RATES OVERSIGHT COMMITTEE OF THE
ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES

FINAL REPORT

November 13, 2019

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SECTION I. INTRODUCTION

The Division of Developmental Disabilities (DDD) is the arm of the Illinois Department of Human Services (DHS) responsible for the system of residential, employment, training, and support services for persons with developmental disabilities in the State of Illinois. DDD currently supports approximately 10,350 individuals in 24-hour Community Integrated Living Arrangements (CILA), 1,035 individuals in Intermittent CILA, 4,800 individuals in Intermediate Care Facilities for Persons with Intellectual and/or Developmental Disabilities (ICFDDs), 20,000 individuals in community day programs and 1,100 individuals in Supported Employment.

In August 2018, as part of the effort to achieve compliance with the Ligas Consent Decree (which involves, among other things, the provision of services to individuals with developmental disabilities in the most integrated setting appropriate to their needs), DDD began a comprehensive process to consider the various components of the existing methodologies for residential, employment, training, and support rates, which date back to the 1980s, and the policies that underpin those components to determine where changes are necessary. The State is subject to a number of non-compliance findings with respect to the Ligas Consent Decree, and service and staffing issues due to the rates available under the Waiver and in ICFDD settings are among the primary concerns identified by the Plaintiffs, Court Monitor and presiding Court. A Rates Oversight Committee, composed of stakeholders throughout the system, was convened to guide the process and seven subject matter subcommittees, also composed of stakeholders, were created to debate, discuss, and make recommendations to the Oversight Committee for rate component and policy changes. The seven subcommittees are as follows: Staffing, Behavioral, Nursing/Medical, Transportation, Employment and Training, Technology, and ICF/IDD. The recommendations developed by the subcommittees, endorsed by the Rates Oversight Committee and approved by DDD and the Department of Healthcare and Family Services (HFS), Illinois' Single State Medicaid Agency, form the base for the development of new rates for services for individuals with developmental disabilities receiving state supports.

DHS/DDD is now under contract with Navigant to develop recommendations for new rate methodologies for both HCBS waiver services and ICF/IDDs. These recommendations will encompass all services that touch on an individual

supported in a residential setting to include, but not be limited to, residential, supported living, personal supports, community day services, supported employment, therapy services, and supplemental services.

This report contains final recommendations for DDD's consideration which represent the culmination of twelve months of work of the seven subcommittees and the Rates Oversight Committee. In the Appendices, the reader will find the rosters of the various committees, the values statement that guided their work, and the scope of services with which they were charged.

Note: For purposes of this report, the term "community system" includes both CILA and ICFDD settings.

SECTION II. OVERARCHING RECOMMENDATIONS FROM THE OVERSIGHT COMMITTEE

1. Immediate intervention must be made to stabilize the community system while the complete rate review is being conducted. Critical areas for consideration include staff wages, particularly regarding enhanced Chicago and Cook County minimum wages, as well as 1/1/20 and 7/1/20 statewide minimum wage increases; nursing hours and wages and level of support to people with extraordinary support needs. Committee chairs do not feel the community system can continue to function at current reimbursement levels during the rate review and development period, which at a minimum will continue through 8/1/20.

2. Rates for people in the community system must be established based upon a robust and individualized assessment and planning process which fully, accurately and reliably captures individual interests, needs and identifies resources necessary to address these. Committee chairs do not feel the current assessment and planning processes, training and tools are adequate to achieve this outcome.

3. The assessment process must be much more sensitive to acuity of need, intensity of supports to address interests/needs and sentinel events that warrant adjustment of resources. The assessment must also capture non-staff services and resources (e.g. transportation, assistive technology) that are essential to meeting the person's needs. Committee chairs do not feel the current assessment tool (ICAP) is adequate to achieve this outcome.

4. Rate components established by the 3rd party rate developer must be based upon actual costs of doing business (not current rates) and incorporate established indices such as DOL BLS, CPI, etc. Once established, rates must be reviewed and updated on a regular basis to reflect the actual cost of providing services.

5. Rates must accurately address non-staffing program support components such as housing, food allowance, supplies, training, vehicle reimbursement, administration inclusive of direct support staff supervision, etc. to ensure adequacy of reimbursement. Committee chairs include ISC services in this

category and agree that the current allocation of ISC resources is inadequate to fulfill the critical functions they are assigned.

6. DHS must review regulations, policies and practices to address barriers to people in community services maximizing choice, independence and flexibility.

7. In order to become competitive for staffing as the State's minimum wage rate increases over the next few years, the DSP wage factor in both the CILA and ICFDD rate methodologies must set at a factor of 1.5 to whatever the minimum wage is at any particular time. This means that when the State minimum wage reaches $15.00/hour in 2025, the DSP wage factor in the methodologies will be set at $22.50/hour.

SECTION III. RECOMMENDATIONS FROM THE SUBCOMMITTEES

A. Staffing Subcommittee

1. Change the Administrative Allowance in the current CILA Rate Methodology from the fixed amount to 10 percent of the total CILA rate. The Administrative Allowance should be a percentage of the total rate as set by any new methodology.

2. The subcommittees of the Rates Oversight Committee are more familiar with the CILA Rate Methodology and the actual costs of providing residential and day services. The staffing subcommittee recommends the Oversight Committee stipulate that all recommendations forwarded to the entity developing the rate methodologies for CILA, day programs and ICF/DDs implement all recommendations equally between any and all rate methodologies developed.

3. People who receive residential services participate in activities and employment in the community which are often outside of "set" or "predetermined" developmental training hours. In light of this, any new funding methodology must take into consideration the reality that participation in activities and employment will be variable in time-of-day, day of week or weekend and duration.

4. In order to assure full access to necessary clinical (including nursing) services, the subcommittee recommends that the Department conduct a study to determine current hourly rates for clinical disciplines and update reimbursement amounts to reflect 2019 market conditions. Hourly reimbursement rates should be updated annually. Current hourly limits for individual disciplines should be eliminated and replaced with an annual maximum value of $13,473 (or current amount) of licensed clinical services without any prior authorization required.

5. The ICILA program should be updated to include a streamlined process for accessing additional staffing hours beyond the standard 15 hours/week which will allow for greater flexibility so that individualized needs are considered. Staffing resources should be flexible and address the

individualized needs and interests of the person as outlined in the Personal Plan and Implementation Strategy. The billing structure should accommodate both individual and small group service provision.

6. The subcommittee recommends the Division pursue a DSP credentialing program which includes enhanced reimbursement for staff who meet the credentialing criteria, and a mechanism for assuring that agencies employing DSPs who meet the credentialing criteria pay credentialed DSPs the higher wage.

7. The subcommittee recommends that Staff Medication Administration be a funded rate component in CILA/DT/ICFDD rate methodologies.

B. Nursing/Medical Subcommittee

1. Apply the current rate methodology of enhanced rates of CILA – 4 individuals or fewer – to CILAs where there are 5 or more individuals.

2. Reimburse providers for annual re-evaluation of authorized direct care staff for medication administration as required by 59 Ill. Admin.Code 116.40.

3. Develop a standardized annual re-evaluation tool or process required by Section 116.40.

4. Eliminate Section116.40j/k, which states that if a provider is unable to reassign staff, the provider will need to add another authorized direct staff.

5. Reimburse providers for "on-call" requirement set out in 116.50 by adding this to the RN basic oversight hours.

6. Reimburse providers for completing annual Individual Health Supports and Assessment as required by Section 116.90 by adding to the RN oversight hours. Amend the requirement that all individuals must have a Self-Administration of Medication Assessment (SAMA) completed annually.

Instead, once an initial assessment is completed and the individual is determined to be "not independent" to administer their medications, only repeat the assessment if the individual expresses an interest in becoming independent or the individual has successfully completed a goal to become independent.

7. Develop a standardized Individual Health Supports and Assessment.

8. The Division consider a medication technician program.

9. All registered professional nurses seeking approval to be Nurse-trainers must possess a registered nurse license. A mentoring program can be submitted for approval by the Division for all new graduate nurses who are approved to be RN trainers.

10. Nursing serve hours should be based on individual need regardless of the size of the living arrangement. The Division should continue to apply the current enhanced methodology based on Health Care Level, Medication Administration (# of medications) and Treatment Received. RN Basic Nursing Oversight hours should be increased.

C. Assistive Technology Subcommittee

1. Improve the approval process to speed up access to currently funded Assistive Technology (AT).
    a. DDD should simplify the process of accessing the current AT funding and then disseminate this approval process to waiver recipients, families, and providers so more people can access AT currently in the waiver.
    b. Clarify and streamline approval process with HFS, especially for items that require a denial from HFS before consideration by other funding sources.
    c. Create a fast-track process for AT items that are needed to ensure people moving into waiver services and affordable housing. We have

seen the slow process result in the loss of housing which has a short turnaround of availability.

d. Include and update clear wording on AT in all applicable Rules.
e. Request that HFS reviews and modernizes its approach to funding AT through the State Plan.
f. HFS should clarify the process for people living in ICFDDs with individuals, families, and providers so that they can more frequently access current State Plan AT funding.

2. DHS should appoint a technology subject matter expert and technology champion who can work with the advisory committee and ensure ongoing prioritization and integration of technology through DDD.

3. Increase funding to access assistive technology evaluation, implementation, training, and follow up services, which enable AT professionals to make recommendations and see the process through to a successful conclusion.
   a. Many situations involve the need for a clinician (OT, PT, SLP, Rehab Engineer) or other qualified AT professional to provide an evaluation of client abilities and identified goals, and then match AT with the appropriate features. The AT devices may need fine-tuning or modification, and in some situations a custom-designed solution may be needed. These activities were cut back due to the budget impasse. We recommend that they be restored.
   b. AT services provided by recognized healthcare professionals (e.g., OT, PT, SLP), which are able to be categorized under existing CPT codes, should be billed in this manner to maximize federal participation in support for AT services. However, CPT code reimbursement rates are low in comparison to actual professional labor costs. We recommend that some categories such as architects needed for home modifications are made not reimbursable. Also, caps exist regarding services under a specific code per day. This discourages the provision of complete services, necessitating multiple visits by the consumer.
   c. Further, many consumers cannot travel to a center-based program at all, due to transportation issues or physical challenges which place the person at risk during extensive travel. These consumers ultimately do not access AT services so there needs to be funding to cover travel especially in more rural areas for AT professionals.

d. Develop additional AT teams in underserved areas of the state to expand access to AT. We see challenges for individuals and families in more rural and remote areas of the state trying to access AT professionals to help assess and support AT in their homes. Although increasing rates and ensuring travel is covered will help, the group is recommending an intentional approach, offering DDD support for AT staff and infrastructure that will help level the playing field regarding access to AT services. In the past, this has taken the form of specific contracts with AT service providers. The financial challenges to AT service providers in underserved areas merits DDD consideration of re-establishing this support.
e. Ensure access to AT training for individuals, families, and staff on all AT devices. The AT work group understands that the initial and subsequent updated and ongoing training of individuals, families, and staff on the operation of specific AT devices being issued to a given consumer often times lies outside of the services that can be reimbursed under CPT code billing. It is critical that the individual, families and staff have initial training to help utilize a device but also it needs to be allowable and fundable to do additional training, especially as staff turnover and change.
f. The AT work group supports the idea of clearer information, education and website resources to increase the understanding of the AT available and the process to access. We recommend that the DDD website should include very clear instructions, process and allowable items for individuals and families as well as for providers. The DDD website could also list resources for continued AT device training for clients, families, and staff to use if/when the AT Professional Services funding was fully utilized.

4. Require and fund annual AT screening, a series of questions included in the annual ISC discovery process, for every adult with developmental disabilities regardless of setting. The screening questions would ensure that AT is discussed as a potential help in independence. This can be done through the independent service coordination agency in its person-centered planning process. If the screening indicates that AT should be investigated, a more comprehensive assessment/evaluation will be required. We would suggest that the AT advisory group potentially

recommend the questions/tool. We just want to ensure to all people have an opportunity to consider AT through their ISC person centered planning.

a. The ISCs should receive both training and additional funding to ensure that case managers can implement the screening and have low enough caseloads to have the time to provide quality screenings.
b. People interested in moving between different settings should be prioritized for the initial screening and potentially the more comprehensive assessment as well as those individuals moving out of transition and who utilized AT during school.

5. Improve coordination between HFS, DHS, and ISBE to address needs for access to AT during transition into adulthood, as well as from the stand point of adults receiving services in different settings (e.g., ICFDD or CILA). This can include a review of current practice as well as a clarification of responsibility, process for access to current AT, and the need for new funding, rules, and recommendations.
   a. Address the gap between school and adult services for transition age youth using AT in school and then lose it when they graduate including:
      - Identify all students who are currently utilizing school-owned AT.
      - Create a fund to purchase AT that can be used once a student graduates and has to return school-owned AT.
   b. Incorporate into the IEP regarding transition a discussion on the students AT needs post-graduation so they can go to the fund as needed.
   c. ISCs should be funded to help to track needs of transition age youth on the PUNS waiting list to ensure when they are pulled they are funded for AT as an adult and potentially could help them connect to the above fund while waiting. We recommend ISBE/transition programs also provide information about any funding resources created.

6. Create a Request for Information (RFI) to providers who are currently privately funding innovative AT projects, to understand what is currently being utilized and the lessons learned from this process. Please note this should be carried out in conjunction with HFS so that providers funded through the adult services waiver and ICFDDs can apply. (DONE)

- Following the RFI, create a pilot program whereby organizations could submit proposals to access a broad array of innovative AT devices and services.

7. Create a fast track process for the acquisition of low-cost AT items. On an annual basis, individuals should be able to access AT items that total less than $500 without the need for screening, assessments, or receipts. AT totaling $500-1000 should be pre-approved with proof of a screening, assessment, or evaluation, and the submission of receipts. AT totaling over $1000 should not be pre-approved, agencies would need to submit documentation of a screening, assessment, or evaluation, and then formally ask for approval of the acquisition of the AT items. We reiterate that for over $1000 that the administration should still take a look at streamlining the review/approval process. The funding above would count towards the cap categories recommended. Assessments should be done by qualified AT professionals.

   AT Acquisition Fast-Track System (proposed)

AT expense	Prior Approval required?	AT A/Eval required?	Documentation required for Prior Approval Decision	Documentation required following Implementation
$0 - $499.99	No	No	N/A	Receipt(s)
$500.00- $999.99	No	Yes	N/A	AT A/Eval rep Receipt(s)
$1000.00- $4,999.99	Yes	Yes	AT A/Eval rep	Receipt(s)
$5,000.00 +	Yes	Yes	AT A/Eval rep Bid solicitation results	Receipt(s)

8. Expand funding for a broader scope of AT devices and services, establish realistic funding caps, and categorize AT funding for addressing of goals

over time (e.g., AT for sensory impairment, AT for Environmental Control, AT for Remote Support).

a. DDD should consider funding of those technologies and services that persons now use to improve functional independence that are no longer considered recreational tools such as tablets, smart phones, internet access, and remote monitoring.
b. Expand the rules and regulations to allow providers to utilize remote support as a service if a person would like to receive it. Retain the current rate for providers regardless of whether they utilize remote supports since it is based on a person's needs and interests, not cost savings. Expand funding for remote support equipment (see grid below).

AT Category	**Funding Limit**	**Availability**
AT & Adaptive Equipment	$4,000	3 years
Specialized Medical Equipment	$3,000	3 years
Environmental/Home Modification	$20,000	10 years
Remote Support Equipment (purchase or rental, maintenance/repair, depreciation, and internet provider costs)	$15,700	annually
Vehicle Modification	$20,000	8 years
AT Professional Services (Evaluations, Implementation, Trainings for individuals, families, and staff, Follow-ups)	$4,000	3 years

9. Create a contracting agreement similar to VR and IATP whereby the administration identifies a provider who can bulk purchase higher end AT. People would not be required to use this provider but it could offer lower cost alternatives and expedited purchasing.

10. Appoint an AT Advisory Committee made up of people with disabilities, families, provider agencies, AT professionals, and other interested stakeholders including from the private sector to offer assistance in

recommendation and rules to DDD/HFS. Their responsibilities should include:

a. The review of regulations to ensure that the broadest opportunity be given to utilize technology for independence and for the implementation of the HCBS settings rule. Regulations that create barriers to utilization or limit independence if AT is used should be removed. A review and update of rules to reflect new technology should be included and definitions for AT be kept very broad in order to allow for growth and change in technology utilized by people with disabilities.
b. Review of findings/reporting of an evaluation team of HFS/DHS staff and other key stakeholders who will collect and analyze data on the usage of different AT funding groups/caps, expenses, and numbers and types of rejections/appeals, in order to implement policy change over time.
c. Support Illinois as a state to join the Coleman Institute's pledge around the rights to AT access for consumers
d. Encourage the governor to support a Technology First Initiative similar to OH, PA, MO, and TN including the creation of a framework and a task force to implement changes.
    - Join the other states with Technology First Initiatives in informal working groups and technical assistance, facilitated by TN.

11. Above suggestions should include people living in ICFDDs as appropriate.

D. Employment and Training Subcommittee

The Employment and Training Subcommittee divided their efforts into two sections – Employment and Training and Meaningful Day Services – and offered a separate set of recommendations for each.

Employment and Training Recommendations

1. Support providing Medicaid Waiver funded supports, possibly through a "Supports Waiver" or the current waivers, specific to transition aged

youth. The supports should include employment and recreational supports that are flexible and meant to bridge the transition between school and adult life. Any waiver targeted to transition aged youth should allow for easy transition between other waivers that may provide increased or different supports.

2. Fill employment-related staff vacancies including hiring a designative Employment First staff within DDD with sole focus on driving employment outcomes in Illinois and fill Employment First Liaison position within the Governor's Office as called for in Executive Order 14-08.

3. Implement Employment First Strategic Plan including identifying specific objectives, milestones, deadlines and action plan and which is overseen by.

4. Re-engage ODEP Employment First Mentoring and/or consider State Employment Leadership Network (SELN) membership for state support/guidance.

5. Revise DSP and QIDP training curriculum to include an employment module.

6. Require annual professional development hours for all staff providing waiver-funded SEP.

7. Require all agencies providing DT or SEP to submit employment data on their clients annually, including name, wages, avg weekly paid hours, benefits, tenure and employer of record.

8. Create Memorandums of Understanding (MOUs) between DDD and ISBE, DRS and Public Health that identify terms of relationship, define systems and policies around access/ownership and are reviewed by Employment First Strategic Planning Committee for feedback and revision.

9. Work with DRS to streamline process for access to waiver-funded SEP when DRS finds an individual ineligible for DRS vocational rehabilitation.

10. In order to increase employment outcomes for individuals with I/DD, the relationship with DRS must be addressed so that clients are able to access waiver funded SEP. A specific process must be developed if we hope to increase employment outcomes for individuals with I/DD on the waiver.

11. Specific process documentation between DRS & DDD should be developed and distributed that outlines specific responsibilities (MOU, interagency agreement, etc.)

12. DDD should accept DRS generated standard Closure Notification document to open waiver funded SEP.

    a. Waiver funding should be made automatically available if a case is closed for any reason other than non-contact (with submission of Closure Notification).
    b. Waiver funding should be made available to individuals already employed or those who find their own job without submitting Closure Notification to DDD if it is in their Person-Centered Plan.
    c. DRS should consider taking more responsibility for notifying provider organization/ISC of ineligibility or pending closures to ensure extended service continuity to waiver funded supports.

13. Hire rates consultant that considers provider-generated financial reports to help create appropriate rates.

14. ICFDD “earned income” policies should be the same as CILA.

15. Create reimbursable Supported Employment curriculum for all staff providing waiver-funded SEP.

16. Illinois should create distinct service definitions underneath the larger SEP designation including job assessment, development and coaching, as well as customized employment definitions. The subcommittee believes that distinct service definitions (job development, job coaching) should be created that would provide guidance on billable hours and time limits for each service definition. It is important that billable hour and time limits are defined appropriately.

17. Each service definition should provide guidance on billable hours and length of time limits. There should be no limits on job coaching unless an extended services option is created to ensure job security for clients.

18. DHS should consider incentivizing providers to be able to provide services under both DRS (as a Community Rehabilitation Provider (CRP) and DDD (waiver). Rates should be streamlined or comparable. The subcommittee recommends ensuring that services are braided so that individuals are able to easily transition from DRS to DDD funded services.

19. Services that precede job development should be waiver funded, once new service definitions are created, and should not require DRS referral (as defined by Person Centered Plan).

Recommendations for Independent Service Coordination (ISC) Agencies:

20. During the PAS Screening and on-going ISSA visits, ISC staff should educate individuals and their families about the myriad of services and supports available above and beyond waiver funded services. PAS agents should also connect families with adult service providers to begin conversations about options so that students and families are well informed.

21. ISC staff should receive training on the range of services available to individuals with I/DD throughout the service system.

22. ISC staff should receive training on helping families conceptualize a "meaningful life" through multiple and varied supports, both paid and unpaid. The earlier these conversations occur the more likely individuals will be prepared for adult life.

Meaningful Day Recommendations

The subcommittee's philosophical assumption in making these recommendations is that an individual's services are not always provided by one provider, but instead, are provided by a range of providers with

expertise in specific areas (which would be managed through the person-centered planning process and ISCs). The subcommittee views supports as those that are home or residentially based and those that are "away from home." For the purposes of these recommendations "away from home" are supports that allow an individual to access spaces outside of the place where they sleep and live.

1. ICF rate determinations should reflect the same economics considerations as used to determine the 31U/31C reimbursement rate.

2. CILA Residential rates should be increased to base funding of 19 hours per day (Monday through Friday) for 1-8 person CILAs so that rates would fully support a 24 hour service day. Organizations providing residential services would have the opportunity to apply for more hours if the person chooses to stay home through At-Home Day Program (if structured program is warranted) or through a new service code for residential providers to provide day supervision (based on needs/desires of individual).

3. Individuals should be allowed up to 40 hours per week for "away from home" supports through any combination (but not simultaneously) of the following:
    - CDS/Other Day Program
    - Community Integration Supports

4. Individuals should be allowed up to 60 hours per week for "away from home" supports (but not simultaneously) if they are working towards employment or are employed (in any combination)
    - CDS/Other Day Program
    - Community Integration Supports
    - Supported Employment

5. Acuity: The Subcommittee recommends a base rate for all "away from home" supports with two levels of acuity-based funding (medical/behavioral 1 & 2) that would require a separate request to the division. The vast majority of individuals would receive the base rate.

- Medical/Behavioral 1: 1:1 staff support needed more than 40% of the time
- Medical/Behavioral 2: 1:1 staff support needed 90%+ or 2:1 staff support needed 40%+

6. Community Day Services (CDS) Rates

    - CDS should have a base rate for all individuals with the opportunity for applying for enhanced rates based on significant medical or behavioral needs (see Acuity).
    - Lunch and transportation (provided by the provider to/from) should be billable time as supervision and support are being provided.
    - CDS would continue to allow for facility-based support with an expectation that individuals are encouraged and supported to access their communities (meeting CMS Settings Rules) while attending facility-based CDS programs. This should continue to be tracked through 31C within the waiver. ICF-DD should find a similar mechanism for this tracking.
    - The Subcommittee recommends that 31C should be explicitly defined as:
        - Activities that take place outside of the facility where day to day activities take place (regardless of who owns the "facility" where the activities take place)
        - 1:4 (staff/individual) ratio or less
    - The 31C (and ICF-DD equivalent) rate should take into account the increased staff to individual ratio, as well as increased transportation and activity costs, which would result in a higher rate for 31C. It would also incentive providers to provide more community-based activities. The same acuity levels for medical/behavioral would apply (see Acuity).
    - ET subcommittee wants to make clear that 1:4 ratio is not ideal for community integration. The subcommittee recommends the additional service category (Community Integration Supports – below) to address more intensive and developed supports options for individuals.

7. At-home Day Program
    - Should automatically allow for 1300 hours/year (5 hrs/day @ 5 days per week) to cover period not included in base residential hours.

- Base rate with the opportunity for applying for enhanced rates based on significant medical or behavioral needs (see Acuity).

8. Other Day Program (ODP)
    - Either grandfather/or transfer existing program participants to 31U/31C OR grandfather existing program participants until the ODP is expanded to include a process to certify new programs. Ideally, ODP would be Medicaid-matchable and require some minimal licensure requirements (or be licensed under other comparable standards).
    - ODP might be programming that occurs in special rec facilities, art studios, or other programs with a specific focus.
    - Base rate with the opportunity for applying for enhanced rates based on significant medical or behavioral needs (see Acuity).

9. Community Integration Supports (New!)
    - New program code and service definition (would require waiver revision)
    - Definition: Support to an individual to allow them to fully engage and interact with their community (volunteering, attending a service, going to the library, etc.). Would not include 1:1 support at a job.
    - 1:1 or 1:2 (staff/individual) ratio.
    - Cannot be billed simultaneous with CDS, ODP, AHDP or SEP.
    - Can occur 7 days per week.
    - Support cannot be provided by a residential staff member that is being paid through the residential rate for supervision or support for the same period of time. These supports are in addition to any supports a person may be able to receive as part of their residential or day options.
    - Support cannot be provided by a CDS, ODP, AHDP or SEP staff member that is being paid through one of these mechanisms for the same period of time. These supports are in addition to any supports a person may be able to receive as part of their residential or day options.

Finally, the Employment and Training Subcommittee offered a series of recommendations directed toward the DHS Division of Rehabilitation Services (DRS) regarding the operation of the Vocational Rehabilitation program, which DRS manages in Illinois. Those recommendations are outside the ability of DDD to

implement alone but are worthy of consideration. DDD will work with DRS on these recommendations apart from the rates work considered here. These recommendations can be found at the back of this report within the Employment and Training Subcommittee "chapter."

E. ICFIDD Rates Subcommittee

1. Any adjustment to the wage factor, as recommended by the Staffing Committee, should not be tied to a mandate to directly pass through that increase to direct care staff wages.

2. The new ICF/DD rate methodology should not adopt wholesale the current ICF/DD model, the new Ohio ICF/DD model or the CILA model. Rather, a process should be developed which would result in a new rate methodology for ICF/DDs.

3. The ICFIDD rate methodology cannot be the same as the waiver methodology because of regulatory differences and service differences. If desired, both rate methodologies could have the same components but then be developed in a way that assures program requirements are followed.

4. The committee strongly recommends that the state retain a third-party consulting firm with expertise and experience in developing rate methodologies for state ICF/DD systems.

5. The consulting firm should work with the current Rates Oversight Committee and ICF/DD subcommittee to perform empirical analyses of relevant data and develop a recommended rate methodology for ICF/DDs based on these analyses and the input of the Oversight Committee and the ICF/DD Committee.

6. All components of the rate methodology should be derived from an analysis of reliable and objective data.

7. Any rate differences based on facility size should be based on an empirical analysis of actual cost data.

8. The number of acuity levels used in the rate methodology, the cut-off for each level, and the rate adjustment used for each level should be based on empirical analysis and actual time studies of the specific services provided to individuals in each level.

9. Reimbursement for nursing and therapy services should be based on time studies of the provision of such services to individuals at each acuity level.

10. The ICF/DD rate methodology should include reimbursement for clients with exceptional needs. The facilities who are currently receiving this rate should be consulted on this part of the rate. Empirical analysis of their data regarding the cost of serving this population should be used to ensure that the reimbursement is sufficient.

11. The new methodology should appropriately reimburse providers for their capital costs. Consideration should be given to adopting a fair rental value methodology which creates incentives for maintaining and investing in up-to-date facilities. The consultant should be asked to address this issue and suggest some alternatives which can adequately account for capital costs.

12. The current rate methodology includes an adjustment for costs based on the geographical location of services. There is no current information which validates these adjustments. The new rate methodology should not assume the current geographical rate multipliers are either necessary or accurate. A careful study should be done of actual differences and of what parts of the rate are affected. If current costs are used to set rates on an annual basis and if, as in Ohio, providers receive reimbursement for their current costs up to a ceiling which is an appropriate percentage above average costs, such a methodology may adequately account for regional cost differences. The consulting firm can determine if this is the case and can evaluate the existence and degree of any regional differences in cost.

13. An interim step is to raise all multipliers to 1 and then look at adjusting the multipliers which are over 1 while the new rate is being implemented.

14. ICF/DD and CILA rates should account for any geographical cost differences in the same way.

15. If there are geographical multipliers, they should only apply to those parts of the rate which are affected by location. (The current multipliers may have been the result of geographical differences in building costs, but they have not been reviewed for thirty years.)

16. Any geographical multipliers should be automatically reviewed annually to determine if the differences continue to exist.

F. Transportation Subcommittee

All recommendations that follow apply to both CILA and ICFDD rate methodologies, where appropriate.

1. Provide current relief to providers from a significant unreimbursed cost burden by updating the numbers in each component established by the 2004 DHS/DDD transportation rates study and incorporate revised rates into CILA and DT rates.

2. Transportation be a required component addressed in Personal Plans.

3. Transportation rates should be unbundled from program rates with regularly mandated (e.g. annual) reviews of the costs in components of the rate undertaken to assure adequate and equitable reimbursement to providers.

4. Develop an individualized rate addressing factors that influence transportation costs.

5. The Department of Human Services DDD should strongly advocate for a review of the Medicaid Medical Transportation billing process to facilitate improved access for people with disabilities.

6. Review the under-utilization of DHS/DDD Non-Medical Transportation as an allowable service under the HCBS Waiver and determine steps that can be taken to reduce any barriers to accessing the service.

7. Consider transportation brokerage services within certain defined geographic areas to identify resources, develop linkages and enable access to transportation for individuals with I/DD.

8. Actively participate in Illinois Department of Transportation Human Services Transportation Planning (HSTP) Regional committees and meetings to establish a coordinated plan with identified strategies and resources dedicated to promoting the development and coordination of accessible transportation for people with intellectual disabilities.

G. Behavioral Supports Subcommittee

All recommendations are intended to apply equally to both CILA and ICFDD where appropriate and applicable.

1. The committee members have noted that the primary obstacle to supporting persons with challenging behavior is the low rate of reimbursement, especially for Direct Support Professionals (DSPs). Raising the state minimum wage to $15.00 per hour will likely exacerbate the current staffing crisis. It is imperative that short-term rate increases are made for staffing while a comprehensive overhaul of the existing rate methodology is explored.
2. There is consensus among committee members that many persons with an intellectual disability benefit from psychotherapy as much as other supportive services such as Applied Behavior Analysis. This is especially true for individuals with a dual diagnosis of an intellectual disability and mental illness. The Division of Developmental Disabilities currently reimburses counseling services at a rate of approximately one-half of that for Behavior Analytic services. It is recommended that these rates be raised to equal levels.

Consistent with the above recommendation, it should be noted that reimbursement rates for counseling as defined in Illinois Administrative Code 140 are currently double those reimbursed through the DD Division. This raises the question whether community providers should be encouraged to become certified mental health providers ("Behavioral Health Clinics") through the Division of Mental Health. Committee members feel raising rates provided by the DD Division is a preferable solution given the additional steps necessary to become DMH certified.

3. The committee members believe that Behavior Analytic services are greatly beneficial in supporting people with intellectual disabilities, including persons with challenging behaviors. The consensus, however, is that it is very difficult to recruit and retain Behavior Analysts (BAs). Community agencies find it difficult to compete with the high salaries offered by various consulting groups around the state. In addition to higher salaries, these groups often offer such "benefits" to staff as being able to work from home. The salary for BAs appears to be rising and is already disproportionate to other key staff members in community agencies. Currently, there are both level 1 and level 2 providers of Behavior Analytic services. Given the difficulty of recruiting behavior analysts, the committee believes that the level 2 professionals provide a valuable service and should continue to be eligible for reimbursement. The committee was unable to reach consensus as to whether or not the eligibility criteria should be increased (to require formal graduate or undergraduate coursework in applied behavior analysis) or whether or not there should be a requirement for supervision under a licensed professional. These questions will need to be considered going forward, including in the context of legislation that has been proposed related to the licensure of behavior analysts.

   Currently, there are very limited rules or guidelines related to the delivery and documentation of Behavior Analysis services. Should there be a requirement that behavior analysts spend a minimal percentage of their time on-site with staff or people receiving services as opposed to potentially completing the majority of their billable work from their home or office? Should there be other guidelines in place to ensure that services

are resulting in a beneficial outcome for persons receiving services? Currently, waiver participants are eligible for 104 hours of service per year. How do we know that people are benefitting from these services? The current work group was unable to reach consensus on such issues. It is likely that the DD Division and HFS will want to continue exploring the parameters related to Behavior Analytic services.

The committee recommends that the DD Division provide greater clarity regarding the necessary items and documents that need to be included in the packet of information required to certify a Level 2 Behavior Therapist. The committee recommends the DD Division update the forms on the DHS website to provide more specific information for providers.

4. The guidelines and reimbursement for 1-2 person homes needs to be addressed. Clearly, there are people with challenging behaviors who need smaller settings both for their benefit as well as to minimize their impact on others. The committee members concurred that the existing rates prevent the use of small settings, especially in the context of the current staffing crisis. For many community agencies, small settings are at particularly high risk for closure given their drain on staffing and financial resources.

   The committee recommends that the DD Division review the current rate structure for the provision of smaller settings, 4 person or fewer, for CILA homes. The committee also recommends a review of the rate structure to allow for smaller Community Day Service programs. The committee feels smaller settings can be beneficial for individuals. Currently, the rates do not adequately fund the smaller settings.

5. The committee recommends that procedures be developed to identify those persons who require the most extensive behavioral supports given their presenting issues, history of challenging behaviors, traumatic histories, etc. The consensus is that the current system of care does not do an appropriate job of matching the needs of people with providers who have the technical skills to meet those needs. Members agreed that developing a scoring/ranking system that could be used to facilitate

decisions related to residential placement (size of setting, specialized expertise of provider) would be beneficial. Existing scales/measures could be used to facilitate decision making, as could information from the CIRAS data reporting system. Trinity has developed a preliminary tool (The Community Behavior Risk Measure) which might be helpful in identifying persons with extraordinary support needs. The committee recommends that the DD Division review the current rate structure for individuals with the most extensive behavioral support needs and provide increased rates to support these individuals.

6. The committee recommends increased funding / reimbursement for environmental modifications such as fenced yards or time delay locks for persons who struggle with elopement, "hardening" of homes to prevent damage to walls and windows, etc. Members also believe that there should be increased reimbursement for property damage (including vehicles) and clarifying the process for accessing these funds.

7. The committee recommends that the future model of service delivery continue to offer some version of Additional Behavior Supports (akin to the current 53R/D program). It seems obvious that individuals with extraordinary behavioral and medical support needs will continue to require enhanced staffing supports. The reimbursement for staff providing such enhanced supports should exceed the rate for traditional DSPs given the skill set required for the role. The current staffing crisis and rate of pay makes it increasingly difficult for community providers to utilize this potential resource. Staff cannot be hired to fill these roles with the existing levels of reimbursement. Commonly, staff are often paid over-time (at a high cost) to provide these services. The committee recommends that reimbursement for these services is increased and that criteria for these DSP staff are developed. Enhanced training requirements could include a specified number of hours beyond DSP training in such areas as certification in crisis prevention procedures (such as CPI, Safety Care, etc.), understanding mental illness, data collection procedures, the application of behavioral principles, basic counseling skills, understanding trauma, responding to suicidal ideation, medication side-effects, self-care skills, etc.…

Committee members noted that many community providers are currently reluctant to request 53R/D funding due to the inability to fill staff positions and Office of the Inspector General substantiating neglect when additional staff members are not on duty.

8. The committee recommends that individuals receiving home-based services be eligible for a specified number of hours of behavior analysis (BA) services outside of their monthly dollar allotment. Persons funded for home-based services must use a portion of their monthly funding to pay for BA services (unlike Intermittent CILA where 104 hours of BA supports are available). Additionally, it is recommended, the new funding model allow for persons not receiving waiver funding to be granted a specified number of behavior analysis services to address extreme behavioral challenges. The committee believes this could be useful and help prevent additional issues or concerns while families are waiting to receive services.

9. There is no reimbursement for community providers to train staff in nationally recognized crisis prevention procedures (such as CPI and Safety Care). Costs include both trainer certification and the actual training of staff members including DSPs. The use of "therapeutic holds" presents potential risks and legal liability. These are only offset by on-going practice and rehearsal (and the accompanied cost of training, which is significant). The committee recommends that DHS implement training reimbursement (similar to QIDPs and DSPs) for organizations that provide training for crisis prevention procedures.

   With regard to training, the committee recommends the DD Division add a module to the basic DSP curriculum (the 40-hour classroom portion) regarding the application of fundamental behavioral principles related to people with intellectual disabilities. The committee felt the information could be similar to what is currently offered in the QIDP training curriculum.

10. The committee recommends that the DD Division convene a work group to revisit policies regarding the use of psychotropic medications for persons with intellectual disabilities. The current policies universally treat psychotropic medications as rights restrictions requiring human rights

approval as well as interventions with the goal of decreasing medications. This is true even for persons who have a formal psychiatric diagnosis. The current policy is not consistent with practices for people who do not have intellectual disabilities and take psychotropic medications. Further, the requirement for non-psychotropic interventions (such as behavior support plans) increases service cost with no clear outcome. Many people receive behavior analysis services purely because they take psychotropic medications. The committee clearly understands that psychotropic medications may be misused for behavioral control or sedation (versus the treatment of a mental illness). Thus, it is recommended that a work group be convened to revise existing policies in a manner that protects people receiving services.

11. Committee members noted that it is incredibly difficult to assist individuals with intellectual disabilities in receiving in-patient psychiatric services – even when it is obvious that they are a threat to themselves and others. Hospitals frequently deny admission claiming the crisis is "behavioral" rather than psychiatric. Given that many individuals with intellectual disabilities require a level of personal assistance beyond typical, the committee recommends that in-patient hospital rates be considered for persons identified as having intellectual disabilities. Alternatively, it would be helpful to create a funding mechanism to reimburse (hospitals on a per-hour or per diem basis), when additional staff resources are necessary and implemented. It might also be helpful to incentivize hospitals (especially down state) to create specialized, small in-patient units for persons with intellectual disabilities.

    The committee also recommends the modification of rules to allow individuals receiving in-patient care to visit potential community placements while in the hospital. This would allow for better choice and meeting the needs of the individual. Currently, this is not allowable. It is common for individuals with intellectual disabilities to be unable to return to their homes or previous community providers following hospitalization. The lack of a mechanism for these individuals to visit potential new providers increases the length of hospital stay.

12. The committee recommends the DD Division work towards funding additional specialized, community-based residential settings for persons who require the most extensive supports to meet their behavioral challenges. These options could include increasing the number of short-term and long-term stabilization homes. It appears that the creation of the long-term stabilization homes has been delayed due to lack of an appropriation. It is not clear why a few sites cannot be created given that the CILA model could be applied with minor (primarily staffing and training) adjustments.

APPENDIX 1. RATES OVERSIGHT COMMITTEE MEMBERSHIP

Howard A Peters, III, Chair, Former Secretary of DHS and Consultant

Kathy Ward, Acting Director, Division of Developmental Disabilities, DHS

Kelly Cunningham, Deputy Administrator, Long Term Care and Behavioral Health, HFS

Mark Hellner, Executive Director, Center for Disability & Elderly Law and father of a teenage boy on the Autism Spectrum

Laurie Jerue, Parent

Vicki Niswander, Parent

Susan Kahan, LPCP, Institute on Disability and Human Development, University of Illinois at Chicago and Parent of an adult child with Autism

Tavarus Wesley, Self-advocate

Ron Messner, Executive Director, Apostolic Christian LifePoints

Mike Bibo, President, Center for Developmental Disabilities Advocacy & Community Supports

Art Dykstra, CEO, Trinity Foundation and CEO, Cherry Hill Consulting Group

Dan Strick, CEO, New Star

Ben Stortz, CEO, Cornerstone Services, Inc.

Lore Baker, President & CEO, Association for Individual Development

Ronnie Cohn, *Ligas* Court Monitor

Barry Taylor, VP for Civil Rights and Systemic Litigation, Equip for Equality and counsel for the Plaintiffs in *Ligas*

Scott Mendel, Parent and pro-bono counsel for the Intervenors in *Ligas*

Kim Mercer-Schleider, Director, Illinois Council on Developmental Disabilities

Meghan Maine, Deputy General Counsel, Division of Litigation Management, DHS

Melissa Wright, Contractual Staff to the Oversight Committee

APPENDIX 2. SUBCOMMITTEE MEMBERSHIPS

Staffing

Kathy Carmody, Chair, CEO, Institute on Public Policy for People with Disabilities
George Bengel, Staff, Waiver Rates Unit Supervisor, Bureau of Reimbursements and Program Support, DHS/DDD
Bobby Gillmore, Staff, Bureau Chief, Bureau of Reimbursements and Program Support, DHS/DDD
Dr. Rajnish Mandrelle, Chief Operating Officer, Associations for Individual Development
Stan Rives, Chief Financial Officer, Macon Resources, Inc.
Charlene Bennett, CEO, Individual Advocacy Group
Chad Garland, Director of Residential Services, Cornerstone Services, Inc.
Rachel Fields, Director of Operations, Human Service Center
Abbie Davenport, Residential Services Coordinator, START
Brian Antczak
Chris Hegg Krackenberger, NHA, Administrator, Misericordia
Bobbi Walters, Residential Site Manager, Human Support Services
Diane Farina-White, President & CEO, Community Support Services
Eric Sutter, Senior Vice President of Human Resources, EP!C

Nursing/Medical

Dr. Rajnish Mandrelle, Chair, Chief Operating Officer, Association for Individual Development
Anne Fitz, RN, Staff, Statewide Nursing Coordinator, Bureau of Clinical Services, DHS/DDD
Crystal Streitmatter, Administrator of Group Homes, Apostolic Christian LifePoints
Sharon Parker-Love, RN, Director of Health Services, Trinity Services
Sheila Lullo, Executive Vice President/Vice President of Programs, Clearbrook
Michele Goldsboro, LPN, DDC, START
Rosemary Cornell
Melissa McDaniel, Parent
Tanya Durrer, RN, Human Support Services
Gaylord Villers, Parent

Kathleen Brown, RN, CDDN, Developmental Disabilities Nurses Association
Jeff Stauter, Executive Director, Kreider Services, Inc.

Assistive Technology

Meg Cooch, Chair, Executive Director, The Arc of Illinois
Kit O'Brien-Cota, Staff, Program Manager, Life Choices, DHS/DDD
Sarah Myerscough-Mueller, Vice President of ID/DD Policy, Illinois Association for Rehabilitation Services
Connie Melvin, Director of National Association of Qualified Intellectual Disability Professionals and Technology Enhancing Consultant with Trinity Services
Glenn Hedman, Director, Assistive Technology Unit, University of Illinois at Chicago
Bob Okazaki, President & CEO, Avenues to Independence
Chad Rollins, Executive Director, William M. BeDell ARC
Missy Kichline, Parent and Outreach Coordinator for the ARC of Illinois Life Span Program
Pam Capraro, Parent, Misericordia
Anu Khetarpal, Director of Quality Improvement and Staff Development, Association for Individual Development
Lore Baker, President & CEO, Association for Individual Development

Employment and Training

Allison Stark, Chair, President & CEO, Orchard Village
Jayma Bernhard, Staff, Bureau Chief, Bureau of Quality Management, DHS/DDD
Brandy Moore, Coordinator of Rehabilitation Services, START Inc.
Laura Anderson, President/Owner, Winning Systems, Inc.
Necole Mills, Vice President of Community Programs, Community Support Services
Michael Predmore, Senior Vice President of Day Programs and Education, Marcfirst
Michael Glanz, Executive Director, The ARC of the Quad Cities Area
Sarah Myerscough-Mueller, Vice President of ID/DD Policy, Illinois Association for Rehabilitation Services
Adam Cooper, Self-advocate

Don Henzlik, Parent
Mike Diaz, Administrator of Employment Services and Community Day Services, Misericordia
Amanda Long, Manager of Day Services, Kreider Services
Jennifer Kowalkowski, Director of Employment Services, Cornerstone Services, Inc.
Debbie Harris, Director of Adult Programs, Keshet
John Marchioro, Trainer Staff Development, Division of Rehabilitation Services, DHS

ICF/IDD

Ron Messner, Chair, Executive Director, Apostolic Christian LifePoints
Mike Bibo, President, Center for Developmental Disabilities Advocacy & Community Supports
David Brooks, CEO, Individual Advocacy Group
Scott Mendel, Parent and pro-bono counsel for the Intervenors in Ligas
Art Dykstra, CEO, Trinity Foundation and CEO, Cherry Hill Consulting Group

Transportation

Dan Fitzgerald, Chair, CEO, Horizon House of Illinois Valley, Inc.
Andrea Medley, Strategic Planning Unit Supervisor, DHS/DDD
Mark Rudolph, CEO, KCCDD
Jason Clark
Corey Gumm, Senior Division Director, Keystone Alliance
Cindy Haworth, Associate Executive Director, Garden Center Services
Bill Dwyer, President & CEO, Helping Hand Center
Bob Peterson, Self-advocate
Jamie Durdel, President & CEO, Tazewell County Resource Centers, Inc.

Behavioral Supports

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Erin Wade, PhD., Staff, Clinical Psychologist, Jack Mabley Developmental Center, DHS/DDD
Kristin Huffman-Gottschling, PhD, LCSW, Executive Director, PACTT
Kelly Stumme
John Pingo, President & CEO, Goldie Floberg Center
Jennifer Gentile, Vice President for Programs, Orchard Village
Brenda Devito, LCPC, Vice President of Program Services, Clearbrook
Gail Schmidt, Parent
Tina Fogerty, Chief Operating Office, Trinity Services, Inc.

APPENDIX 3. GUIDING VALUES

GUIDING VALUES FOR RATES METHODOLOGIES

OVERSIGHT COMMITTEE AND SUBCOMMITTEE WORK

Members of the Oversight Committee and Subcommittees considered all work within the context of the following guiding values:

Flexibility

Portability

Acuity-driven

Self-direction

Independence

Choice

Smaller settings

Community Inclusion

And at all times, keeping the person to be served in the forefront of all conversations.

As discussions progressed, members were asked to considerwhether policies or proposals under consideration promote the guiding values or are an impediment to them. If impediments were identified, the committees were to “reconsider and revise” the policy to be consistent with the values stated above.

APPENDIX 4. SCOPE OF SERVICES

RATE METHODOLOGIES OVERSIGHT COMMITTEE

SCOPE OF SERVICES

Role:

The Rate Methodologies Oversight Committee serves in an advisory capacity to the Department of Human Services, Division of Developmental Disabilities regarding the reconfiguration of rates for Community Integrated Living Arrangement (CILA) rate and the Intermediate Care Facility for Persons with a Developmental Disability (ICF/DD). The Oversight Committee functioned as the central repository of the work of the various subject matter subcommittees, who considered the rate components of both the rates as well as the policies that underpin those rates. Findings and recommendations of the Sub-Committees were submitted to the Oversight Committee.

The Oversight Committee's responsibilities are as follows:

Responsibilities:

- Received report-outs from the chairs of the subcommittees.
- Provided advice and guidance to the subcommittees as requested and/or needed.
- Provided guidance on "parking lot" issues to the extent needed.
- Considered Division policies not covered by the subcommittees.
- Synthesized disparate pieces of information filtering up from the subcommittees into a cohesive set of policies and rate components which will be utilized by a contracted third party for rate development.

Resources:

- Division of Developmental Disabilities staff and data

- National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- National subject matter experts as needed.

RATE METHODOLOGIES SUBCOMMITTEES

SCOPE OF SERVICES

Role:

The Rate Methodologies Subcommittees serve in an advisory capacity to the Rates Methodologies Oversight Committee regarding the reconfiguration of rates for Community Integrated Living Arrangement (CILA) rate and the Intermediate Care Facility for Persons with a Developmental Disability (ICF/DD). The subcommittees considered the rate components of both the rates as well as the policies that underpin those rates. As such, the subcommittees had a great deal of latitude in terms of what issues they took up. They had discretion to either choose a narrow approach to the work, focusing only on the rate components and associated policies, or a broader, systemic approach within the particular subject matter. Subcommittees filtered their work through the Oversight Committee.

Responsibilities:

- Considered all aspects of the rate methodology associated with the subject matter of the subcommittee as well as all policies associated with the components. Recommended adjustments, including the elimination of policies and practices that no longer represent best practice or move the system forward.

- Considered new policies not currently in place and recommended those that support and promote the Values laid out for this work.
- "Parked" any issues or concerns for which the subcommittee was unable to come to consensus or work through and brought those parking lot issues to the Oversight Committee for advice and guidance.
- Considered all issues within the "silo" of the subject matter subcommittee without concern for what other subcommittee are thinking. The Oversight Committee synthesized disparate pieces of guidance from the various subcommittees.

Resources:

- Division of Developmental Disabilities staff and data
- National Association of State Directors of Developmental Disabilities Services (NASDDDS)
- National subject matter experts as needed.