACT AFTER ACCOUNTING FOR SERVING INDIVIDUALS ON THE DD WAITLIST

Our fiscal impact estimates assume that the costs of services offered under CFC will be similar to the costs experienced under the existing 1915(c) waivers. If the State were to implement CFC, it would make changes to the structure of HCBS services. However, we chose to assume that these costs would be flat for the following reasons:

- The types of changes necessary would depend upon the extent to which the State chooses to shift existing services within CFC and how it will design the CFC benefits. As we discuss in the next section, the State will need to make a number of operational design choices, many of which may have cost implications. It was beyond the scope of this effort to identify and cost out all of the design choice.
- The State will have substantial flexibility in designing CFC and can take steps to mitigate any cost increases.

If the State chooses to proceed with CFC, we strongly recommend that the effort to develop operations have a companion effort to try to estimate the potential costs.

There was one major issue that has cost implications for implementing CFC that we were compelled to consider: the extent to which CFC would provide services to individuals on a DD waitlist who are not currently receiving supports. Because CFC represents a shift to an entitlement (i.e., the State cannot establish waitlists and must serve everyone who is eligible), this is a substantial barrier for Illinois. The other states that have received approval for CFC or are far along in the process of developing CFC have an existing Medicaid state plan personal care program that is already an entitlement.

Exhibit 2 provides a summary of the major steps we took to estimate the potential costs of serving individuals under CFC under several scenarios. The letters in the first column of this exhibit correspond to columns in ***Exhibit 3***, which provides the actual estimates.

	EXHIBIT 2: DATA SOURCES FOR ASSUMPTIONS AND CALCULATIONS FOR FISCAL IMPACT ANALYSIS
A	**DD waitlist who may shift to CFC:** We developed an estimate of the potential number of people on a DD waitlist using information from the October 2013 Prioritization for Urgency of Need for Services (PUNS) Waitlist. We assumed that only individuals requesting personal care might shift to community if CFC in the scenarios that did not offer a residential option. For the other scenarios, we used the entire waitlist.
B	**Number on waitlist who cannot be located:** Typically, not everyone on a waiting list for whom a waiver slot becomes available enrolls in the waiver because the individual cannot be located, is not eligible, or declines to enroll. We developed an estimate of the percentage of people on the waitlist who would not enroll based on the most recent experience the State had when selecting a cohort of individuals from waitlist as part of Ligas settlement. These data suggest that 18% of waitlist participants would not enroll.
C	**Number on waitlist already receiving services**: DDD staff reported that a based on the Ligas experience, approximately 12% of people who enroll for a DD waiver were already receiving services under another waiver. We removed this percentage from the analysis because the discussion with DDD staff suggested that they would likely get a similar amount of services under another waiver, such as those offered by DRS.
D	**Percentage of rest of waitlist who will choose CFC**: For certain scenarios, we needed to develop an assumption regarding the percentage of remaining individuals who would select CFC. In scenarios in which CFC was structured similar to some or all of a DD waiver, we assumed that 100% of these individuals would enroll. However, for the first two scenarios we assumed that CFC would be structured similar to existing DRS waivers. Because, according to DDD, most individuals on waitlist likely are already eligible for these waivers, CFC should not create an additional incentive or opportunity that does not already exist. To be conservative, we assumed that 20% of the remaining waitlist would enroll in CFC, however, it could be argued that this percentage should be closer to zero.

E	**Number of rest of waitlist who will choose CFC**: This column combined data from the earlier columns using the following formula: D * (A - (B + C))
F	**Estimated per recipient cost**: Based upon SFY 2010 372 report. Used cost for personal care for scenarios 1-4 and overall cost per recipient for scenarios 5-6
G	**Total Cost for DD Waiver recipients potentially served through CFC**: This column combined data from the earlier columns using the following formula: E*F
H	**Estimated additional federal dollars from CFC**: Based on SFY 2010 372 reports
I	**Difference (waitlist costs - new dollars):** This column combined data from the earlier columns using the following formula: G-H
J	**Estimated additional State dollars**: State dollars are only needed if I is positive number. Given the enhanced match, the State share = I*.44

FINDINGS

EXHIBIT 3: FISCAL IMPACT ANALYSIS SUMMARY

		A	B	C	D	E	F	G	H	I	J
								In $ Millions in 2010			
Proposed CFC Structure (Scenarios)		DD waitlist who may shift to CFC	# on waitlist who cannot be located	# on waitlist already receiving services	% of rest of waitlist who will choose CFC	# of rest of waitlist who will choose CFC	Estimated per recipient cost	Cost for serving DD waitlist under CFC	Estimated additional federal dollars from CFC	Difference (waitlist costs - new dollars)	Estimated additional State dollars
1	Mimics elderly/PD waivers	15,356	2,833	1,843	20%	2,136	$13,356	$28.5	$106.0	($77.5)	$0
2	Mimics elderly/PD/ SLF waivers	15,356	2,833	1,843	20%	2,136	$13,356	$28.5	$123.6	($95.0)	$0
3	Expanded to cover services similar to DD non-residential	15,356	2,833	1,843	100%	10,680	$13,356	$142.6	$122.7	$20.0	$8.8
4	Expanded to cover services similar to DD non-residential plus SLF	15,356	2,833	1,843	100%	10,680	$13,356	$142.6	$140.2	$2.4	$1.1
5	Covers all possible services	22,867	4,219	2,744	100%	15,904	$30,496	$485.0	$199.9	$285.1	$125.4

Because the extent to which CFC might provide new services on the DD waitlist will likely differ depending upon the structure of CFC, we developed estimates for five different scenarios in ***Exhibit 3***:

1. In this scenario, the State implements CFC in a manner that mimics the services offered under the waivers operated by DRS and the elderly waiver. CFC does not cover any residential services and the consumer directed option shares the structure as the DRS operated personal attendant service. Because this scenario does not offer benefits that differ substantially from those offered under DRS, the only difference from the current service structure relevant to people on the DD waitlist is that they could also be eligible if they met the ICF-MR LOC and do not meet the nursing facility LOC. In our conversation with staff at DDD, although they do not have data that have used to estimate the portion of individuals who meet the ICF-MR LOC, but do not meet the NF-LOC, they suspect the number is very low. Thus, it made sense to assume that a relatively low portion of the pool of people on a DD waitlist would enroll in CFC because if they wanted this service package, they would have enrolled in a DRS waiver. For this analysis, we assume that 20% of the people on the waitlist who want personal care and are not already enrolled in a DRS or other waiver would enroll in CFC.

   Under this scenario, no additional State dollars would be necessary and the State would have to decide how to allocate $77.5 million in new federal dollars. These new federal dollars would need to be spent on Medicaid funded HCBS. Because the 20% assumption does not have an empirical basis, we calculated breakeven scenarios: the highest participation rate for which no additional State dollars would be necessary. Under this scenario, more than 74% of the potential pool of new individuals would need to enroll before the State was obligated to commit new dollars.

2. This scenario is the same as the previous scenario with the exception that CFC is expanded to allow coverage of SLFs. Because SLF licensing criteria would limit the ability of SLFs to serve individuals with IDD, we used the same assumptions as the first scenario.

   This scenario increases the overall new federal dollars to $95 million per year. The breakeven percentage for enrollees was 86%.

3. In this scenario, the State implements CFC in a manner so that it encompasses the range of home-based services that is analogous to those covered in the DRS, elderly, and DD waivers. This includes covering the more flexible consumer directed model offered for DD. Because under this scenario individuals on the waitlist could get the range of home-

based services currently available under a DD waiver, we assume that 100% of the individuals who want personal care (after the subtractions in columns B and C) would select the waiver.

In this scenario, the costs of serving the additional individuals currently on the waitlist in CFC would exceed the additional federal dollars brought in from CFC by $20 million. Because this would require additional State dollars, the State would receive the enhanced match for these dollars. The total amount of additional State dollars needed is estimated to be $8.8 million (44% of $20 million).

4. This scenario is similar to Scenario 3, except we add the additional federal dollars from including SLF in CFC. These additional dollars low the estimate of additional State dollars needed to $1.1 million.

5. The scenario assumes that CFC would be defined to include all home-based and residential services. The major changes for this scenario is that we consider all of the individuals on the PUNS waitlist (not just those requesting personal care) and we use the average cost for serving someone on the waiver, versus just the average personal care cost. Because this per recipient cost average includes individuals in residential settings, this cost is more than twice as high as in the previous scenarios.

   In this scenario, the costs of serving all of the waitlist exceed the additional CFC funds by $285.1 million. Of this amount, the State portion would be $125.4 million.

CAVEATS

As we discussed earlier, this study used a relatively simple approach for estimating potential costs. The actual costs will be influenced by a variety of additional factors that could not be accounted for as part of this study.

As we noted, our estimates assumed that the basic structure (including rates, assignment of hours or budgets, etc.) of existing services would not be modified from the structure under waivers. The State will likely make changes to this structure in ways that may increase or decrease costs. It was beyond the scope of this effort to identify and cost out all of the possible options for making these changes.

In ***Exhibit 4***, we identify a number of specific issues which may increase or decrease costs.

FINDINGS

EXHIBIT 4: ISSUES THAT COULD NOT BE ADDRESSED AS PART OF ANALYSIS

Issues that may increase cost

The Service Cost Maximums (SCMs), which establish the maximum budget a person can receive, differ across waivers. Under CFC, these SCMs would need to be aligned. There will likely be considerable pressure against lowering SCMs for any subset of participants. Therefore, the common SCM chosen as part of CFC may be higher than the weighted average of SCMs currently used for the waivers.

In all programs that set individual budget caps such as SCMs, there is a gap between actual spending and the SCM. Under CFC, some individuals may have additional flexibility, especially related to choosing who to hire. This flexibility may narrow the gap.

There may be individuals who are not on the DD waitlist who choose to enroll in CFC. Given the high level of awareness about the PUNS waitlist, this is not likely to be a large number of people.

Issues that may increase new federal dollars

Unlike 1915(c) waivers, CFC does not include a mandate to use Medicaid State Plan services before using CFC services. Therefore, it may be possible to shift additional services currently funded under State Plan to CFC.

Our estimates are based upon SFY 2010 spending. Adjusting spending to reflect current spending will increase the pool of dollars that are available. However, this will also impact the cost per recipient estimates for serving people shifting from the DD waiting lists.

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

Operational Issues to be addressed as Part of Implementation

Exhibit 5 presents operational issues that will need to be addressed as part of implementation. In this exhibit, we also identify other initiatives that may require similar changes to operations, such as:

- The State is submitting an 1115 demonstration waiver that proposes to integrate many of the existing HCBS waivers.
- Illinois is participating in the CMS funded Balancing Incentives Program (BIP). Under this initiative, the State has committed to several structural changes, notably, establishing a Uniform Assessment Tool (UAT) for all populations receiving HCBS and ensuring that providers of case management do not have a financial conflict-of-interest.
- The settlement of the Ligas lawsuit requires that the State serve a portion of the individuals on the DD waitlist.
- The settlement of the Hempe lawsuit requires that the State provide a higher level of service to individuals aging out of the MFTD waiver.

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

EXHIBIT 5: ISSUES THAT WILL HAVE TO BE ADDRESSED AS PART OF CFC IMPLEMENTATION

	CFC IMPLEMENTATION ISSUES	PART OF 1115?	RELATED TO OTHER INITIATIVES	MITIGATION STRATEGIES/NOTES
			Applies to All Waivers	
1	Need to make assessment and support planning tools more consistent across all waivers.	Yes	BIP, UAT	May be able to have specialized strategies or modules that only apply to certain populations
2	Strengthening and standardizing person-centered planning	Yes	HCBS Rules	
3	Integrating service definitions, requirements, and rates for personal care and related services	Yes		May be able to include SLFs for only older adults by applying licensing criteria that limit use by different populations
4	Integrating quality management requirements	Partially		
			DDD	
5	Shift to entitlement making some individuals on DD wait list eligible	Partially	Ligas partially covers	Structure benefits similar to elderly/PD waiver; add additional eligibility criteria such as hand-on assistance w/ ADL
6	Revising DD community service cost maximum methodology	Likely		N/A if adopt structure similar to DRS model and maintain DD waivers

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

	CFC IMPLEMENTATION ISSUES	PART OF 1115?	RELATED TO OTHER INITIATIVES	MITIGATION STRATEGIES/NOTES
		DRS		
7	Allowing consumers directing their services to set rates	Possibly		CA appears to have gotten around this as part of their CFC application
		DRS & DDD		
8	Integrating consumer directed options across DDD and DRS	Probably		Adopt model similar to DRS if concern is to limit costs from DD waitlist
		DD & SLF		
9	Conflict-free case management (SLF/DD)	Probably not	BIP, HCBS Rules	Could have independent assessor develop high-level support plan and provider develop detailed plan

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

ISSUES APPLYING TO ALL WAIVERS

Uniform Assessment Tool

As part of its BIP work plan, the State is moving toward a common tool called the UAT that will collect assessment information needed for determinations for most or all of the waivers. This tool could be used to meet the need for a needs-based assessment approach across populations meeting institutional level of care for CFC.

Because of the diversity in need and population groups, the State may wish to consider specialized modules that only apply to certain disabilities or populations or other screens which trigger a more in depth evaluation of specific needs (e.g., behavioral health, caregiver assessment, etc.).

Strengthening and Standardizing Person-centered Planning

CFC has a number of requirements related to person-centered planning. The State will need to make substantial changes to current operations to meet these requirements.

However, CMS' recently published final rules for HCBS have similar requirements for person-centered planning. Thus, the State will need to make these changes regardless of the decision to proceed with CFC. In addition, CMS has indicated that these requirements will be included in the terms and conditions for any 1115 demonstration that included HCBS.

Integrating Services across Waivers

A CFC option in Illinois would need to offer a single package of services. Illinois' current HCBS waivers contain a number of services in common that would qualify as a CFC service, however, these services differ in definition, scope and cost thresholds. The State would need to align these service requirements under CFC.

This standardization of HCBS services also appears to be a major component of the proposed 1115 demonstration waiver. Examples of services that would need to be standardized include personal care, home delivered meals, consumer directed services, and homemaker services.

Illinois' waivers also contain other services that may be unique to a specific waiver or population group (e.g. SLF services only apply to older adults). In these cases the State might want to retain the unique focus of the service and would understandably have concerns about expanding its scope if the service is incorporated under a CFC entitlement.

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

Oregon's CFC program provides a strategy for addressing this issue. Oregon incorporated its residential services under CFC by referencing the licensing authority of the particular residential service. This provided the state with a means to maintain unique qualities of the service defined under the license. (For example, the license regulation might define/limit who could be admitted.) To the extent that Illinois desires to include a service like SLF, some analysis of the licensing regulations could help determine the impact of including it under CFC.

Integrating Quality Management Requirements

Adoption of CFC would require alignment of quality management strategies and requirements across HCBS programs. CFC also adds a requirement that at least part of the data used for quality assurance be collected directly from program participants. The current waivers each have approved quality assurance plans. Under CFC there would need to be a common set of quality indicators, discovery processes, and remediation activities.

Under the consolidated HCBS benefit included in the 1115 demonstration, the State would presumably want to integrate quality management structures. However, there is no requirement for direct data collection from program participants.

Collecting data from program participants does not necessarily require conducting additional surveys. For example, IDoA currently includes a measure of participant experience in the assessment and reassessment process for the waiver targeting older adults. This approach would appear to meet the CFC requirement.

ISSUES RELATING TO DEVELOPMENTAL DISABILITIES

Shift to an Entitlement

As mentioned previously, CFC is a State Plan service and creates a new entitlement for any individual found to be eligible and in need of the services included under CFC. While our methodology for the fiscal impact estimates discussed this issue and tried to project costs, we acknowledge that our approach used a relatively simple methodology and even the most sophisticated modeling approach cannot foresee unexpected policy or operational events that may substantially impact actual costs. There is always a risk that these estimates are too high or too low.

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

While serving more individuals from the wait list offsets additional funds from CFC, the State is already moving in that direction, albeit without enhanced federal funding. The State has already made a commitment to serve more individuals on the waitlist under the Ligas settlement. In addition, one of the arguments for the 1115 has been that the demonstration will allow the State to further cut down the DD wait list.

Revising the DD Community Service Cost Maximum

DDD waivers currently use service cost maximums that are approximately equal to three hundred percent of SSI. CFC requires a budget methodology that is commonly applied and reflects assessed needs. Because the current DD waiver methodology does not vary by assessed need, the State would need to revise the method of allocating resources for people with DD in the community. As noted earlier, this methodology would also need to be aligned with approaches used for the other waivers.

ISSUES RELATING TO DRS WAIVERS – ALLOWING CONSUMERS TO SET RATES

The CFC rules appear to require that states offering participant-direction allow individuals to establish their own rates in paying for personal care and similar services as part of managing their own budgets. Specifically, the rules require that individuals who are directing their service have the following authority: "Determining the amount paid for a service, support, or item, in accordance with State and Federal compensation requirements." When comparing current operations in Illinois with CFC requirements, DRS staff were concerned that this could conflict with collective bargaining agreements dictating wages for staff providing similar services under the current DRS waivers. This could also be an issue for implementing the 1115 if in consolidating the waivers. We discuss this issue in the next section.

California may offer an example for how to implement CFC while still respecting collective bargaining agreements. Similar to Illinois, California has collective bargaining agreements that cover staff providing such services. California appears to have worked out a way to honor these collective bargaining agreements as part of its CFC plan. This may be the case because of it was successfully argued that these agreements are part of State "compensation requirements."

ISSUES RELATING TO DRS AND DDD WAIVERS – INTEGRATING CONSUMER DIRECTED OPTIONS

DRS and DDD waivers offer consumer directed services, but major differences exist in how the consumer directed services operate, including how budgets are allocated. As noted in the earlier sections, under CFC, a set of standard services would need to be offered to everyone. This is also likely to be the case for consolidating the waivers under CFC.

OPERATIONAL ISSUES TO BE ADDRESSED AS PART OF IMPLEMENTATION

If the State were to move forward with CFC, it would have four potential options:

- The State could elect not to include a consumer directed option under CFC. Thus, the option would be eliminated for both the DRS and DDD populations.
- The State could include a consumer directed model similar to the DRS approach. The result would be that individuals in a DD waiver would have to use the DRS approach.
- The State could include a consumer directed model similar to the DDD approach. The State would still need to develop a needs-based approach for developing individual budgets. The result would be that individuals in a DRS waiver would have to use this approach. This may create issues for current collective bargaining agreements.
- The State could offer two different consumer directed models, one corresponding to the DDD approach and the other corresponding to the DRS approach. The major impact would be that individuals would be able to pick which model they preferred.

ISSUES RELATING TO DDD AND SLF – CONFLICT-FREE CASE MANAGEMENT

CFC requires independent assessment and conflict free case management. Currently in Illinois support plans for individuals receiving DDD waiver services or SLF services are developed by case managers employed by service providers. In our discussions with staff they noted the value of having provider employed case managers for people in residential settings able to perform ongoing evaluation and coordination of the residential supports with other non-residential services. The State has already committed to making these changes as part of BIP. In addition, CMS' recently published final rules for HCBS require conflict-free case management.

The State may be able to meet the conflict-free requirement by having independent staff conduct the comprehensive assessment and lead the development of a high-level support plan. Provider coordinators for individuals in residential settings could then develop a more detailed plan for implementing this higher-level plan.