Bureau of Managed Care
Managed Care Organizations
Policy / Procedures

General HCBS Waiver Guidance

Addressing Single Services in Division of Rehabilitation Services (DRS) Waivers

The purpose of this policy is to provide guidance to Managed Care Organizations (MCOs) regarding the requirements for DRS Waiver customers meeting certain service level requirements.

DRS does not have a current policy that dictates a minimum number of waiver services required to maintain eligibility for the waiver program. HSP determines annual eligibility around impairments and unmet needs identified by the Determination of Need (DON). For fee-for-service customers DRS subsequently writes a service plan that provides service(s) for every unmet need identified on the most recent DON assessment. When DRS completes an annual redetermination and the customer has declined waiver services to meet each of the previously identified unmet need(s), DRS will score the need column of that function as met at the next DON assessment. This has the potential to reduce an individual's DON score.

Policy for Customers Needing Single Services

MCO care coordinator will notify DRS when a health plan member indicates that they only want a single service such as Home Delivered Meals or Emergency Home Response. MCOs will share information, such as how the waiver member is meeting the needs that are identified on the current DON as unmet, without waiver service intervention. If it appears that the customer does not require services in function areas that were originally scored as unmet on the DON, it is imperative that MCO staff inform the HSP counselor so that a more accurate DON score could be rendered at the next redetermination. MCOs should inform the HSP Counselor in the WebCM case notes.

Please submit any questions to: DHS.HSPManagedCare@illinois.gov

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Policy History
General Contract Monitoring

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