HB5605

LRB104 19549 KTG 32997 b

104TH GENERAL ASSEMBLY

State of Illinois

2025 and 2026

HB5605

Introduced 2/13/2026, by Rep. Anne Stava

SYNOPSIS AS INTRODUCED:

New Act

Creates the Community Supported Living Arrangement Services Act. Provides that the Department of Human Services, Division of Developmental Disabilities shall work in coordination with the Department of Healthcare and Family Services to develop, implement, and operate, and to submit, through the Department of Healthcare and Family Services, amendments to the Illinois Adults with Developmental Disabilities Section 1915(c) Home and Community-Based Services Waiver, subject to approval by the Centers for Medicare and Medicaid Services. Provides for establishment of provider licensing, certification, and oversight standards for Community Supported Living-24 Hour services consistent with existing State authority for community-based residential services, but with the person's own home not requiring licensing or Bureau of Accreditation, Licensure and Certification reviews. Provides for 24-hour availability of trained personnel for individuals with intense physical, medical, or behavioral support needs. Contains provisions regarding: covered services; enrollment; the use of tools such as the Health Risk Screening Tool; housing independence; staffing and workforce standards; phased implementation; Person-Centered Plans; dignity of risk; compliance with mandates; quality assurance; evaluations; a Community Supported Living Advisory Council; reports; fiscal issues; administrative issues; and other matters. Effective immediately.

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A BILL FOR

AN ACT concerning developmental disabilities.

Be it enacted by the People of the State of Illinois, represented in the General Assembly:

Section 1. Short title. This Act may be cited as the Community Supported Living Arrangement Services Act.

Section 2. Findings; purpose.

(a) Findings.

(1) Risk of institutionalization and waiver gaps.

(A) Many individuals with developmental disabilities in Illinois, particularly individuals with intense physical, medical, or behavioral support needs, are institutionalized because their complex needs cannot be met through Illinois' current home and community-based service system. Other individuals remain at significant risk of institutionalization due to gaps in available home and community-based services and supports. As reflected in recent national data, as of the most recent reporting period, 16 states and the District of Columbia operate no state-run developmental disability institutions, and the majority of remaining states serve fewer than 500 individuals in such settings, demonstrating the feasibility of serving individuals with complex support needs in community-based settings when appropriate

services are available.

(B) Unnecessary institutionalization violates federal law, departs from generally accepted national standards and research-documented best practices for supporting individuals with developmental disabilities to obtain quality of life outcomes and results in higher public costs on average than home and community-based services. In Illinois, the average annual cost of placement in a State-operated developmental center, the most restrictive and least preferred setting, exceeds $320,000 per individual, compared to approximately $71,328 per individual for services delivered through the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver and other services from the Medicaid state plan.

(C) Existing Developmental Disabilities Division Home and Community-Based Service waivers in Illinois are not designed to meet the needs of individuals with complex medical, physical, or behavioral support requirements, and do not consistently reflect recognized best practices identified through national research and quality frameworks, including work by the University of Minnesota's Institute on Community Integration and by the Council on Quality and Leadership. These limitations contribute to the continued "placement" of individuals with complex needs in more restrictive and costly

institutional settings, while reducing the funding available to add community infrastructure and to address the waiting list.

(D) Assessment tools developed primarily for institutional or congregate service delivery models and grounded in a deficit-based or medical model, may systematically underestimate the support needs of individuals with complex medical, physical, or behavioral conditions who seek to live in their own homes and participate in community life, increasing the risk of service gaps and unnecessary institutionalization. The use of modern, validated assessment tools that measure support intensity and health and safety risk, including structured instruments such as the Health Risk Screening Tool and other validated tools, is necessary to accurately identify medical, behavioral, and supervision risks and the supports and services to address them relevant to safe and inclusive community living.

(E) Behavioral assessment findings are frequently documented but not meaningfully incorporated into eligibility determinations or service authorization decisions within Illinois' existing waiver structure. The absence of clear statutory direction requiring consideration of documented behavioral acuity contributes to service denials, prolonged waiting periods, caregiver collapse, crisis intervention, and unnecessary

institutional placement.

(F) Federal Medicaid law and guidance do not approve or require the use of any specific assessment instrument but instead require that assessment methodologies accurately identify individual need and support compliance with health, welfare, and community integration requirements.

(G) Inaccurate or incomplete assessment of individual support needs increases the likelihood of service gaps, family caregiving burden, emergency interventions, hospitalization, crisis placement, and institutionalization, resulting in higher long-term public costs and poorer self-determination, health, and quality of life outcomes for individuals.

(H) Federal statutes, regulations and guidance require access to integrated community-based services and supports that promote autonomy, dignity, and quality of life outcomes, including but not limited to:

(i) the Americans with Disabilities Act (ADA) (42 U.S.C. 12101 et seq.);

(ii) Olmstead v. L.C., 527 U.S. 581 (1999);

(iii) Ligas v. Maram Consent Decree (N.D. Ill. 2011);

(iv) the federal Home and Community-Based Service Settings and Person-Centered Planning Rule (79 Fed. Reg. 2947; 42 CFR 441.301(c), 441.710);

(v) the 2024 enhanced integration mandate under Section 504 of the Rehabilitation Act; and

(vi) the 2024 Centers for Medicare and Medicaid Services Home and Community-Based Services Final Rule.

(I) Federal deinstitutionalization transition programs, including Money Follows the Person, which provides a fiscal incentive to states with an enhanced federal Medicaid match for 365 days following an individual's transition from an institutional setting, exist to support individuals with developmental disabilities and complex support needs in moving to integrated community-based services, including assistance with transition-related costs such as rental deposits, home furnishings, and other allowable start-up expenses. Failure to fully utilize these transition authorities represents a missed opportunity to reduce institutional reliance, increase cost-effective community living options and quality of life outcomes, and advance compliance with federal integration mandates.

(J) This Act is intended to be implemented in a manner consistent with federal Medicaid statute and regulations governing Home and Community-Based Services waivers, including requirements applicable to services authorized under Section 1915(c) of the Social Security Act.

(2) Legal and policy foundations for community supported living arrangements.

(A) Statutory authority.

(i) Medicaid Home and Community-Based Services were authorized by Congress in 1981 under Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) to permit states, subject to federal approval, to furnish community-based services as an alternative to institutional care for individuals who would otherwise require an institutional level of care. Illinois applied for and received federal approval for its Home and Community-Based Services waiver serving adults with developmental disabilities in 1989.

(ii) The Section 1915(c) Home and Community-Based Services authority was implemented through federal regulations at 42 CFR Part 441 beginning in 1985 and is administered by the Centers for Medicare and Medicaid Services (CMS). In 1990, Congress enacted the Community Supported Living Arrangements Act as an amendment to the Medicaid Home and Community-Based Services statute, expanding the menu of permissible waiver services to explicitly recognize Community Supported Living Arrangements as a service option, for the first time separating Medicaid funding for community living supports from housing and facilities. Following this statutory amendment, CMS issued service definitions and guidance enabling states to implement

Community Supported Living Arrangements services within approved 1915(c) waivers.

States have since implemented Community Supported Living Arrangements services to support individuals with developmental disabilities in living in their own homes, apartments, family homes, or other integrated community-based residential settings, consistent with nationally recognized best practices promoted by the National Association of State Directors of Developmental Disabilities Services.

(iii) Community Supported Living Arrangements Services are an addition to the services that may be funded under Medicaid Home and Community-Based Services waivers. Community Supported Living Arrangements services are not a funding mechanism and are distinct from self-directed service models, including Illinois Home-Based Services. Community Supported Living Arrangements services are intended to operate as certified and provider-delivered, accountable residential support services with accountability for staffing, service delivery, and health and welfare protections in the individual's own home, including their family's home and not in a licensed facility.

(iv) Home and community-based services authorized under Section 1915(c) are administered and overseen by

the Centers for Medicare and Medicaid Services pursuant to 42 CFR Part 441, which requires compliance with person-centered planning, health and welfare assurances, provider qualifications, service quality, and community integration standards.

(B) Federal regulations and integration standards.

(i) The 2014 CMS Home and Community-Based Services Settings Rule (79 Fed. Reg. 2947, January 16, 2014; 42 CFR 441.301(c)(4)-(5)) requires that services be provided in community-integrated settings that respect individual informed choice, privacy, autonomy, and self-determination.

(ii) The 2024 enhanced integration mandate under Section 504 of the Rehabilitation Act strengthens and clarifies the requirement that all entities receiving federal financial assistance provide services to individuals with disabilities in the most integrated setting appropriate to their needs, aligning Section 504 enforcement with the integration principles of the Americans with Disabilities Act and Olmstead v. L.C.

(iii) The 2024 CMS Home and Community-Based Services Final Rule updates and expands upon the 2014 rule by reinforcing requirements for person-centered planning, informed choice (including meaningful opportunity to explore and visit service and housing options), community integration, and quality

oversight. The rule emphasizes equitable access to integrated housing and employment, strengthened accountability systems, and workforce stabilization to ensure meaningful outcomes that promote independence, inclusion, community belonging, and choice.

(3) Supreme Court and consent decree guidance.

(A) Olmstead v. L.C., 527 U.S. 581 (1999) The U.S. Supreme Court held that the unjustified segregation of individuals with disabilities constitutes discrimination in violation of the Americans with Disabilities Act (ADA) and that states are required to provide services in the most integrated setting appropriate to the needs of individuals with disabilities, which is a very different standard from the special education standard from 1975 of "least restrictive environment".

(B) The Ligas v. Maram Consent Decree (N.D. Ill. 2011) mandates that the State of Illinois ensures meaningful opportunities for individuals with developmental disabilities to transition from institutional settings to community-based living arrangements, and to avoid unnecessary institutionalization, consistent with the requirements of the Americans with Disabilities Act and the principles articulated in Olmstead.

(C) Compliance with Olmstead and the Ligas Consent Decree requires the availability of an array of community-based residential service options that can

support all individuals, including those with complex medical, physical, or behavioral needs in integrated settings of their choice with appropriate safeguards for health and welfare.

(4) Person-centered planning and dignity of risk.

(A) Person-centered planning, as required under federal Home and Community-Based Services regulations promulgated in 2014 (42 CFR 441.301(c)), is essential to ensure that individuals can make informed choices about their services, supports, and daily lives based upon their individual strengths, preferences, and interests. Such informed choice requires that the service system make available and accessible the full range of federally authorized home- and community-based service options, so that individuals and, when appropriate, their families or representatives, may understand, consider, and select among those options.

(B) The principle of dignity of risk recognizes that individuals have the right to make informed decisions, including those involving risk, while maintaining appropriate safeguards for their health, safety, and well-being.

(5) Workforce importance and challenges.

(A) Well-trained personnel, including direct support professionals, Qualified Intellectual/Developmental Disabilities Professionals, and Independent Service

Coordinators, are essential to the effective provision of individualized supports that produce measurable quality of life outcomes and ensure provider accountability.

(B) Workforce shortages of trained, competent direct support professionals and specialized staff present a significant barrier to achieving the goals of community integration, independence, and person-centered supports for all individuals with developmental disabilities, particularly individuals with complex support needs.

(C) Addressing workforce shortages through enhanced training, certification, compensation, and career development pathways is essential to ensure quality, safety, and continuity of services in community settings.

(b) Purposes. The purposes of this Act are to:

(1) Amend the existing Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver to:

(A) add Community Supported Living Arrangements as a residential service category authorized under Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), consistent with federal Home and Community-Based Services authority and CMS service definitions and guidance;

(B) rename Intermittent Community-Integrated Living Arrangements as Community Supported Living Arrangements-Intermittent; and

(C) add CSL-24 as a distinct waiver service option for individuals with complex medical, physical, or behavioral

support needs, in order to ensure access to a viable community-based living option for individuals whose needs cannot be met through intermittent CSL and who do not want congregate facility-based service models.

(2) Enable eligible individuals to live safely and independently in integrated community settings of their choice (including a home they own, lease, rent, or a family home) with up to 2 housemates of their choosing, supported by 24-hour medically or behaviorally competent personnel.

This standard is consistent with best-practice guidance from the Council on Quality and Leadership and national outcomes data from the Residential Information Systems Project at the University of Minnesota's Institute on Community Integration, which demonstrate that individuals with developmental disabilities, including those with complex support needs, experience better quality of life outcomes in person-chosen, non-provider-owned living arrangements with three or fewer residents that support health, safety, community integration and belonging, and quality of life than in provider owned, licensed group homes.

(3) Ensure services are provided in accordance with federal Home and Community-Based Services authority, CMS regulations, and state rules while promoting person-centered planning, dignity of risk, and full community integration, inclusion and belonging.

(4) Support workforce development, ongoing training, and

technical assistance, and maintain professional standards and certification of competencies, including a code of ethics for direct support professionals, Qualified Intellectual/Developmental Disabilities Professionals, Independent Service Coordinators, nursing staff, and employment support personnel.

(5) Reduce or prevent reliance on institutional or congregate settings while enhancing access to community-integrated life, personal "informed choice", and autonomy.

(6) Create capacity-building and high-fidelity community supports that continue to promote and preserve dignity, independence, inclusion, and belonging.

(7) Require independent external evaluation of the program (such as by the University of Illinois Chicago or CQL) and limit initial enrollment and geographic scope to ensure quality supports, accountability, and measurable outcomes.

(8) Expand Home and Community-Based Services options so Illinoisans with complex or intense support needs can live in integrated community settings with 24-hour supports, rather than in institutions or licensed group homes (community-integrated living arrangements), through the addition of CSL-24 services to the existing Adults with Developmental Disabilities Home and Community-Based Services Waiver.

(c) Legislative intent and interpretation. It is the

intent of the General Assembly that CSL-24 services be available to individuals whose assessed needs cannot be safely or sustainably met through existing waiver services, including Home-Based Services, and that the receipt of limited, intermittent, or insufficient services shall not be construed as evidence that an individual's needs are adequately met.

Section 3. Definitions. As used in this Act:

"CMS" means the Centers for Medicare and Medicaid Services.

"Community Supported Living Arrangements services" means, as defined in federal statute and implementing regulations, one or more services provided by a State authorized under this Section to assist an individual with a developmental disability in activities of daily living necessary to enable the individual to live in the individual's own home, apartment, family home, or leased or rented dwelling furnished in a community supported living arrangement setting. Such services may include, but are not limited to:

(1) Personal assistance services;

(2) Training and habilitation services necessary to support increased community integration, independence, and productivity;

(3) Twenty-four-hour emergency assistance, as defined or approved by the Secretary;

(4) Assistive technology;

(5) Adaptive equipment;

(6) Other services approved by the Secretary, except for services excluded under subsection (g) of the authorizing statute; and

(7) Support services necessary to enable participation in community activities.

The terms "Community Supported Living" and "Community Supported Living Arrangements" are used interchangeably and refer to the same federally authorized service category under Section 1915(c).

"Community Supported Living-Intermittent" means the service formerly known as Intermittent Community Integrated Living Arrangement under the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver, providing less than 24-hour staff support in an individual's own home or apartment.

Community Supported Living-Intermittent services are aligned with Community Supported Living Arrangements authority under 42 U.S.C. 1396n(c) and the Home and Community-Based Services requirements at 42 CFR 441.301 and are intended for individuals whose assessed needs do not require continuous or 24-hour supervision or clinical oversight.

Community Supported Living-Intermittent services do not include provider responsibility for continuous or 24-hour staffing or clinical oversight.

"Community Supported Living-24 Hour" or "CSL-24" means a

provider-delivered Community Supported Living Arrangement service, subject to certification, qualification, and oversight requirements established by the Department added to the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver, providing continuous, 24-hour availability of trained direct support, supervision, and clinical oversight, as identified in the individual's Person-Centered Plan.

CSL-24 services are authorized under Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) and 42 CFR 441.301, and are designed to support individuals with intense physical, medical, or complex behavioral support needs to live in their own home, leased or rented apartment, or family home.

CSL-24 services include full provider responsibility for health and welfare, staffing, nursing delegation, and behavioral supports as specified in the Person-Centered Plan.

CSL-24 services shall not be subject to funding caps applicable to intermittent or congregate residential services and shall be authorized based on validated assessment results, including a required health and safety risk assessment such as the Health Risk Screening Tool, together with a comprehensive Person-Centered Plan developed by a trained Independent Service Coordinator in compliance with federal person-centered planning requirements under the 2014 Home and Community-Based Services Settings Rule.

Assessment requirements for CSL-24 services shall be

distinct from, and shall not alter assessment or eligibility requirements applicable to other waiver services.

CSL-24 services shall not be considered Residential Habilitation, Community-Integrated Living Arrangements, or any congregate residential service model, and shall not be subject to provider-owned or provider-controlled housing, site-based occupancy assumptions, or group residential staffing methodologies.

"Intense physical and medical support needs" means the needs of an individual requiring frequent or continuous support, supervision, or nursing intervention or delegation to manage conditions such as seizures, respiratory support, enteral feeding, positioning, medication administration, or other significant health-related interventions, consistent with the Home and Community-Based Services waiver authority under 42 U.S.C. 1396n(c) and 42 CFR 441.301(b)(1)(ii)

"Intense and complex behavioral support Needs" means the needs of an individual who requires structured behavioral supports, crisis intervention, or positive behavioral strategies due to challenging or high-risk behaviors that would otherwise result in institutional placement, consistent with service definitions under 42 U.S.C. 1396n(c) and 42 CFR 441.301(b)(1)(ii).

"Behavioral Acuity" means the presence of significant behavioral support needs that require ongoing supervision, intervention, or specialized supports to ensure health,

safety, and community stability, as demonstrated through professional assessment, documented behavioral history, or validated behavioral risk or support intensity tools. Behavioral acuity may be demonstrated through professional assessment, documented behavioral history, Functional Behavioral Assessments, Behavior Support Plans, validated behavioral risk or support-intensity tools, documented crisis events, placement disruption, or other evidence indicating moderate to severe behavioral support needs requiring ongoing supervision, intervention, or specialized supports regardless of whether the individual is currently in crisis.

"Caregiver collapse" means a situation in which unpaid family or informal caregivers are no longer able to safely or sustainably provide necessary supports due to age, health, exhaustion, or increased support needs of the individual, resulting in heightened risk of crisis or institutional placement.

"Person-Centered Plan" means an individualized plan of services developed in accordance with Section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)) and 42 CFR 441.301(c)(1)-(2), led by the individual and reflecting individual's preferences, goals, and desired outcomes.

The Person-Centered Plan shall provide sufficient time, information, and support for the individual to explore and make informed choices regarding housing and living arrangements (where they want to live with up to 2

housemates), required services and supports, providers, and short and long-term goals.

"Enhanced Service Coordination" means an increased level of Independent Service Coordination and provider-based case management required for individuals with higher assessed acuity, including increased frequency of monitoring, coordination, documentation, and on-call availability, commensurate with the individual's assessed health, safety, and supervision risks.

"Independent Service Coordinator" means an individual employed by an Independent Service Coordination agency under 59 Ill. Adm. Code 120.40(a)(6) and consistent with 42 CFR 441.301(c), responsible for eligibility determinations, facilitation of person-centered planning, and ongoing service coordination for individuals with developmental disabilities with at least quarterly in-person visits and meetings.

"Housing navigator" means an individual or entity designated or contracted by an Independent Service Coordination agency or the Department to assist individuals with developmental disabilities in locating, securing, and maintaining affordable, and, when necessary, accessible, integrated community housing consistent with the individual's preferences and outcomes identified through the person-centered planning process.

"Direct support professional" means an individual who meets the training and competency requirements established in

59 Ill. Adm. Code 119 and Section 10 of the Mental Health and Developmental Disabilities Administrative Act, and who provides habilitation, personal care, or other direct support to individuals with developmental disabilities.

"Qualified Intellectual/Developmental Disabilities Professional" means a professional employed by a provider agency who meets qualifications described in 42 CFR 483.430(a)(2) and 59 Ill. Adm. Code 115.10, possesses specialized training or experience in supporting individuals with intellectual or developmental disabilities, and is responsible for implementing the Person-Centered Plan, and coordinating services in compliance with federal and state requirements.

Coordination of services includes but is not limited to:

(1) Planning and coordinating services and staff schedules.

(2) Monitoring health, safety, and well-being, including through remote oversight;

(3) Arranging transportation and access to community resources.

(4) Assisting with financial management, bill payment, or home accessibility modifications.

(5) Coordinating healthcare, therapies, prescriptions, medical appointments, supplies, and durable medical equipment.

(6) Full responsibility for daily life coordination.

(7) Providing on-call support for emergencies.

On-call support shall be used to ensure safety and continuity of care and shall not override the individual's autonomy or informed choice.

"Home and Community-Based Services settings rule" means the final rule issued by the Centers for Medicare and Medicaid Services at 79 Federal Register 2947 (January 16, 2014), codified at 42 CFR 441.301(c)(4)-(5), 441.530(a)(1)(i), and 441.710(a)(1)(i), establishing requirements that Home and Community-Based Services settings be integrated in the community and support individual autonomy, privacy, and access to community life and choice of services.

"Dignity of risk" means the recognition that individuals with disabilities have the right to make informed choices about their lives, including choices that involve risk, consistent with the autonomy, dignity, and choice provisions of 42 CFR 441.301(c)(4)(i)-(v) and related CMS guidance.

"Money Follows the Person" means the federal program authorized under Section 6071 of the Deficit Reduction Act of 2005 (42 U.S.C. 1396a note) as extended by Congress which provides enhanced federal matching funds for up to 365 days to assist Medicaid beneficiaries in transitioning from institutional settings to community-based services.

"Health Risk Screening Tool" means a validated, nationally recognized health and safety risk assessment tool that is currently used within Illinois' developmental disabilities

service system to identify medical, behavioral, and environmental risks, including the level of health-related support and monitoring necessary to ensure an individual's health, safety, and welfare in community-based settings or a substantially equivalent successor tool approved by the Department.

"Health Risk Screening Tool level of care" means the level of care designation assigned to an individual based on the results of the Health Risk Screening Tool, which identifies Levels of Care 1 through 6. Levels of Care 4 (extensive), 5 (pervasive), and 6 (complex) reflect elevated to extreme health and safety risk, indicating the need for enhanced supports, monitoring, or clinical oversight.

"Remote support and monitoring technology" means non-intrusive, person-centered technology used to support health, safety, independence, and community living, including but not limited to wearable health monitoring devices, environmental sensors, personal emergency response systems, medication reminders, and two-way communication technologies.

Remote support and monitoring technology shall be used only with the informed consent of the individual or the individual's legally authorized representative, shall be integrated into the Person-Centered Plan, and shall not include continuous video surveillance or audio monitoring of private living spaces.

"Augmentative and Alternative Communication" means all

forms of communication other than oral speech that are used to express thoughts, needs, wants, and preferences, including but not limited to speech-generating devices, communication boards, symbol systems, eye-gaze systems, sign language, and other low-tech or high-tech communication methods.

Augmentative and Alternative Communication includes the equipment, software, customization, training, and staff support necessary to ensure effective, functional communication across settings, consistent with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

"Risk of institutionalization" includes circumstances in which existing waiver services are capped, unavailable, intermittently staffed, or otherwise insufficient to safely meet assessed medical, behavioral, or supervision needs, resulting in reliance on unsustainable unpaid caregiving.

Section 4. Program established; administration.

(a) Administering agency. The Department of Human Services, Division of Developmental Disabilities is designated as the administering agency and shall work in coordination with the Department of Healthcare and Family Services, Illinois' single State Medicaid agency, to develop, implement, and operate, and to submit, through the Department of Healthcare and Family Services, amendments to the Illinois Adults with Developmental Disabilities Section 1915(c) Home

and Community-Based Services Waiver, subject to approval by the Centers for Medicare and Medicaid Services.

The Department of Human Services, Division of Developmental Disabilities shall have delegated authority from the Department of Healthcare and Family Services, consistent with federal and state law and subject to available appropriations, to contract with providers, establish and administer rates, certify and monitor providers, and adopt implementing rules, subject to approval by the Department of Healthcare and Family Services as required for Medicaid compliance and federal financial participation.

Provider licensing, certification, and oversight standards for CSL-24 services shall be established by the Department consistent with existing State authority for community-based residential services, but with the person's own home not requiring licensing or Bureau of Accreditation, Licensure and Certification reviews, and approved by the State Medicaid agency as required for federal financial participation.

(b) Advisory Council. The Department shall establish and convene a Community Supported Living Advisory Council to advise the Department on implementation, training, quality standards, evaluation findings, and oversight of CSL-24 services under this Act, as further described in Section 18 of this Act.

(c) Non-interference and independent implementation.

(1) Nothing in this Act shall be construed to require

the modification, redesign, consolidation, suspension, or reevaluation of any existing service, rate methodology, eligibility criteria, assessment process, or administrative rule under the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver as a condition of implementing CSL-24 services.

(2) The Department shall not delay implementation of CSL-24 services due to proposed, pending, or future changes to other waiver services, assessment tools, rate structures, or administrative processes, except as strictly necessary to obtain federal approval specific to CSL-24.

(3) CSL-24 services shall be implemented independently of any broader waiver redesign, rate rebasing, assessment reform, or system transformation efforts.

(d) Implementation timeline.

(1) Within 180 days after the effective date of this Act, as administratively feasible and subject to receipt of any required federal approvals, the Department shall initiate implementation activities specific to CSL-24 services, including but not limited to provider qualification standards, service definitions, and administrative rules necessary to operationalize CSL-24.

(2) Implementation activities under this subsection shall proceed concurrently with, and not be delayed by,

unrelated waiver amendments, assessment reforms, rate rebasing efforts, or system redesign initiatives.

(3) Nothing in this subsection shall be construed to require implementation prior to receipt of any federal approvals specific to CSL-24, provided that the Department shall pursue such approvals expeditiously.

(e) Rate development, cost neutrality, and federal approval.

(1) The Department of Human Services, in coordination with the Department of Healthcare and Family Services, shall establish reimbursement rates for CSL-24 services that reflect the intensity, complexity, and continuous responsibility associated with providing twenty-four-hour staffing, health and welfare oversight, nursing delegation, behavioral supports, and provider accountability, as required under this Act.

(2) The Department of Human Services and the Department of Healthcare and Family Services shall develop and submit to the Centers for Medicare and Medicaid Services any required waiver amendments, rate methodologies, cost-effectiveness demonstrations, or cost-neutrality analyses necessary to implement CSL-24 services in compliance with Section 1915(c) of the Social Security Act and applicable federal regulations.

(3) Implementation of CSL-24 services is contingent upon receipt of required federal approvals. Nothing in

this Act shall be construed to require expenditures in excess of amounts authorized under the approved Medicaid waiver or to constitute an unfunded mandate.

Section 5. Eligibility, enrollment, implementation, transition, and evaluation.

(a) Target population and eligibility; CSL-24. This Section applies only to CSL-24 services and shall not modify eligibility or access criteria for other waiver services, nor be conditioned upon changes to other waiver services or assessment systems.

Eligibility criteria specific to CSL-24 services are used solely to determine service appropriateness and authorization and shall not establish a separate waiver eligibility category, enrollment group, benefit package, or waiver authority.

(1) Nothing in this Section shall be construed to require enrollment in CSL-24 services as a condition of accessing other waiver services, or to limit access to less intensive services when appropriate to an individual's assessed needs. Support Needs:

(A) The waiver shall serve individuals with documented needs by one or more clinical assessments and qualified professionals, for one or more of the following:

(i) Intense physical or medical support needs;

(ii) Intense or complex behavioral support needs; or

(iii) Continuous or 24-hour availability of supervision, direct support, or clinical oversight necessary to ensure health, safety, and meaningful community living.

(B) Individuals eligible for CSL-24 services shall demonstrate, through validated assessment tools, a need for continuous or 24-hour availability of medical, behavioral, or supervisory supports to prevent institutional placement and to support safe, integrated community living.

(C) An individual shall not be deemed ineligible for CSL-24 services solely because the individual is currently receiving Home-Based Services or other waiver services, when such services are insufficient to meet assessed needs or to prevent risk of institutionalization.

(2) Risk of Institutionalization; Family Home Eligibility. Individuals shall be eligible if they are at risk of institutionalization or currently residing in:

(A) State-operated developmental centers;

(B) Intermediate Care Facilities for Individuals with Intellectual/Developmental Disabilities (ICF/MC/DD);

(C) Nursing facilities; or

(D) Other institutional or congregate settings.

(3) Individuals residing in the family home also qualify if they:

(A) Are age 22 or older;

(B) Would be eligible for institutional placement in the absence of unpaid family caregiving supports, including where caregiver age, health, or sustainability creates a foreseeable risk of placement; or

(C) Desire to live in a home of their own or remain in the family home with individually tailored supports through CSL-24 services.

(4) Age and Functional Criteria: Participants must be 18 years or older and meet Medicaid institutional level-of-care requirements and applicable waiver-specific functional or medical criteria.

Assessment: Eligibility and service authorization shall be determined using validated assessment instruments that accurately identify an individual's medical, behavioral, physical, and supervision support needs necessary for safe, community-based living. The instruments must be administered by professional staff who have been trained with documented competency to perform the assessments.

In determining eligibility for CSL-24 services, the Department shall consider documented behavioral acuity,

including but not limited to information derived from Functional Behavioral Assessments, Behavior Support Plans, Health Risk Screening Tool behavioral risk indicators, clinical or psychiatric evaluations, and documented incident, crisis, or placement disruption history.

A health and safety risk assessment, such as the Health Risk Screening Tool, or a substantially similar validated instrument, shall be required for all individuals seeking or receiving CSL-24 services, and for individuals applying through or enrolled in the Prioritization of Urgency of Need for Services (PUNS) process where required by the Department.

Assessment results shall be used to inform eligibility determinations, service authorization, staffing requirements, and individualized needs-based funding levels.

Health Risk Screening Tool results shall not be used as the sole determinant of waiver eligibility and shall be considered in conjunction with person-centered planning, clinical judgment, and other validated assessment information.

Individuals with a Health Risk Screening Tool Level of Care of 4, 5, or 6 shall be considered to have significant health and safety risk that must be explicitly considered in eligibility determinations and service planning, including consideration for CSL-24 services.

An individual shall not be denied access to CSL-24 services solely due to the timing or completion status of a Health Risk Screening Tool assessment when other evidence demonstrates comparable health or safety risk.

Assessment results shall not be used to require placement in a congregate, provider-controlled, or institutional setting when community-based supports can reasonably meet the individual's assessed needs and such services must be made available for legal compliance with federal laws and court decisions.

The Department may utilize additional validated assessment tools, as appropriate, to inform service planning and support intensity. Nothing in this subsection shall be construed to require the use of the Supports Intensity Scale (SIS®) as a condition of eligibility or access to services, provided that the assessment methodology used is validated, nationally recognized, and capable of accurately identifying individual support needs consistent with federal Home and Community-Based Services requirements.

No eligibility determination, service authorization, staffing level, or funding decision under this Act shall be reduced, delayed, denied, or conditioned based on the assumed availability of unpaid family caregiving, remote support or monitoring technology, community day services, employment services, or other non-residential supports.

Assessment results, including ICAP and MBI findings, when used solely as supplemental historical context and not as determinative measures, shall be used to inform service intensity and support design and shall not be used as a basis for exclusion or denial of CSL-24 services.

(5) Service Packet: Individuals seeking CSL-24 services shall submit a complete service packet in the form and manner prescribed by the administering agency.

(b) Enrollment priority. Priority determinations under this subsection apply solely to enrollment sequencing when CSL-24 service capacity is temporarily limited and shall not affect Medicaid waiver eligibility, service authorization, or access to other waiver services.

Priority shall be applied only among individuals who have already been determined eligible for and authorized to receive CSL-24 services under the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver.

Priority enrollment shall be given to individuals with intense support needs who:

(1) Reside in a family home with a caregiver providing primary unpaid supports that are no longer sustainable, including individuals whose current waiver services (such as Home-Based Services) are inadequate, unavailable, or capped at levels insufficient to meet assessed needs, and who would be at risk of institutionalization without CSL-24 services; or

(2) Are currently in State-operated developmental centers,

ICF/MC/DD facilities, nursing facilities, or similar institutional settings and express a desire to live in the community.

Once determined eligible for CSL-24 services, individuals shall not be subject to an additional service-specific waiting list beyond temporary capacity limitations addressed through phased implementation.

(c) Written notice of acceptance or rejection.

(1) Provider agencies shall issue written notice of acceptance or rejection of each complete service packet within 30 calendar days of receipt.

(2) Notice shall include:

(A) The specific reasons for acceptance or rejection;

(B) Identification of any supports required to serve the individual that the provider cannot currently furnish; and

(C) Instructions for correction, resubmission, or appeal consistent with state and federal Medicaid requirements.

A provider's inability or refusal to serve an individual due to behavioral acuity or support complexity shall not be construed as evidence that the individual is ineligible for CSL-24 services.

Nothing in this subsection shall be construed to grant provider agencies authority to determine Medicaid eligibility

or waiver eligibility, which shall remain the responsibility of the administering agency.

(d) Phased rollout for quality and capacity reasons. CSL-24 services are established as a permanent service option under the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver. Phased implementation is authorized solely for purposes of quality assurance, provider capacity development, workforce readiness, and program evaluation, and shall not be construed as a pilot, demonstration, or temporary program.

(1) Phase I-Initiation. The purpose of phase I is to ensure quality implementation and data collection prior to statewide expansion.

(A) Initial enrollment shall be limited to no more than 250 participants in 4-5 Independent Service Coordination regions including urban, suburban, and rural areas for the first 3 to 5 years.

(B) Providers must be fully certified and credentialed prior to enrollment of participants, demonstrating compliance with Home and Community-Based Services settings requirements, staff training and competency standards, and program quality benchmarks.

The initial provider development and capacity-building phase is expected to require 6 to 9 months prior to the enrollment of the first CSL-24 participants.

Data collected during Phase I shall inform the

independent external evaluation required for any subsequent expansion.

(2) Phase II-IV-Expansion. Expansion shall occur contingent upon:

(A) Findings from independent external evaluation and implementation of any recommended modifications for improvement;

(B) Demonstrated provider capacity and readiness; and

(C) Legislative approval.

(e) Transition and grandfathering.

(1) Individuals transitioning from other waivers or institutional settings shall receive continuity of care protections, including:

(A) No interruption of essential supports during transition;

(B) Coordination between current and new providers; and

(C) The ability to transition at any time subject to eligibility and priority criteria.

(2) Money Follows the Person Utilization Requirement. To the maximum extent permitted under federal law, the Department shall prioritize use of available Money Follows the Person enhanced federal matching funds (approximately 75%) for up to 365 days for individuals transitioning from institutional settings into CSL-24 services.

MFP funds may be used for housing transition costs, start-up expenses, assistive technology, environmental modifications, and other allowable one-time transition supports necessary for safe community living and community belonging.

Transition planning shall include coordination with available federal transition funding, including Money Follows the Person, consistent with Section 11 of this Act.

(f) Timeline and reporting.

(1) The administering agency shall maintain and publish a timeline for waiver submission, provider certification, and phased enrollment.

(2) Annual progress reports shall be submitted to the General Assembly and the Department of Healthcare and Family Services and shall include:

(A) Number of participants enrolled;

(B) Number of transitions completed;

(C) Compliance with implementation milestones; and

(D) Annual costs and projected savings.

Reports shall be segregated by Health Risk Screening Tool Level of Care, documented behavioral acuity or behavioral support needs, age, referral source, prior living arrangement, and referral outcome (accepted, denied, pending), including reasons for denial or delay.

Section 6. Assessment and level-of-need framework.

(a) Scope of application. The assessment and level-of-need framework described in this Section applies only to individuals seeking or receiving CSL-24 services and shall not alter assessment requirements, eligibility criteria, or funding methodologies for other services within the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver unless expressly authorized by statute.

(b) Comprehensive person-centered assessment. The Department shall ensure that all individuals seeking or receiving CSL-24 services receive a comprehensive, person-centered assessment that accurately identifies functional, behavioral, and supervision support needs necessary for safe community-based living.

(c) Required health and safety risk assessment. The Department shall require use of the Health Risk Screening Tool, or a substantially similar validated health and safety risk assessment, for all individuals seeking or receiving services under this Waiver, including individuals applying for or enrolled through the Prioritization of Urgency of Need for Services (PUNS) process.

This requirement may be satisfied through the Health Risk Screening Tool or through a substantially similar State-defined risk assessment methodology, provided that such methodology:

(1) identifies health and safety risks across all hours of the day;

(2) informs the need for continuous or 24-hour availability of supports;

(3) identifies required safeguards, staffing patterns, and clinical oversight;

(4) is documented in and integrated into the Person-Centered Plan; and

(5) incorporates behavioral risk and support needs identified through Functional Behavioral Assessments, Behavior Support Plans, or other validated behavioral assessment methodologies, and integrates such findings into the Person-Centered Plan.

Nothing in this Section shall be construed to require use of a specific proprietary tool, provided the assessment methodology used meets federal Home and Community-Based Services health and welfare assurance requirements.

(d) Determination of 24-Hour support needs. Assessment results shall identify health and safety risks across all hours of the day and shall explicitly determine the need for continuous or 24-hour availability of supports where applicable.

Assessment results shall explicitly determine the need for continuous or 24-hour availability of supports without presuming congregate, facility-based, or provider-controlled residential placement based solely on acuity or support

intensity.

For individuals with complex medical, physical, or behavioral support needs, the assessment shall identify, at minimum:

(1) Medical complexity and nursing-related needs;

(2) Behavioral interventions, supervision intensity, and related support needs, including staffing skill level and consistency requirements with no use of seclusion or restraints;

(3) Health and welfare risks across all hours of the day; and

(4) The need for monitoring, supervision, or clinical supports.

(e) Role of technology in risk mitigation. Assessment results, including Health Risk Screening Tool findings, may be used to identify where remote support or monitoring technology could mitigate identified health or safety risks or enhance early detection of changes in condition, when such technology is preferred by the individual and integrated into the Person-Centered Plan.

The availability or use of remote support or monitoring technology shall not, by itself, be used to reduce authorized staffing or nursing supports, nor to deny eligibility for CSL-24 services, when in-person supports are otherwise determined to be necessary through person-centered planning.

(f) Health Risk Screening Tool Levels of care and

eligibility consideration. Individuals with a Health Risk Screening Tool Level of Care of 4, 5, or 6 shall be presumed to require consideration of enhanced supports, without presuming congregate or institutional placement.

Health Risk Screening Tool Levels of Care 4, 5, or 6 shall be considered in eligibility determinations, service authorization, staffing requirements, service coordination intensity and individualized funding levels, including consideration for CSL-24 services, as identified through the person-centered planning process.

Health Risk Screening Tool Levels of Care inform service planning, support intensity, and risk mitigation and do not independently determine Medicaid waiver eligibility.

(g) Use of additional assessment tools. The Department may utilize additional validated assessment instruments, including tools that measure support intensity or functional needs, to inform service planning and funding determinations. All staff administering the assessment instruments must be trained and certified as competent to provide the assessments with fidelity.

Nothing in this Section shall be construed to require the use of the Supports Intensity Scale (SIS®) as a condition of eligibility or access to services.

The use of additional assessment tools shall not result in the disregard or devaluation of documented behavioral acuity, medical risk, or supervision needs identified through other

validated assessments.

(h) Prohibition on reliance on legacy or deficit-based tools. The Department shall not rely solely on legacy or deficit-based assessment tools such as the Inventory for Client and Agency Planning (ICAP), that were developed for institutional or congregate models and do not adequately capture individualized health risk, supervision needs, or 24-hour community-based support requirements for any individual with a disability to be a member of their home community with appropriate individualized supports from trained and certified competent staff.

(i) Needs-based funding. Funding for Community Supported Living services shall be based on assessed individual need and shall not be determined through averaged, capped, or population-based funding methodologies.

Funding determinations shall reflect the risks and safeguards identified through required health and safety risk assessments, including the need for continuous or 24-hour availability of supports.

Nothing in this subsection shall be construed to exempt CSL-24 services from federal waiver cost-neutrality requirements, which shall be satisfied through individualized budgets and aggregate cost comparisons as required under Section 1915(c).

(j) Prohibition on ICAP-Based rate or staffing determinations for CSL-24. Notwithstanding any other provision

of law, rule, or waiver methodology, the Inventory for Client and Agency Planning (ICAP) or other legacy or deficit-based instruments shall not be used as the primary basis for determining eligibility, staffing levels, service intensity, or funding for CSL-24 services.

No assessment instrument developed primarily for institutional or congregate service models shall be used to deny access to CSL-24 services or to justify placement in a congregate or institutional setting.

Behavioral complexity or intensity shall not, by itself, constitute a basis for denial of eligibility, reduction of services, or exclusion from CSL-24 services.

(k) Reassessment. Reassessments shall occur at least annually and whenever a participant's needs materially change.

(l) Integration with PUNS. The Department shall incorporate Health Risk Screening Tool results into the Prioritization of Urgency of Need for Services (PUNS) process to ensure that individuals with significant health and safety risks are accurately identified and prioritized.

A Health Risk Screening Tool Level of Care of 4, 5, or 6 shall be recognized as evidence of urgent need due to heightened risk of institutionalization, health deterioration, or caregiver collapse.

Behavioral acuity documented through Functional Behavioral Assessments, Behavior Support Plans, Health Risk Screening Tool behavioral risk indicators, documented crisis or

placement disruption history, or other validated behavioral assessment tools shall be recognized as evidence of urgent need when such needs materially increase the risk of institutionalization, placement disruption, or caregiver collapse.

(m) Proprietary tool safeguard. Nothing in this Act shall be construed to require the use of a specific proprietary assessment instrument, provided that any alternative tool used is validated, nationally recognized, and capable of accurately identifying health, safety, and support needs consistent with federal Home and Community-Based Services requirements.

Section 7. Covered services.

(a) General principles.

(1) The Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver, as amended by this Act, shall provide a flexible array of home and community-based services designed to meet each participant's individualized needs and preferences as identified in the Person-Centered Plan.

(2) Services shall be delivered in accordance with federal Home and Community-Based Services regulations and shall be flexible in type, intensity, and setting to ensure person-centeredness, informed choice, and promote independence, health, and community integration.

(3) Providers furnishing CSL-24 services shall

maintain 24/7 emergency and crisis backup coverage to respond to participant health, safety, or behavioral emergencies, especially for individuals with high-intensity medical or behavioral support needs.

(4) Services authorized under CSL-24 shall not be subject to hourly, daily, weekly, or monthly service caps except as required to ensure compliance with federal waiver cost-neutrality requirements, applicable to other waiver services including indirect staffing, on-call coverage, or supervisory limits, and shall be authorized solely based on assessed individual need and the Person-Centered Plan, except as required for federal waiver cost-neutrality compliance.

(5) Coordination across residential and day services. Providers of CSL-24 services and Independent Service Coordinators shall coordinate with employment providers, community day providers, and other service entities to ensure continuity of staffing, nursing oversight, behavioral supports, and transportation necessary to support meaningful community participation and belonging throughout the day.

Service coordination responsibilities shall not be fragmented in a manner that results in denial of access to employment, community day, or meaningful activities for individuals with complex medical, physical, or behavioral support needs.

(b) Covered services shall include, but are not limited to, the following:

(1) Intensive Individualized Service Coordination. This service builds upon the standard Independent Service Coordination function, providing an enhanced level of support for individuals with complex medical, behavioral, or physical support needs who require frequent, proactive coordination to ensure health, safety, and stability in community settings.

(A) Development and ongoing implementation of a comprehensive Person-Centered Plan including:

(i) Assistance in accessing and coordinating necessary medical, behavioral, and integrated and inclusive community-based services and supports.

(ii) Ongoing monitoring of the individual's health, welfare, and progress toward desired outcomes with increased frequency and intensity as needed to address risks or changes in status.

(iii) Coordination of transitions between institutional, congregate settings; or other settings into or within Community living arrangements.

(iv) Development and maintenance of a 24-hour individualized backup and emergency response plan to ensure continuity of support, including identification of formal and informal supports.

(B) Enhanced service coordination for high-acuity

individuals. Individuals with a Health Risk Screening Tool Level of Care of 4, 5, or 6, or with documented behavioral acuity as defined in Section 3, shall receive enhanced service coordination, commensurate with assessed acuity and risk, which shall include, at a minimum:

(i) Increased frequency of Independent Service Coordinator contact, monitoring, and documentation;

(ii) Lower Independent Service Coordinator caseload ratios proportional to the individual's assessed health, safety, and supervision needs;

(iii) Proactive coordination of medical, behavioral, nursing, and crisis prevention supports, including coordination across providers and systems of care;

(iv) Ongoing review of health and safety risks, mitigation strategies, and required adjustments to services or supports; and

(v) Rapid response coordination during changes in condition, hospitalization, emergency department use, behavioral crises, or other destabilizing events.

Enhanced Service Coordination under this subsection shall be reflected in rate-setting, staffing expectations, and caseload standards

applicable to Independent Service Coordination and provider-based case management functions.

(2) Housing Navigator Services:

(A) assist the individual in identifying, securing, and maintaining affordable and, when needed, accessible community-based housing aligned with the individual's preferences and Person-Centered Plan.

(B) Housing Navigator responsibilities include:

(i) Identifying available, affordable, and accessible housing options and related supports within the individual's preferred communities.

(ii) Assisting individuals and families with completing housing, leasing, and rental assistance applications, including requests for reasonable accommodations.

(iii) Developing and maintaining relationships with landlords, property managers, housing developers, public housing authorities, and other community partners to expand integrated housing opportunities.

(iv) Coordinating with Independent Service Coordination agencies, service providers, housing authorities, and other local partners to support housing searches, applications, transitions, and ongoing tenancy needs.

(v) Providing tenancy-sustaining supports,

including assistance with lease renewals, communication with landlords, and identification of additional services or interventions needed to maintain housing stability.

All housing-related activities shall comply with the federal Home and Community-Based Services Settings Rule (42 CFR 441.301(c)(4)) and the integration principles affirmed in Olmstead v. L.C.

(3) Community Supported Living Services, consisting of the following distinct service options:

(A) Community Supported Living-Intermittent (formerly Intermittent Community-Integrated Living Arrangement) provides less than 24-hour staff support consistent with existing waiver service parameters.

(B) CSL-24.

Provides continuous, 24-hour provider responsibility for staffing, supervision, health and welfare, nursing delegation, and behavioral support as identified in the Person-Centered Plan.

(4) Behavioral stabilization and crisis prevention.

(A) Services shall be based on non-aversive, positive behavioral interventions and trauma-informed care.

(B) Restrictive procedures such as seclusion or restraint shall only be used as a last resort, on a temporary and emergency basis and must:

(i) Be based on a comprehensive evaluation and recommendations from a professional who is licensed or certified in behavioral management approaches for people with developmental disabilities;

(ii) Be developed using evidence-based or evidence-informed practices;

(iii) Be supported by documented justification; and

(iv) Be reviewed and approved by an independent human rights committee consistent with State rule and federal CMS guidance.

(5) Community integration and companion supports.

(A) Assistance that enables active participation in community-integrated activities.

(B) One-to-one supports in community settings or home-based supports directly related to community participation, as defined in the Person-Centered Plan.

(C) Services authorized under CSL-24 shall not be subject to preset hourly, daily, weekly, or monthly service caps. Service intensity and duration shall be authorized solely based on assessed individual need and documented in the Person-Centered Plan.

(D) Communication Access and Augmentative and Alternative Communication Supports. For individuals who rely on Augmentative and Alternative Communication, services shall include one-to-one

staffing or dedicated trained staff for communication support when required to ensure the person's right to effective communication, self-direction, and participation in home, community, employment, or meaningful day activities.

Such supports shall include trained direct support professionals or other staff who are competent in the individual's Augmentative and Alternative Communication system and communication strategies, as documented in the Person-Centered Plan.

The provision of Augmentative and Alternative Communication devices or technology alone shall not be considered sufficient if the individual requires ongoing or intermittent human support to use the system effectively.

(6) Skilled nursing services. Licensed nursing services provided on a part-time or intermittent basis, including:

(A) Health assessment and monitoring;

(B) Medication management; and

(C) Nursing care, including delegation to trained DSPs as allowed under State law and the Nurse Practice Act.

(7) Employment and meaningful day supports.

(A) Customized employment discovery, profile, plan, job development, systematic instruction, and

long-term supports (in person or virtual) after employment is secured, when indicated, according to the individual's need for support.

(B) A Customized Employment Discovery Profile and Plan shall first be provided through the Division of Rehabilitation Services (DRS), as required under federal vocational rehabilitation and CMS Medicaid Home and Community-Based Services regulations, unless there is documentation that DRS cannot begin the process within 30 days, after which the Home and Community-Based Services waiver can pay for those services. Once there is a Customized Employment plan in place, DRS is obligated to provide or purchase job development and at least 180 days of ongoing support, after which funding for long-term supports is transferred to Home and Community-Based Services.

(8) Equipment, technology, and environmental modifications.

(A) Purchase, rental, or maintenance of items, devices, or systems that increase or maintain functional independence, including but not limited to:

(i) Personal emergency response systems, including installation, maintenance, and monthly response center fees, that enable participants to signal a response center to secure help in an emergency.

(ii) Home and vehicle accessibility modifications;

physical changes to a private residence, automobile, or van, necessary to accommodate the participant and improve functional access, safety, or independence.

(iii) Assistive technology and durable medical equipment, including the purchase or rent of items, devices, or product systems that increase or maintain a person's functional status and level of independence, including design, fitting, adaptation, maintenance and training or technical assistance related to the use of such equipment.

(iv) Augmentative and Alternative Communication supports, including speech-generating devices, communication boards, symbol systems, switches and alternative access devices, eye-gaze systems, low-tech and high-tech communication tools, and related software or applications, together with necessary customization, programming, accessories, mounting, maintenance, repair, replacement, and training or technical assistance for the individual and supporting staff, when required to ensure effective communication, informed choice, self-advocacy, health and safety, and participation in home and community life.

(v) Disposable medical supplies, including nutritional supplements necessary to maintain or improve an individual's health and functional status,

and to support continued residence in the community.

(vi) Standard limitation. Except as provided in subparagraph (vii), the total aggregate cost for adaptive equipment, assistive technology, environmental modifications (including home and vehicle accessibility modifications), remote support-equipment, and related installation, maintenance, repair, and monitoring costs shall not exceed the maximum amount otherwise permitted under the Illinois Adults with Developmental Disabilities Section 1915(c) Home and Community-Based Services Waiver, as approved by CMS, or any successor waiver provisions.

(vii) Enhanced limitation for CSL-24. Subject to CMS approval, for individuals authorized to receive CSL-24 services, the limitation described in subparagraph (vi) shall be increased to an aggregate amount equal to 2 times the maximum amount otherwise permitted under the approved waiver, when such modifications, equipment, or technology are necessary to support health, safety, or continued community living and are documented in the Person-Centered Plan. This enhanced limitation applies only to CSL-24 and shall not alter limits applicable to other waiver services.

Implementation of this enhanced limitation is

subject to CMS approval and shall be carried out in a manner consistent with federal waiver cost-neutrality requirements.

(viii) Remote Support and Monitoring Technology. For individuals receiving CSL-24 services, remote support and monitoring technology may be authorized as a supplemental support when documented in the Person-Centered Plan and determined to enhance safety, independence, or continuity of care.

Remote supports shall not replace required in-person staffing, nursing oversight, or supervision identified through assessment and person-centered planning, but may be used to supplement supports during periods of stability, overnight hours, or transitions, consistent with individual preference and assessed risk.

(9) Transportation services. Transportation (accessible as needed) to enable community participation, employment, and access to health care or social activities, as specified in the Person-Centered Plan.

(10) Extended State Plan Services. Physical therapy, occupational therapy, and speech-language therapy designed to maintain or improve function and to train support staff, as identified in the Person-Centered Plan.

(11) Institutional Transition Supports (MFP-Aligned). For individuals transitioning from institutional settings

into CSL-24 services, the Department shall ensure coordination between waiver services and the Money Follows the Person program. Transition planning shall begin prior to discharge and include identification and timely access to MFP-funded transition supports unless the individual is determined ineligible for MFP or MFP funding is unavailable.

(12) Enhanced community day and meaningful day supports for individuals with complex needs.

(A) Community day, employment, and meaningful day services shall be available to individuals receiving Community Supported Living-Intermittent or CSL-24 services and shall be designed to support full participation in integrated community life.

(B) For individuals with intense physical, medical, or behavioral support needs, community day and meaningful day services shall include, as identified in the Person-Centered Plan:

(i) One-to-one or enhanced staffing ratios, including continuous supervision when required for health or safety;

(ii) Skilled nursing services or nursing oversight, including medication administration, monitoring, and delegation during day activities;

(iii) Behavioral support staff, crisis prevention supports, and positive behavioral

interventions;

(iv) Transportation supports, including staff-accompanied transportation when required.

(C) These supports shall be considered integral components of community day and meaningful day services and shall not be denied solely because they are not listed as stand-alone services within the waiver.

(D) Reimbursement rates for community day and meaningful day services shall include acuity-based rate add-ons to reflect the actual cost of providing one-to-one staffing, nursing supports, and specialized supervision.

(E) The Department shall comply with the Americans with Disabilities Act (42 U.S.C. 12101 et seq.) and Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), and shall not exclude any individual from community day or meaningful day services on the basis of disability or disability-related support needs. The Department shall provide reasonable modifications, auxiliary aids, services, and supports necessary to ensure equal access to such services.

Reasonable modifications shall be provided unless the Department demonstrates that such modifications would fundamentally alter the nature of the service.

Section 8. Person-centered planning and budgets.

(a) Each participant shall have a Person-Centered Plan developed and implemented in accordance with federal Home and Community-Based Services requirements and the 2014 CMS Settings Rule.

The Person-Centered Plan shall be led by the participant and facilitated by trained facilitators or navigators using federally recognized person-centered planning principles, including those reflected in the National Center for Advancing Person-Centered Practices and Systems. The Person-Centered Plan process may include friends, family, and other stakeholders and shall:

(1) document the participant's goals, preferences, strengths, and desired outcomes;

(2) reflect informed choice among available services, supports, and providers; the Person-Centered Plan shall identify communication needs, including the use of Augmentative and Alternative Communication, and shall specify any required staffing supports necessary to ensure effective communication, informed choice, and self-advocacy across all settings;

(3) explicitly incorporate the principle of dignity of risk; and

(4) identify strategies and safeguards necessary to maintain the participant's health, safety, and well-being while respecting autonomy and choice including nursing

delegation plans (if applicable), required provider response times, staffing patterns, indirect staffing supports, on-call coverage, and community integration plan.

Meaningful day, community participation, and employment integration. For individuals receiving CSL-24 services, the Person-Centered Plan shall include goals and preferences related to meaningful day activities, community participation, or employment, and shall identify the services, staffing, nursing supports, behavioral supports, transportation, and coordination necessary to support participation across the full day.

The absence, delay, or limited availability of employment, community day, or meaningful day services shall not be used to deny, delay, reduce, or terminate access to CSL-24 services.

(b) Individual budgets. Individual budgets shall be based on the participant's assessed level of need, as determined through validated assessment instruments and the person-centered planning process.

(1) Budget determinations shall be informed by required health and safety risk assessments, including the Health Risk Screening Tool or a substantially similar validated instrument, as well as documented behavioral assessment levels, and shall not rely on legacy or deficit-based tools, including the Inventory for Client and Agency Planning (ICAP), as the primary basis for

funding amounts, staffing levels, or service intensity for CSL-24 services.

(2) Funding shall not be tied to the individual's location, residence type, or provider-operated setting, but shall be directly linked to the supports and services in the individual's own home, identified in the participant's Person-Centered Plan, to be reviewed at least annually.

(3) Budgets for CSL-24 shall not impose direct or indirect service caps other than those necessary to ensure compliance with federal waiver cost-neutrality requirements, including limits on supervisory staffing, indirect staffing, or on-call coverage, when such supports are necessary to address assessed health, safety, or supervision needs and are documented in the Person-Centered Plan.

(4) Staff sharing in CSL-24: Person-Centered Plans shall determine whether staff sharing is appropriate based on individual health, safety, and support needs. Overnight staff sharing may be allowed only when it does not compromise individual support, and clear contingency and response protocols are documented in each participant's Person-Centered Plan.

(c) Cost parameters and CMS cost-effectiveness.

(1) The State shall establish individualized budgets using an approved, needs-based methodology that reflects

the participant's assessed medical, behavioral, and physical support requirements.

(2) Consistent with CMS cost-effectiveness standards for 1915(c) waivers, the State shall ensure that the aggregate costs of services and supports provided to waiver participants do not exceed the aggregate costs of serving an equivalent number of individuals in comparable institutional settings, Intermediate Care Facilities (ICFs/IID).

(3) The State shall maintain documentation demonstrating cost neutrality in accordance with CMS requirements, including adherence to the approved cost-neutrality formula, and reporting standards.

(d) Annual review and revision. The administering agency shall establish procedures for annual review and revision of the Person-Centered Plan and individual budget to ensure responsiveness to changes in the participant's needs, goals, or circumstances.

(e) Support adjustments without relocation.

(1) Changes in a participant's medical, behavioral, physical, or communication needs shall not require relocation from the participant's chosen home, including a family home, apartment, or leased residence.

(2) When needs decrease or increase, the Department shall adjust services, staffing levels, nursing supports, assistive technology, or other accommodations necessary to

maintain the individual safely in their existing home whenever possible.

(3) Increased support needs shall not be used as justification to require placement in a congregate, provider-controlled, or institutional setting.

(4) Relocation may occur only when requested by the participant or when all reasonable support adjustments have been exhausted and continuation in the current setting would pose a documented, unavoidable risk that cannot be mitigated through additional services and assistive technology.

(5) Increased support needs, staffing intensity, or service cost shall not be used as justification for relocation, waiver termination, or placement in a congregate or institutional setting.

(6) Changes in an individual's communication needs, including increased reliance on Augmentative and Alternative Communication, shall be addressed through adjustments to staffing, training, or supports and shall not be used as justification for service reduction, denial, or relocation.

(f) Participant-Initiated Revisions. Participants shall have the right to request revisions to their Person-Centered Plan or individual budget at any time when there is a change in their condition, circumstances, or personal preferences. The administering agency shall respond to such requests in a

timely manner and provide written notice of approval or denial, including the reason for the determination and instructions for appeal.

(g) Independent Service Coordination Oversight. Independent Service Coordinators shall conduct at least quarterly reviews of Person-Centered Plan implementation for individuals receiving CSL-24 services, including verification that authorized staffing levels, indirect supports, and on-call coverage are being provided as approved and that risk mitigation strategies are effective. Findings shall be documented and used to inform service adjustments when needed.

Section 9. Provider requirements and selection. The Department shall implement an initial, phased deployment of CSL-24 services with a limited number of qualified providers, not to exceed 7, that demonstrate expertise and a documented success record with the Department of supporting individuals with complex medical or behavioral needs in small, integrated community settings serving 4 or fewer individuals.

Nothing in this Section shall be construed to limit future expansion of qualified providers upon demonstration of provider readiness, workforce capacity, and compliance with program standards.

This initial provider limitation is intended solely to ensure quality, workforce readiness, and fidelity to person-centered, community-based service provision during

early implementation and shall not be used to restrict long-term access, participant choice, long-term provider participation, geographic access, or statewide availability of CSL-24 services. This initial implementation shall apply only to CSL-24 services and shall not limit access to Community Supported Living-Intermittent services.

(a) Provider independence and housing ownership.

(1) No provider of community-based services under Community Supported Living Arrangements -Intermittent or CSL-24 shall own, lease, manage, or otherwise exercise control over the housing or residential setting in which a participant resides, except as permitted under federal Home and Community-Based Services regulations where the participant retains full tenant rights, meaningful choice, and the ability to select and change service providers independent of housing.

(2) Housing and services shall be functionally independent to ensure participants' rights to privacy, autonomy, and control over their living environment and to avoid risk of institutionalization.

(b) Provider qualification, certification and selection.

(1) All providers shall meet the qualification standards established by the administering agency and shall demonstrate capacity to deliver services consistent with person-centered planning, informed choice, and community integration requirements with demonstrated

compliance with the federal Home and Community-Based Services Settings Rule.

Qualification standards shall include but not be limited to:

(A) Minimum quality and performance standards;

(B) Criminal background and registry checks;

(C) Evidence-based clinical and nursing protocols;

(D) Staffing ratios and competency standards;

(E) Emergency response and backup coverage plans; and

(F) Medication administration and delegation protocols.

(2) Participants shall have the right to select from qualified providers and to change providers without penalty.

(3) The administering agency may limit participation in CSL-24 services to providers that demonstrate specialized competency in supporting individuals with complex medical, physical, or behavioral needs, including nursing delegation, crisis response, and high-acuity staffing capacity, without limiting participant choice among qualified providers.

(4) Participant Choice of Provider. Nothing in this Section shall be construed to permit assignment of a provider without the informed choice and consent of the participant or the participant's legally authorized

representative, consistent with federal Home and Community-Based Services requirements.

(c) Compliance and corrective action. The administering agency shall establish monitoring procedures to ensure provider compliance with federal and state Home and Community-Based Services settings requirements, the ADA, Section 504, and all terms of this Act.

(1) Providers found to be out of compliance shall be required to implement a corrective action plan within a defined timeframe.

(2) Failure to achieve compliance within the required period after notice and opportunity to correct may result in suspension, termination, or decertification of the provider's participation in the program.

(3) Participants affected by provider suspension or termination shall receive timely notice and assistance with transition to another qualified provider of their choice (if desired) to ensure continuity of care and compliance with Olmstead v. L.C. and the Ligas Consent Decree.

(d) Transparency and public reporting. The administering agency shall maintain and publish an annual report and online public registry of all approved providers, including:

(1) current compliance status with Home and Community-Based Services settings and program requirements;

(2) corrective action plans and resolution status, where applicable;

(3) any enforcement actions, suspensions, or terminations taken during the reporting period.

This information shall be publicly accessible and regularly updated to promote accountability, quality improvement, and informed participant choice.

The administering agency shall annually report provider capacity limitations, including the number of individuals denied services due to staffing, nursing, or acuity-related constraints, geographic gaps in provider availability, and recommended corrective actions.

(e) Temporary suspension of new admissions.

(1) If a provider is determined to be out of compliance with Home and Community-Based Services requirements, participant rights, or quality standards, the administering agency may impose a temporary suspension of new admissions following notice and in accordance with applicable due process requirements.

(2) The suspension shall remain in effect until the provider demonstrates full compliance through verification by the agency or its designee.

(3) During such suspension, the agency shall ensure that participants currently served by the provider continue to receive all necessary supports without disruption.

(f) Provider expansion criteria. The administering agency shall establish objective criteria and a transparent process for expanding provider participation in CSL-24 services beyond the initial implementation phase.

Such criteria shall consider, at a minimum:

(1) demonstrated unmet participant need;

(2) geographic access and equity;

(3) provider performance and compliance history; and

(4) workforce capacity and readiness.

Nothing in this subsection shall require expansion beyond the Department's administrative capacity but the Department shall ensure that provider participation is not permanently limited where unmet need exists.

Section 10. Workforce development, training and retention. All workforce standards, staffing ratios, caseload requirements, training obligations, wage enhancements, and workforce-related provisions set forth in this Section apply solely to CSL-24 services and shall be implemented subject to federal approval, waiver authority, and available appropriations.

Nothing in this Section shall be construed to require modification of workforce standards, staffing ratios, wages, or caseloads applicable to any other waiver service or program.

(a) Staffing ratios and caseloads.

(1) The administering agency shall establish minimum direct support professional to participant ratios, based on participant acuity, including medical, physical, and behavioral support needs.

(2) For high-acuity participants, ratios shall be lower as needed to ensure health, safety, and quality services and supports and quality of life outcomes.

(3) Nursing supports:

(A) Participants requiring skilled health care supports shall have access to licensed nursing services for assessment, monitoring, training, and delegation of health-related tasks in accordance with the Illinois Nurse Practice Act and Medicaid requirements.

(B) Nursing coverage levels shall be determined through the person-centered planning process and informed by validated assessment tools including required health and safety risk assessments such as Health Risk Screening Tool, to ensure appropriate RN/LPN availability for both direct and indirect clinical oversight.

(C) Providers shall maintain sufficient nursing capacity to ensure timely response to changes in condition, medication management, and emergency situations.

(D) When nursing delegation is used, DSPs must

receive competency-based training and supervision by a qualified nurse, consistent with delegation rules and participant safety requirements.

(4) Qualified Intellectual/Developmental Disabilities Professionals shall have caseloads commensurate with participant acuity. Individuals with Health Risk Screening Tool Levels of Care 4, 5, or 6 shall require lower Qualified Intellectual Disabilities Professional caseload ratios to ensure adequate oversight, coordination, and accountability for health, safety, and quality of life outcomes, with caseload limits to be established in rule and not to exceed a range of 4 to 7 participants unless the Department documents justification based on assessed acuity and risk.

(5) Providers shall maintain sufficient staffing to ensure 24/7 coverage, including direct support and paid indirect supports and coordination such as planning, monitoring, emergency response, staff coordination, emergency backup staff, and service scheduling.

(6) Staff sharing and overnight support:

(A) Staff sharing is permissible only when consistent with each participant's Person-Centered Plan and individual risk assessment.

(B) Overnight staff may support more than one participant in a household only if:

(i) All individuals are asleep;

(ii) Health and safety monitoring is assured; and

(iii) Emergency response protocols enable immediate assistance.

(b) Initial competency-based training and certification.

(1) All direct support professionals, Qualified Intellectual Disabilities Professionals, and Independent Service Coordinators shall complete mandatory, competency-based initial training and certification prior to providing services.

(2) The training shall be based on nationally recognized standards, including the College of Direct Support, the National Alliance for Direct Support Professionals Code of Ethics, and the National Center on Advancing Person-Centered Practices and Systems curriculum.

(3) Initial training shall include, at a minimum, the following core areas:

(A) Person-centered thinking, planning, and implementation, consistent with National Center on Advancing Person-Centered Practices and Systems and CMS Home and Community-Based Services regulations;

(B) Positive behavioral supports and non-aversive crisis prevention, including functional behavior understanding and de-escalation strategies;

(C) Health, safety, and nursing supports,

including:

(i) Nursing delegation and medication administration;

(ii) Health risk screening and monitoring using validated health and safety risk assessments, such as the Health Risk Screening Tool;

(iii) Prevention and recognition of the "Fatal Five", the 5 leading causes of preventable death among individuals with developmental disabilities, consistent with nationally recognized clinical guidance;

(iv) Emergency response and procedures, including fire safety, medical emergencies, and natural disasters;

(v) Indirect supports and coordination, including service monitoring, scheduling, and communication across providers;

(vi) Participant rights and Home and Community-Based Services compliance, including privacy, autonomy, choice, and community integration consistent with 42 CFR 441.301(c)(4);

(vii) Any additional topics required by the administering agency for compliance with state and federal standards.

(c) Annual refresher training and competency assessment.

(1) All direct support professionals, Qualified Intellectual/Developmental Disabilities Professionals, and Independent Service Coordinators shall complete annual refresher training and competency assessments designed to reinforce and update essential skills with improved best practices and advances in assistive technology.

(2) Annual training shall include, at a minimum, instruction in the following areas:

(A) Person-centered practices, including review of plan implementation and progress toward individualized outcomes;

(B) Health and safety, including updates to Health Risk Screening Tool assessments, medication administration, infection control, and emergency response procedures;

(C) Positive behavioral supports and trauma-informed care;

(D) Community participation, belonging, and development of relationships and natural (unpaid) supports;

(E) Development of profiles and strategies for meaningful community day activities and customized employment;

(F) Advances in assistive technology and applications that support increased independence and self-determination;

(G) Participant rights, appeals, and advocacy, including access to ombuds and grievance procedures;

(H) Incident reporting and abuse prevention, including identification, mandatory reporting requirements, and documentation protocols;

(I) Compliance with the Home and Community-Based Services Settings Rule, reinforcing autonomy, integration, privacy, and informed choice; and

(J) Emerging topics, as identified by the administering agency, including new regulatory updates, assistive technology, or communication supports.

(d) Workforce stabilization, retention, and incentives. The administering agency shall implement programs to promote workforce competencies, stability, and retention, through competency-based training and performance standards, including:

(1) Wage enhancements and salary floors for direct support professionals and Qualified Intellectual/Developmental Disabilities Professionals serving high-acuity CSL-24 participants.

(2) Tuition reimbursement, credentialing support, and professional development opportunities.

(3) Career ladder and mentorship programs.

(4) Other incentives designed to recruit, retain, and maintain a competent, high-quality workforce in community

supported living settings to ensure provider accountability for participants' health, safety, and quality of life outcomes.

Any wage enhancements or salary floors referenced in this subsection shall be implemented solely through approved reimbursement rates and shall not create obligations beyond those authorized under the approved Medicaid waiver.

(e) Oversight and compliance. The administering agency shall:

(1) monitor adherence to staffing ratios, Qualified Intellectual Disabilities Professional caseload limits, and 24/7 coverage requirements;

(2) ensure completion of all training and refresher requirements;

(3) monitor workforce retention and vacancy rates; and

(4) report annually to the General Assembly and the public, with CSL-24-specific data, on staffing levels, caseload compliance, nursing coverage, training completion, vacancy rates, and workforce stability outcomes.

(f) Alignment with Person-Centered Plans and Home and Community-Based Services requirements. All staffing, training, and retention policies under this Section shall be implemented in a manner that ensures:

(1) full adherence to each participant's Person-Centered Plan, including opportunities to

experience choices, make informed choices, individualized goals and outcomes, risk and benefit decisions, and required supports;

(2) provision of indirect supports and coordination, such as scheduling, monitoring, emergency response, and service management, in accordance with participant needs; and

(3) compliance with federal Home and Community-Based Services rules, including integration, autonomy, privacy, and access to community life.

Section 11. Rate-setting and finance. Upfront funding authorization is required for implementation of CSL-24 services, including training and infrastructure investments.

(a) Rate Methodology. Enhanced rates, staffing ratios, nursing supports, and workforce standards described in this Act shall apply to CSL-24 services and shall be tiered based on assessed acuity.

Rate methodologies shall explicitly account for enhanced service coordination requirements for individuals with higher assessed health and safety risk (Health Risk Screening Tool Levels of Care 4, 5, or 6), or intensive behavioral support needs, including lower caseload ratios, increased monitoring, and on-call availability.

The administering agency shall establish a rate-setting methodology that:

(1) funds services based on each participant's Person-Centered Plan, including all direct and paid indirect supports required to achieve goals and maintain health and safety;

(2) Residential staffing, supervision, and funding for CSL-24 services shall not be reduced, offset, or conditioned upon assumptions of participation in community day services, employment services, or other non-residential waiver services;

(3) compensates Qualified Intellectual Disabilities Professionals, Independent Service Coordinators, DSPs, and nursing staff appropriately, reflecting staff training, certification level, supervision responsibilities, and the intensity of coordination and oversight required by assessed acuity;

(4) day support cost inclusion. Rates shall account for the full cost of participation in community day and meaningful day activities for individuals with complex needs, including staffing, nursing oversight, transportation, and supervision required during non-residential hours without reducing residential funding levels. Participation in employment, community day, or meaningful day services shall not be required as a condition of maintaining CSL-24 services, nor shall the cost of such services be used to reduce residential, nursing, or coordination funding authorized under an

individual's Person-Centered Plan; and

(5) remote support and monitoring technology costs. Costs associated with approved remote support and monitoring technology, including equipment, installation, maintenance, and response services, shall be treated as allowable waiver expenses when authorized in the Person-Centered Plan and shall not be offset by reductions in staffing or nursing supports.

(b) Rates and staffing assumptions for CSL-24 services may not be reduced through administrative rule, provider guidance, or operational policy in a manner inconsistent with individualized Person-Centered Plans without express statutory authorization.

(c) For purposes of federal Medicaid cost neutrality, CSL-24 services shall be evaluated against the cost of institutional and congregate care settings from which participants would otherwise receive services, including ICF/IID facilities, and nursing facilities, and not against average per-participant waiver costs for lower-acuity populations.

(d) Fiscal Justification for Enhanced Environmental Modifications. The Department shall recognize that enhanced funding for home accessibility and environmental modifications for individuals receiving CSL-24 services is a cost-effective accommodation that reduces hospitalization, emergency interventions, caregiver collapse, and reliance on

institutional placement, and supports compliance with federal community integration mandates and Medicaid cost-neutrality requirements.

The enhanced limitation authorized under Section 7 shall be incorporated into the waiver amendment submitted to the Centers for Medicare and Medicaid Services and shall not be reduced, restricted, or eliminated through administrative rule, rate methodology, provider guidance, or waiver operational policy absent express statutory authorization.

Any reduction of the enhanced limitation applicable to CSL-24 services shall require express legislative authorization and may not be implemented solely through administrative rule, provider guidance, or waiver operational policy.

(e) Medical necessity of environmental and home accessibility modifications. Environmental and home accessibility modifications authorized for CSL-24 services shall be considered medically necessary habilitative supports and shall not be reduced, delayed, or denied for reasons of budgetary convenience where such action would reasonably be expected to increase the risk of hospitalization, property damage, personal injury, direct support professional or other caregiver collapse, or institutional placement.

(f) Funding and State match.

(1) The administering agency shall implement rates in accordance with CMS waiver approval; the state match and

funding requirements shall follow federal and state regulations.

(2) All rates must support quality, safety, and the provision of person-centered, community-based services consistent with federal Home and Community-Based Services requirements.

(3) The Department shall consider the use of Money Follows the Person funding as a transition financing tool that supports waiver cost-effectiveness and reduces reliance on high-cost institutional care.

(g) Workforce-Linked Incentives.

(1) Rates may include provisions for wage enhancements or salary floors for DSPs serving high-acuity participants.

(2) Rates must support training, credentialing, and retention programs to maintain a competent, high-quality workforce, or equivalent ongoing funding must be separately available for these purposes.

(h) Budget Oversight.

(1) The administering agency shall periodically review and adjust rates to ensure that

(A) funding levels are sufficient to meet participant needs;

(B) Home and Community-Based Services compliance is maintained;

(C) Measurable outcomes in health, safety, and

community integration are achieved; and

(D) Reinvested savings are fully utilized to strengthen community-based supports and prevent institutional placement.

(2) Rate Adequacy Review for CSL-24. In conducting reviews under this subsection, the administering agency shall specifically evaluate CSL-24 reimbursement rates to ensure continued alignment with documented participant health, safety, staffing, and clinical support needs, including workforce-related costs and acuity-driven service intensity.

Such review shall not rely solely on historical averages, cost containment targets, or assumptions derived from lower-acuity waiver services.

Section 12. Quality assurance, monitoring, safeguards, and evaluations.

(a) Participant rights and appeals.

(1) Participants shall have the right to appeal any denial of eligibility, service authorization, or change to services, including changes to Person-Centered Plans or budgets.

(2) Restrictive interventions, if ever necessary, shall require prior external review and approval by a human rights committee and documentation consistent with federal Home and Community-Based Services rules and best

practices, except in documented emergency situations where post-incident review is required.

(3) Participants shall have access to an independent ombuds or advocacy system to:

(A) Support individual rights;

(B) Ensure due process and fair hearings; and

(C) Provide assistance during appeals or grievances.

(b) Monitoring and compliance

(1) Providers shall be subject to regular monitoring and audits to ensure compliance with:

(A) Federal Home and Community-Based Services settings rules and the definitions of Community Supported Living Arrangements services, including full and faithful implementation of each individual's Person-Centered Plan;

(B) State licensing and regulatory requirements; and

(C) Program standards established under this Act.

Monitoring shall include review of staffing levels, service delivery, communication supports, nursing oversight, and safeguards identified in the Person-Centered Plan to verify that authorized services are delivered as approved.

(2) Providers shall implement health and safety oversight, including:

(A) Clinical audits.

(B) Nursing competency checks.

(C) Medication administration oversight.

(D) Emergency response protocols.

(3) Providers shall maintain incident reporting and abuse prevention systems consistent with state law and federal Home and Community-Based Services assurances, and participants shall have access to independent ombuds or advocacy services to protect rights and ensure accountability.

(4) Corrective action plans shall be required for providers found out of compliance, including potential suspension, termination, or decertification when deficiencies pose a risk to health, safety, or participant rights.

(5) Providers shall maintain and submit documentation demonstrating adherence to person-centered practices, staffing requirements, training, and safety protocols.

(6) The administering agency shall track key performance indicators to monitor program operations and provider compliance. These indicators shall inform oversight, corrective action, and quality improvement efforts. Performance metrics shall be tracked and reviewed annually, including:

(A) DSP, behavioral interventionists and nurse vacancy rates.

(B) Provider compliance findings and corrective actions.

(C) Participant safety incidents and resolutions; and

(D) Participant satisfaction and quality of life indicators.

(E) Number of participants receiving CSL-24 services, by assessed acuity level using validated assessment methodologies.

(7) The administering agency shall track and publicly report the number of individuals receiving CSL-24 who are denied access to community day or meaningful day services or customized employment due to staffing, nursing, or support needs, including the reason for denial and length of delay, and shall identify corrective actions to address service gaps.

(c) External evaluation and metrics.

(1) The administering agency shall contract with an independent evaluator (such as University of Illinois Chicago or CQL) to assess program effectiveness and quality of life outcomes.

(2) Evaluation metrics shall include, at a minimum:

(A) CQL 21 Personal Outcome Measures or equivalent quality of life metrics;

(B) Health outcomes, including rates of hospitalization, emergency department utilization, and

preventable medical events, including indicators associated with preventable morbidity and mortality commonly referred to in national best practice as the "Fatal Five," or comparable evidence-based risk frameworks used to identify leading causes of preventable death among individuals with developmental disabilities;

(C) Community integration outcomes, including participation, social inclusion and belonging, and employment;

(D) Institutional placements avoided, including transitions from State-operated developmental centers, Intermediate Care Facilities, nursing facilities, or other congregate settings;

(E) Service utilization and acuity measures based on validated assessment tools;

(F) Use and effectiveness of Specialized Service Teams where applicable;

(G) Number of individuals transitioned from Short-Term Stabilization Homes;

(H) Access to and outcomes from mental and behavioral health services;

(I) Changes in utilization of Medicaid-funded health care services, including primary care, mental health services, emergency department visits, and hospitalizations;

(J) Enhanced quality of life outcomes, including self-determination, stability, and meaningful daily activity;

(K) Participant and family satisfaction;

(L) Workforce stability and competency; and

(M) Cost per participant compared to institutional care.

(3) Evaluation schedule:

(A) Annual formative review: Ongoing assessment of program operations, staffing, and outcome trends.

(B) Year 3 evaluation: Assess impact on institutionalization census rates, participant health outcomes, program costs, and overall effectiveness.

(C) Year 5 comprehensive evaluation: Assess long-term impact on institutionalization, health and quality of life outcomes, and costs; provide recommendations for program improvements and statewide expansion.

(d) Data Collection and Public Reporting.

(1) The administering agency shall publish annual public reports that include:

(A) Acceptance, rejection, and termination rates of service providers, including a summary of the reasons for which individuals were rejected or terminated.

(B) Waitlist counts and demographics.

(C) Aggregate outcome data, service utilization, fiscal information, participant demographics, enrollment counts, and service mix.

(D) Health and community integration outcomes.

(E) Findings from external evaluations.

(F) The number of individuals transitioning from State-operated developmental centers, nursing facilities, and other institutional settings into CSL-24 services using Money Follows the Person funding, including the average time from referral to community living to living in the community.

(2) Reports shall be submitted annually to:

(A) The General Assembly; and

(B) The Department of Healthcare and Family Services.

(e) Legislative Oversight and Corrective Action Reporting. If annual reporting demonstrates a pattern of denials, delays, or service gaps for individuals with documented medical or behavioral acuity, the Department shall report to the General Assembly the corrective actions taken and any recommended statutory or administrative changes necessary to ensure compliance with federal integration and Home and Community-Based Services requirements.

Section 13. Participant rights and protections.

(a) There shall be a guarantee of a process and time for

informed choice and consent, meaningful and effective communication, dignity and human rights, access to personal property, control over daily schedules, and protections from isolation or restrictive practices in all services and settings established under this Act.

(b) The right to dignity of risk shall be protected, including the right to make informed decisions, to refuse services, and to appeal decisions without retaliation.

(c) Individualized restrictive procedure protocols and prior external review are required before any restrictive intervention, except in documented emergency situations subject to post-incident review, and emphasize non-aversive, trauma-informed practices.

(d) Participants shall retain all rights guaranteed under the Mental Health and Developmental Disabilities Code and the Mental Health and Developmental Disabilities Confidentiality Act, including rights to dignity, autonomy, due process, informed consent, and the confidentiality of personal and medical information. These rights shall apply fully to all Community Supported Living-Intermittent and CSL-24 services, providers, and settings established under this Act.

(e) There shall be privacy protections for remote supports. Any use of remote support or monitoring technology shall comply with federal Home and Community-Based Services privacy, autonomy, and dignity requirements. Individuals shall have the right to decline or discontinue use of such

technology at any time without penalty or loss of services.

Section 14. Housing and settings requirements,

(a) Community-integrated housing.

(1) Waiver services, with assistance from the Housing Navigator and Independent Service Coordinator, shall support individuals to live in affordable, accessible when needed, integrated, community-based housing that the individual owns, leases, rents, or otherwise controls, consistent with the individual's preferences and Person-Centered Plan.

(2) Participants shall have freedom of movement and access to community life comparable to that of individuals without disabilities. Housing arrangements shall ensure full tenant rights, including control over:

(A) Leases and utilities;

(B) Visitors;

(C) Daily schedules and activities;

(D) Privacy and personal property, including telephones and computers; and

(E) Choice of one or 2 housemates, if desired.

(3) Participants shall have the right to use assistive technology, adaptive equipment, and communication or mobility devices of their choice in their home and community, consistent with their Person-Centered Plan.

(4) Housing shall not be owned, leased, or otherwise

controlled by the service provider, consistent with the federal Home and Community-Based Services Settings Rule, to prevent replication of institutional or congregate models. Housing arrangements for CSL-24 participants shall not be structured, clustered, or financed in a manner that replicates congregate residential models or limits individual choice of residence.

Nothing in this subsection shall be construed to prohibit a provider from providing or coordinating services in a residence that is owned, leased, or controlled by the participant or the participant's family.

(5) CSL-24 services shall not be provided in settings designed, financed, or operated in a manner that functionally replicates congregate or institutional residential models, including clustered housing arrangements established primarily for programmatic convenience rather than individual choice.

(b) Accessible and affordable housing.

(1) The administering agency shall encourage collaboration with the Illinois Housing Development Authority (IHDA) and other housing authorities to identify and secure accessible, affordable housing for participants.

(2) Housing supports may include home modifications, accessibility improvements, or rental assistance as needed to enable safe, independent living, and shall include

reasonable accommodations required under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

(c) Integration with person-centered planning. Housing choices shall be incorporated into the Person-Centered Plan, ensuring that participants' preferences, goals, and community integration needs are fully considered.

(d) Stability and responsiveness to changing needs.

(1) Housing arrangements established under this waiver shall not require a participant to relocate solely due to changes in medical, physical, behavioral, or support needs, except at the request of the participant or where continuation would pose an unavoidable and documented risk that cannot be mitigated through reasonable supports.

(2) When a participant's needs change, the waiver services, including the Person-Centered Plan team, shall adjust supports, staffing levels, and accommodations necessary to maintain the individual's chosen home whenever possible.

(3) Housing-related supports and services shall be reviewed at least annually, and more frequently upon the request of the participant when significant changes in needs occur.

(4) The administering agency shall ensure that service providers prioritize continuity of housing, individualized supports, and avoidance of displacement.

(e) Family Home Protections.

(1) A family home shall be recognized as a permissible and fully integrated community setting for CSL-24 services.

(2) Receipt of CSL-24 services shall not require a parent, guardian, or family member to vacate the home as a condition of service authorization.

(3) The presence of family members in the home shall not be construed as incompatible with provider responsibility for health and welfare when roles and responsibilities are clearly defined in the Person-Centered Plan.

Section 15. Transition rules; continuity of care.

(a) The Department shall establish rules governing the voluntary transition of individuals currently receiving services in Community-Integrated Living Arrangements, Intermediate Care Facilities, nursing facilities, or other Medicaid waivers into CSL-24 services. Such rules shall include continuity of care protections, individualized transition planning requirements, and applicable notice and appeal rights to ensure uninterrupted services and safeguards for health and welfare.

(b) Individuals shall be permitted to request a change in waiver services, subject to applicable eligibility criteria and available service capacity. Individuals shall not be

penalized, deprioritized, or otherwise disadvantaged solely due to prior waiver enrollment, current service type, or previous residence when seeking access to CSL-24 services.

Section 16. Federal/CMS alignment and waiver authority.

(a) The Department of Healthcare and Family Services and the Department of Human Services are authorized to submit amendments to the Illinois Adults with Developmental Disabilities 1915(c) Home and Community-Based Services Waiver to add CSL-24 services and to rename Intermittent Community-Integrated Living Arrangements as Community Supported Living-Intermittent, consistent with federal Home and Community-Based Services requirements and subject to public notice, stakeholder input, and comment prior to CMS submission.

(b) Notwithstanding any other provision of law, rule, or waiver methodology, the provisions of this Act governing CSL-24 services shall supersede any conflicting requirements applicable to congregate, facility-based, or intermittent residential services under the Illinois Adults with Developmental Disabilities Home and Community-Based Services Waiver and shall be implemented independently and without delay due to unrelated waiver modifications, except where CMS approval requires specific sequencing for CSL-24.

Section 17. Workforce and recruitment strategy.

(a) Funding shall be provided for DSP training for complex medical and behavioral supports, including competency-based curricula, loan repayment or bonus programs, and wage incentives.

(b) Funding shall be provided for training for nurses, Independent Service Coordinators, and Qualified Intellectual Disabilities Professionals as described in Section 10.

(c) The administering agency shall develop and maintain a workforce shortage contingency plan, including overtime protocols, cross-training strategies, and training pipelines with community colleges or accredited programs, and to report annually on workforce capacity and implementation status.

Section 18. Rulemaking, Interagency coordination and advisory body.

(a) Rulemaking Authority. The Department of Human Services, Division of Developmental Disabilities is authorized to adopt rules and binding program standards necessary to implement this Act and the related waiver amendments, in accordance with the Illinois Administrative Procedure Act, including public notice and comment.

(b) Community Supported Living Advisory Council.

(1) The Department shall establish a Community Supported Living Advisory Council to provide ongoing, structured oversight and guidance on the design, implementation, operation, and evaluation of CSL-24

services under this Act and the related Medicaid waiver amendments.

The Advisory Council shall advise the Department and the Department of Healthcare and Family Services on:

(A) Waiver design, submission, and CMS approval strategy;

(B) Implementation timelines and provider readiness;

(C) Workforce standards, training requirements, and retention strategies;

(D) Assessment, eligibility, and service authorization policies;

(E) Quality assurance, health and safety safeguards, and rights protections;

(F) Housing and community integration compliance; and

(G) Program outcomes, cost-effectiveness, and system impact.

The Advisory Council's role shall be ongoing and shall continue throughout the life of the waiver, meeting at least quarterly, and more frequently in year one, unless modified by statute.

(2) The Advisory Council shall include, at a minimum:

(A) Self-advocates receiving or eligible for Community Supported Living-Intermittent and CSL-24 community-based services;

(B) Family members of individuals with complex medical, physical, or behavioral support needs;

(C) Clinicians with expertise in complex medical supports, behavioral health, nursing delegation, or health risk management;

(D) Independent Service Coordinators with experience supporting high-acuity individuals in integrated community living;

(E) Disability rights and advocacy organizations;

(F) Provider representatives with demonstrated experience supporting individuals with complex needs in non-congregate, community-based settings;

(G) Labor representatives representing direct support professionals or nursing staff; and

(H) Academic or research representatives, including from the University of Illinois Chicago or comparable institutions with expertise in disability policy, outcomes, or evaluation.

To ensure independence and avoid provider dominance, no more than 49% of Council members shall be employees of, or representatives for, provider organizations.

(3) Authority, duties, and access to information. The Advisory Council shall:

(A) Review and provide written recommendations on proposed waiver amendments, rules, provider standards, and guidance related to CSL-24 services;

(B) Review implementation data, quality metrics, incident trends, workforce indicators, and service access data;

(C) Advise on corrective actions, policy adjustments, or system improvements necessary to ensure compliance with federal Home and Community-Based Services requirements, the ADA, Section 504, Olmstead, and the Ligas Consent Decree;

(D) Request and receive from the Department and the Department of Healthcare and Family Services within reasonable timeframes, any non-confidential data reasonably necessary to carry out its duties, including aggregate utilization, cost, and outcome data; and

(E) Issue non-binding public recommendations to the Department and the General Assembly.

The Department shall provide a written response to formal recommendations issued by the Advisory Council within 90 days, including any planned actions or reasons for non-adoption.

(4) Meetings, Reporting, and Transparency.

(A) The Advisory Council shall meet at least quarterly, with additional meetings as necessary during waiver submission and initial implementation.

(B) The Department shall provide staff support and ensure timely access to materials necessary for

meaningful participation.

(C) The Advisory Council shall submit an annual written report no later than March 31 of each year to:

(i) The Governor;

(ii) The General Assembly;

(iii) The Department of Human Services; and

(iv) The Department of Healthcare and Family Services.

(D) The annual report shall summarize:

(i) Implementation progress;

(ii) Identified system barriers or risks;

(iii) Recommendations for improvement;

(iv) Workforce and provider capacity concerns; and

(v) Outcomes related to health, safety, community integration, and avoidance of institutionalization.

(E) Reports shall be made publicly available, with appropriate protections for individual privacy.

(F) The Department shall provide a written response to the Advisory Council's annual recommendations within 90 days, identifying actions taken, actions planned, or reasons for non-adoption.

(5) Conflict of interest and ethics. All members shall comply with applicable State ethics, disclosure, and conflict-of-interest requirements, including annual

disclosure of financial or organizational interests related to services covered under this Act.

Section 19. Fiscal impact. The Department of Healthcare and Family Services and the Department of Human Services, Division of Developmental Disabilities shall provide a fiscal impact statement estimating first 3 years of program costs, including start-up (IT, provider competencies, and capacity), ongoing provider rates, administrative and oversight costs, and projected savings from reduced institutional care.

Section 20. Implementation timelines. Initial provider selection and enrollment in training shall occur within 4 months following CMS approval, subject to provider readiness and certification requirements.

Section 99. Effective date. This Act takes effect upon becoming law.