

Bureau of Managed Care
Managed Care Organizations
Policy / Procedures

HCBS Waiver Services Closeout: MCO Responsibilities

MCOs should follow the guidance below as it relates to requesting a Home and Community Based Services (HCBS) waiver be closed for a member. Instructions vary depending on the type of HCBS waiver.

**1. Department of Human Services/Division of Rehabilitation Services (DHS-DRS)
Home Services Program waivers**

MCOs cannot close a waiver case independent of Department of Human Services/Division of Rehabilitation Services (DHS-DRS). MCOs must continue to serve and provide waiver services to the member until the sister agency takes action to close the HCBS waiver case.

Until MCOs are notified by DHS-DRS that they have closed the member's case within the agency's case management platform, the MCO should not end any authorizations for HCBS waiver services.

Closure requests should be made to the DHS-DRS Field Offices. If the MCO does not receive a response from the DHS-DRS field office involved within 30 days, MCOs can reach out to DHS.HSPManagedCare@illinois.gov for resolution.

When an MCO wants to close a waiver case, they must make the request of DHS-DRS and provide the following details:

1. The reason the MCO is initiating waiver closure.
2. Specific examples to support the reason behind waiver closure:
 - a. MCO cannot locate Member,
 - b. Member will not comply with waiver rules, or
 - c. Member requests termination of waiver services.
3. All reasons for closure must be well-documented in the MCO care coordination system .
 - a. If an MCO asks to close a waiver case because they cannot reach a member, HFS and DHS-DRS require the MCO to provide a history of attempted contacts with specific detail around various methods for attempted contact:
 - a. by phone,
 - b. by home visit,
 - c. by reaching out to other providers, the HSP-assigned counselor or the DHS.HSPManagedCare@illinois.gov inbox to inquire best ways to locate,
 - d. different times for attempted calls, and
 - e. home visit attempts.

4. A statement verifying the MCO has sent a Notice of Action letter to the member regarding the intent to close the waiver, that the 15 calendar days due under their appeal rights have passed, and confirmation that no appeal rights were requested from the member.

MCOs should try a variety of methods at various times of the day to contact waiver members. If the MCO has attempted yet failed to contact the member within **sixty (60)** days, the MCO should take appropriate steps to close the waiver.

MCOs should also complete the steps above if the client is hospitalized or a resident of a long term care facility for **sixty (60)** days or longer.

From DRS Rule: Section 684.100: Denial or Termination of HSP (Home Services Program) services

“HSP services shall be denied or terminated and case closure initiated at any time the Customer:

- e) is institutionalized and not expected to be released for a period to exceed 60 calendar days;”

Communicating with Division of Rehabilitation Services every quarter on membership not receiving waiver services

Section 5.7.1.6 of the HealthChoice Illinois contract states:

If Contractor is unable to contact an Enrollee in an HCBS Waiver within 90 days after enrollment, Contractor must, after documenting all forms of no fewer than 5 attempts to contact the Enrollee, contact the appropriate operating agency, provide documentation of the various attempts to contact the Enrollee, and request the Enrollee no longer be in an HCBS waiver.

Effective October 1, 2020, to align with and in support of this language, MCOs must begin submitting a quarterly report to DRS listing names and Recipient Identification Numbers (RINs) of members who have not received any waiver services in the prior quarter reporting period. This report should be sent to DHS.HSPManagedCare@illinois.gov and the MCO’s HFS Account Manager . Plans should list the last date of HCBS services that were provided, along with a statement explaining #s 1-4 above were followed.

This report does not change or replace existing steps in place that are done to notify DRS if a member cannot be located or no longer wants services. This report will be done in addition to timely notifications the MCO makes with DRS staff on case changes.

Communicating with Division of Rehabilitation Services’ Providers

HCBS providers rely on MCOs to provide them with end dates when an HCBS member leaves a health plan in situations when the health plan is terminating HCBS waiver services or when a member is transferring to another health plan.

MCOs have a responsibility to notify providers in writing of the date the MCO's DRS services end. This can be done by email or in hard copy form.

When DHS-DRS takes action to close a DRS waiver case or an HCBS member leaves a health plan, the MCO must notify the provider in writing of the end date. This will avoid billing problems in the future.

2. Illinois Department on Aging (IDOA) Elderly Waiver

While MCOs cannot formally close a waiver case independent of Illinois Department on Aging (IDOA), MCOs can stop providing member services in three instances, with the waiver to close *after* the MCOs have begun the process to stop providing services. Those three instances include:

- In cases involving a Memorandum of Understanding (MOU): When a member breaks or violates their MOU, MCOs can tell the member they are stopping services and provide an end date for that member.
- In cases involving a member who cannot be located, the MCOs can end services.
- In cases involving a member who states they no longer want to receive services.

In both instances, MCOs must notify the Care Coordination Unit (CCU) the same day the member was notified that services are no longer being provided. This CCU notification is done through email by completing the Aging Participant Transfer Form. The CCU will complete the necessary steps and work with IDOA to formally close the waiver.

If 60 days have passed since the date the CCU was notified and the waiver still remains open on the weekly OBRA file the MCO receives from HFS, the MCO should contact Aging.Advisor@illinois.gov to have the OBRA code closed.

In cases involving a member who cannot be located, MCOs should try a variety of methods at various times of the day to contact that member. This includes contacting the provider agency rendering services to learn if they have been serving the member and can provide updated contact information or information on their current location. If the MCO has attempted but failed to contact the member within sixty (60) days, the MCO should contact the CCU to close the waiver and provide them the last day to render service.

1. All reasons for closure must be well-documented in the MCO care coordination system .
 - a. If an MCO asks to close a waiver case because they cannot reach a member, HFS and IDOA require the MCO to provide a history of attempted contacts with specific detail around various methods for attempted contact:
 - a. by phone,
 - b. by home visit,
 - c. by reaching out to other providers or the assigned CCU to inquire best ways to locate,
 - d. different times for attempted calls, and
 - e. home visit attempts.

2. A statement verifying the MCO has sent a Notice of Action letter to the member regarding the intent to close the waiver, that the 15 calendar days due under their appeal rights have passed, and confirmation that no appeal rights were requested from the member.

MCOs should also contact the CCU to request waiver closure if the member is hospitalized or a resident of a long term care facility for sixty (60) days or longer.

From CCP Rule: Section 240.950: Reasons for Termination

“A client shall be terminated from CCP for one or more of the reasons identified in this Section:

- b) client is an in-patient of any institution or is otherwise not available for services for more than 60 calendar days;”

Communicating with Illinois Department on Aging every quarter on membership not receiving waiver services

Section 5.7.1.6 of the HealthChoice Illinois contract states:

If Contractor is unable to contact an Enrollee in an HCBS Waiver within 90 days after enrollment, Contractor must, after documenting all forms of no fewer than 5 attempts to contact the Enrollee, contact the appropriate operating agency, provide documentation of the various attempts to contact the Enrollee, and request the Enrollee no longer be in an HCBS waiver.

Effective October 1, 2020, to align with and in support of this language, MCOs must begin submitting a quarterly report to IDOA listing names and Recipient Identification Numbers (RINs) of members who have not received any waiver services in the prior quarter reporting period. This report should be sent to Aging.Advisor@illinois.gov and the MCO’s HFS Account Manager. Plans should list the last date of HCBS services that were provided, along with a statement explaining #s 1 and #2 above were followed.

This report does not change or replace existing steps in place that are done to notify CCUs if a member cannot be located or no longer wants services. This report will be done in addition to timely notifications the MCO makes with CCUs on case changes.

Provider notification requirements

When an MCO stops providing service – or when a member is no longer enrolled with an MCO, the MCO must notify providers to stop providing services. This written communication should include an end date for the provider, so the provider knows of the last date to provide services. This will avoid billing problems in the future.

Joint Committee on Administrative Rules Administrative Code requires that when an Aging Member’s Community Care Program (CCP) services are terminated, the appropriate provider is notified:

A copy of any notification mailed/hand-delivered to a participant/authorized representative shall be mailed/provided to the appropriate provider on the same date it is mailed/hand-delivered to the participant/authorized representative.

For more information, see this link:

<http://www.ilga.gov/commission/jcar/admincode/089/089002400I09450R.html>

The Aging Participant Transfer form includes a provider notification checkoff field. This field reminds MCOs of their responsibility to inform providers that any prior authorized waiver services should stop when the managed care enrollment ends or when services are no longer being rendered.

3. Department of Healthcare and Family Services/Supportive Living Program waiver

MCOs cannot close a Supportive Living Program (SLP) waiver case independent of Department of Healthcare and Family Services for the Supportive Living Program Waiver. In cases involving a SLP resident who no longer resides at the SLP but the waiver indicator remains open on the case, the MCO should take the following steps:

1. Check with the SLP provider to verify the member is no longer a resident of the SLP.
2. If it is confirmed the member is no longer a resident, ask the SLP provider to enter a discharge date in MEDI. This will close the waiver segment in the HFS system.
3. If it is confirmed the member is no longer a resident, the MCO has asked the SLP to enter a discharge date in MEDI but the discharge date has not been entered, the MCO should contact HFS.SLF@illinois.gov. MCOs should wait 10 business days to contact HFS.SLF@illinois.gov if the SLP provider did not enter the discharge date.

Policy History

Waiver Services Closeout: MCO Responsibilities

Date	Action	Policy Originator
April 2018	Contract Clarification	Lauren Tomko
September 2020	Policy Clarification	Lauren Tomko

Policy Revisions	Revision Approved
September 3, 2020	Laura Ray