**Section 120.530 Home and Community Based Services Waivers for Medically Fragile, Technology Dependent, Disabled Persons**

a) The Department shall administer a home and community-based service (HCBS) waiver program as set forth in Sections 5-2(7) and 5-2.05(a) of the Public Aid Code [305 ILCS 5] and pursuant to Section 1915(c) of the Social Security Act (42 USC 1396n(c)) for disabled persons who are medically fragile and technology dependent.

b) A determination must be made that, except for the provision of in-home care, these individuals would require the level of care provided in a hospital or a skilled nursing facility.

c) The University of Illinois at Chicago's (UIC) Division of Specialized Care for Children (DSCC) shall perform operational functions under the HCBS waiver program pursuant to an interagency agreement with the Department.

d) In addition to being eligible for all of the services set forth in 89 Ill. Adm. Code 140.3, the following services shall be covered when medically necessary for individuals determined eligible for this waiver described in subsection (a):

1) Respite care;

2) Environmental modifications;

3) Special medical supplies and equipment;

4) Family training;

5) Nurse training;

6) Placement maintenance counseling;

7) When not covered under the State Plan, Certified Nursing Assistant (CNA); and

8) When not covered under the State Plan, In Home Shift Nursing.

e) The Department shall determine eligibility. An individual meeting the following criteria shall qualify:

l) The individual is younger than 21 years of age or was a waiver participant the day before turning 21 years of age;

2) The individual is disabled as defined in Section 120.314;

3) The individual scores a minimum of 50 points on the level of care screening described in subsection (h);

4) The estimated cost of the individual's home and community-based services to be paid by the State shall not be greater than 125% of the average cost of the institutional level of care appropriate to the individual's medical needs (hospital or skilled nursing facility).

5) Determination of Financial Eligiblity. For children under 19 years of age, the individual would be finanically eligible for Medicaid if the income and resources of the individual's responsible relative were excluded from consideration. For individuals 19 years of age and older, determination of financial eligibility for Medicaid is made in accordance with 89 Ill. Adm. Code 120.10; and

6) A written person centered plan has been developed and approved pursuant to subsection (f).

f) Person Centered Plan

1) The Department shall determine the home and community-based services based on a written person centered plan developed using an individualized approach, and using a process led by the participant or family or legal representative (or a combination as appropriate), and if desired in consultation with the DSCC care coordinator. In addition to being led by the participant or family receiving services and supports, as required per 42 CFR 441.301(c)(1), the person centered process:

A) Includes people chosen by the participant or family.

B) Provides necessary information and support to ensure that the participant or family directs the process to the maximum extent possible and are enabled to make informed choices and decisions.

C) Is timely and occurs at times and locations of convenience to the participant or family.

D) Reflects cultural considerations of the participant or family and is conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

E) Includes strategies for solving conflict or disagreement within the process.

F) Provides conflict free case management by requiring separation of case management and service provision functions. Case management for participants is provided by UIC employees, who are not waiver service providers. Case management is considered an administrative service and is claimed as an administrative expense through the waiver authority.

G) Offers informed choices to the participant regarding the services and supports they receive and from whom.

H) Includes a method for the participant or family to request updates to the plan as needed.

I) Records the alternative home and community-based settings that were considered by the participant or family.

2) At a minimum, the person centered plan shall identify an appropriate primary residence, describe the medical and other services to be furnished, the frequency of the services, the type of provider required to render the services and a description of the family's or legal representative's active participation, to the fullest extent possible, as caregivers in meeting the participant's medical needs. As required per 42 CFR 441.301(c)(2), the person centered plan must:

A) Reflect the participant’s strengths and preferences.

B) Reflect clinical and support needs as identified through the comprehensive assessment.

C) Include individually identified goals and desired outcomes.

D) Reflect the services and supports that will assist the participant to achieve identified goals, and the providers of those services and supports, including natural supports. Natural supports are unpaid supports that are provided voluntarily to the participant in lieu of 1915(c) HCBS waiver services and supports.

E) Reflect risk factors and measures in place to minimize them, including individualized back-up plans and strategies when needed.

F) Be understandable to the participant receiving services and supports, and the persons important in supporting the participant. At a minimum, the plan must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who are limited English proficient.

G) Identify the individual or entities responsible for monitoring the plan.

H) Be finalized and agreed to, with the informed consent of the participant in writing, and signed by all individuals and direct service providers responsible for its implementation.

I) Be distributed to the participant and all individuals and direct service providers responsible for its implementation.

J) Prevent the provision of unnecessary or inappropriate services and supports.

3) The Department may, in its discretion, approve a cost-effective alternative to services in the person centered plan, as long as the alternative services meet the medical needs of the participant.

4) When determining the hours of care necessary to maintain the participant at home, consideration shall be given to the availability of other services, including direct care provided by nonpaid caregivers, such as, but not limited to, the participant's family or legal representative, that can reasonably be expected to meet the medical needs of the participant.

5) As required by 42 CFR 441.301(c)(3), the person centered plan must be reviewed, and revised upon reassessment of functional need, at least every 12 months, when there is a significant change in the participant’s circumstances or needs, or at the request of the participant or family.

g) Eligibility Denials or Terminations

1) An individual shall not be determined eligible for coverage under the waiver if:

A) The individual requires institutionalization solely because of a severe mental or developmental impairment.

B) The individual does not meet the minimum score required under subsection (e)(3).

C) The individual does not require:

i) the provision of at least one waiver service, as documented in the person centered plan, and

ii) the provision of waiver services at least monthly or, if the need for waiver services is less than monthly, the participant requires regular monthly monitoring which must be documented in the person centered plan.

2) Termination of coverage under the waiver shall be initiated upon the occurrence of any of the following events:

A) Failure of the participant, family or legal representative to comply with care coordination activities that are required in order to initiate and maintain eligibility for the waiver. These activities include focused assessments, comprehensive assessments, face-to-face visits and home visits. The care coordinator shall document the failure in the participant's case record.

B) Interference by a participant's family or legal representative with the provision of services specified in the person centered plan, including but not limited to, refusing to allow a provider into the participant’s home to provide services. The provider shall document the interference, as well as notify the care coordinator so that the interference can be documented in the participant's case record.

C) Failure of a participant, family or legal representative to cooperate with the Department, DSCC, or service providers, not otherwise specified in (A) or (B), in implementing person centered plan, if the Department determines that, as a result of that noncooperation, theplan cannot be implemented or the health and well being of the participant could be jeopardized. The care coordinator shall document the failure in the participants case record.

D) Upon renewal for continued participation in the waiver, the participant does not meet the requirements set forth in in subsection (g)(1).

3) A transition period of no more than 60 days, during which the participant will continue to receive services through the waiver, will be provided on terminations resulting from subsections (g)(1)(B) and (C).

h) DSCC shall perform a level of care screening for the waiver as follows:

1) The level of care screening will be performed using a Department approved screening tool.

2) The level of care screening will be performed as follows:

A) On all new requests for admission to the waiver;

B) On all renewals for continued participation in the waiver; and

C) Whenever there is a significant change in the participant's status or care needs.

3) The level of care screening will consist of the following elements:

A) Technology needs will be screened to determine the risk of disability or death if the technology is lost, as well as the degree of skill for assessment and judgment needed to operate the technology; and

B) Medical fragility will be screened to determine the frequency and need for skilled care.

(Source: Amended at 45 Ill. Reg. 9995, effective July 26, 2021)