Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

State of Illinois –Waiver for Adults with Developmental Disabilities

Submission Date:	**February 28, 2007 Amendment: June, 2008**

CMS Receipt Date *(CMS Use)*	

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This is a request for the renewal of the Waiver to provide home and community-based supports to eligible adults with developmental disabilities (Control #350.90.03). The supports provided are designed to prevent or delay out-of-home residential services for participants or to provide residential services in the least restrictive community setting for participants who would otherwise need ICF/MR level of care.

The proposed amendment:

- Increases overall waiver capacity.
- Removes the requirement for a high school diploma or GED for domestic employees providing Personal Support. We have found that this requirement appears to have had the unanticipated consequence of limiting enrollment of potential providers in the Hispanic/Latino and other ethnic populations.
- Adds the phrase "in a human service field" after Bachelor's Degree in the provider qualifications for Behavior Intervention and Treatment. This phrase was inadvertently omitted from the original request.

Application for a §1915(c) Home and Community-Based Services Waiver

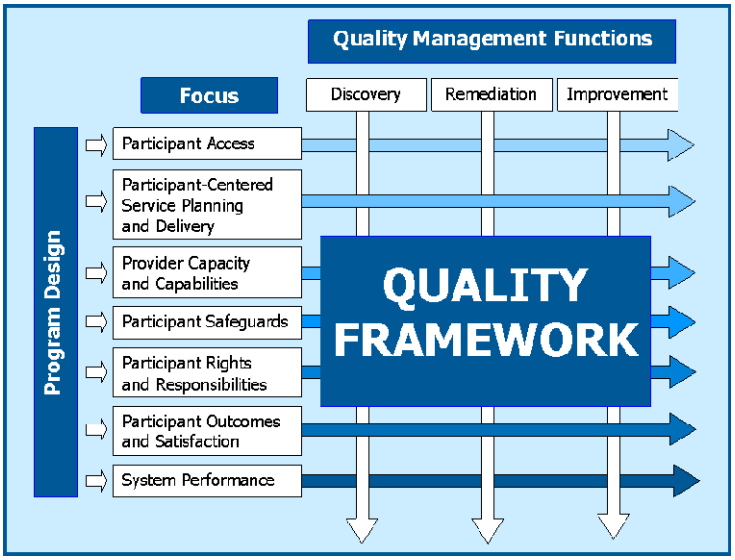
PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State Plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- **Participant Access**: *Individuals have access to home and community-based services and supports in their communities.*
- **Participant-Centered Service Planning and Delivery**: *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- **Provider Capacity and Capabilities**: *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- **Participant Safeguards**: *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- **Participant Rights and Responsibilities**: *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- **Participant Outcomes and Satisfaction**: *Participants are satisfied with their services and achieve desired outcomes.*
- **System Performance**: *The system supports participants efficiently and effectively and constantly strives to improve quality.*



The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.

1. Request Information

A. The **State** of **Illinois** requests approval for a Medicaid home and community-Based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. Waiver Title (*optional*): Waiver for Adults with Developmental Disabilities

C. Type of Request *(select only one)*:

○	**New Waiver (3 Years)**	CMS-Assigned Waiver Number (*CMS Use*):	
○	**New Waiver (3 Years) to Replace Waiver #**		
	CMS-Assigned Waiver Number (*CMS Use*):		
	Attachment #1 contains the transition plan to the new waiver.		
○	**Renewal (5 Years) of Waiver #**		
●	**Amendment to Waiver #**	0350.90.R1	

D. Type of Waiver *(select only one)*:

○	**Model Waiver**. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
●	**Regular Waiver**, as provided in 42 CFR §441.305(a)

E.1 Proposed Effective Date: July 1, 2007

E.2 Approved Effective Date *(CMS Use):*

F. Level(s) of Care. This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State Plan *(check each that applies)*:

☐	Hospital *(select applicable level of care)*	
	○	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
	○	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
☐	Nursing Facility *(select applicable level of care)*	
	○	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
	○	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140

■	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:
	Not applicable

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities *(check the applicable authority or authorities)*:

☐	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I			
☐	Waiver(s) authorized under §1915(b) of the Act. *Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:*			
	Specify the §1915(b) authorities under which this program operates (*check each that applies*):			
	☐	§1915(b)(1) (mandated enrollment to managed care)	☐	§1915(b)(3) (employ cost savings to furnish additional services)
	☐	§1915(b)(2) (central broker)	☐	§1915(b)(4) (selective contracting/limit number of providers)
☐	A program authorized under §1115 of the Act. *Specify the program:*			
■	Not applicable			

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Adult Developmental Disabilities Waiver provides supports to eligible adults with developmental disabilities ages 18 and older. The supports provided are designed to prevent or delay out-of-home residential services for participants or to provide residential services in the least restrictive community setting for participants who would otherwise need ICF/MR level of care.

The Waiver affords participants the choice between participant direction and more traditional service delivery, or a combination of the two options. The number of participants served each year is based on available State appropriation levels.

Participants who choose home-based supports may select from a menu of services based on their individual needs within an overall monthly services cost maximum. Typical services chosen by participants may include day programs as well as direct services provided by common law employees or by employees of direct service agencies. Participants also have a variety of therapies and other services available to them.

Residential services participants are provided with residential services and supports from the qualified provider of their choice. These participants may also select day programs and have a variety of therapies and other services available to them.

All participants receive assistance in directing service delivery options from independent Individual Service and Support Advocates (ISSA). Participants may also choose assistance in paying common law employees and certain service providers from a Financial Management Service (FMS) entity.

Contracted independent screening and service coordination agencies across the State serve as the local point of access for adults with developmental disabilities.

The Division of Developmental Disabilities within the Illinois Department of Human Services operates the Adult Developmental Disabilities Waiver.

3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

A. Waiver Administration and Operation. Appendix A specifies the administrative and operational structure of this waiver.

B. Participant Access and Eligibility. Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.

C. Participant Services. Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.

D. Participant-Centered Service Planning and Delivery. Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).

E. Participant Direction of Services. When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. *(Select one)*:

●	The waiver provides for participant direction of services. *Appendix E is required.*
○	Not applicable. The waiver does not provide for participant direction of services. *Appendix E is not completed.*

F. Participant Rights. **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.

G. Participant Safeguards. Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.

H. Quality Management Strategy. Appendix H contains the Quality Management Strategy for this waiver.

I. Financial Accountability. Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.

J. Cost Neutrality Demonstration. Appendix J contains the State's demonstration that the waiver is cost neutral.

4. Waiver(s) Requested

A. Comparability. The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State Plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.

B. Income and Resources for the Medically Needy. Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy *(select one)*:

❍	Yes
●	No
○	Not applicable

C. Statewideness. Indicate whether the State requests a waiver of the statewideness requirements in §1902(a)(1) of the Act *(select one)*:

○	**Yes** *(complete remainder of item)*
●	**No**

If yes, specify the waiver of statewideness that is requested *(check each that applies)*:

☐	**Geographic Limitation**. A waiver of statewideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. S*pecify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area*:
☐	**Limited Implementation of Participant Direction**. A waiver of statewideness is requested in order to make ***participant direction of services*** as specified in **Appendix E** available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. *Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area*:

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

A. Health & Welfare: The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:

1. As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
2. Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
3. Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.

B. Financial Accountability. The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.

C. Evaluation of Need: The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

D. Choice of Alternatives: The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:

1. Informed of any feasible alternatives under the waiver; and,
2. Given the choice of either institutional or home and community-based waiver services.

Appendix B specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.

E. Average Per Capita Expenditures: The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State Plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.

F. Actual Total Expenditures: The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.

G. Institutionalization Absent Waiver: The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.

H. Reporting: The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State Plan

and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.

I. Habilitation Services. The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.

J. Services for Individuals with Chronic Mental Illness. The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

A. Service Plan. In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including Medicaid State Plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid Agency. Federal financial participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

B. Inpatients. In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.

C. Room and Board. In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.

D. Access to Services. The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.

E. Free Choice of Provider. In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.

F. FFP Limitation. In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.

G. Fair Hearing: The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.

H. Quality Management. The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity

and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.

I. Public Input. Describe how the State secures public input into the development of the waiver:

The State gathered public input for this Waiver application from the Statewide Advisory Council (SAC) on Developmental Disabilities, local network advisory councils, the Waiver Ad-Hoc Committee, and a series of focus groups on the Strategic Plan arranged by the Waiver Operating Agency.

On an ongoing basis, the SAC meets once each quarter. It is comprised of a direct consumer, a family member, and a provider elected from each of the local network advisory councils across the state; a representative from the Center for Capacity Building on Minorities with Disabilities Research at the University of Illinois at Chicago; a representative from the federally-funded Illinois Council on Developmental Disabilities; a representative from Equip for Equality, the State's protection and advocacy organization; and a director from one of the State-Operated Developmental Centers in Illinois. Medicaid Agency staff routinely attends. All members are welcome to provide individual comments as well as viewpoints from their respective affiliations to the SAC. Meetings are also well attended by the public. A segment of each meeting is devoted to giving audience or network advisory council members the opportunity to address the SAC on a topic of their choosing relating to developmental disabilities.

When the SAC needs detailed input on complex matters, ad-hoc committees are formed as needed. Ad-Hoc committees have a broad spectrum of membership that typically includes consumers, family members, providers, trade group members, and other advocates. As ad-hoc committees develop their reports and recommendations, updates of their meetings and drafts of their work are distributed at the SAC. Comments from SAC members are routinely sought and incorporated into the finished committee products. Such an ad-hoc committee was created to assist the State in the development of this application.

The multi-year DDD Strategic Plan was developed with extensive inputs received from direct consumers and families at over 30 statewide focus group meetings held across the state. The information gathered in the focus groups provided valuable insights into the wide-ranging array of service preferences. The focus group dialogues had significant influences on the development of the Adult Developmental Disabilities Waiver.

J. Notice to Tribal Governments. The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.

K. Limited English Proficient Persons. The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

A. The Medicaid Agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Linda
Last Name:	Roehrs
Title:	Bureau Chief
Agency:	Department of Healthcare and Family Services
Address 1:	Bureau of Interagency Coordination
Address 2:	607 East Adams, Floor 6
City	Springfield
State	IL
Zip Code	62701-2033
Telephone:	(217) 557- 1863
E-mail	Linda.Roehrs@illinois.gov
Fax Number	(217) 557-8604

B. If applicable, the State Operating Agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Reta
Last Name	Hoskin
Title:	Associate Director
Agency:	Department of Human Services
Address 1:	Division of Developmental Disabilities
Address 2	319 E. Madison Street, Suite 3M
City	Springfield
State	IL
Zip Code	62701
Telephone:	(217) 782-9421
E-mail	Reta.Hoskin@illinois.gov
Fax Number	(217) 558-2799

8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid Agency or, if applicable, from the Operating Agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid Agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____ **Date:** **June 15, 2007**

State Medicaid Director or Designee

First Name:	Theresa
Last Name	Eagleson
Title:	Medicaid Director
Agency:	Healthcare and Family Services
Address 1:	Division of Medical Programs
Address 2:	201 South Grand Avenue East, 3rd Floor
City	Springfield
State	IL
Zip Code	62763
Telephone:	(217) 782-2570
E-mail	Theresa.Eagleson@illinois.gov
Fax Number	(217) 782-5672

Attachment #1: Transition Plan

Specify the transition plan for the waiver:

Not applicable.

Appendix A: Waiver Administration and Operation

1. State Line of Authority for Waiver Operation. Specify the state line of authority for the operation of the waiver *(select one)*:

○	The waiver is operated by the State Medicaid Agency. Specify the Medicaid Agency division/unit that has line authority for the operation of the waiver program (*select one; do not complete Item A-2*):
	○ The Medical Assistance Unit *(name of unit)*:
	○ Another division/unit within the State Medicaid Agency that is separate from the Medical Assistance Unit (name of division/unit)
●	The waiver is operated by **Illinois Department of Human Services (DHS), Division of Developmental Disabilities**, a separate agency of the State that is not a division/unit of the Medicaid Agency. In accordance with 42 CFR §431.10, the Medicaid Agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid Agency to CMS upon request. *Complete item A-2.*

2. Medicaid Agency Oversight of Operating Agency Performance. When the waiver is not operated by the Medicaid Agency, specify the methods that the Medicaid Agency uses to ensure that the Operating Agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid Agency assessment of Operating Agency performance:

The Department of Healthcare and Family Services, Illinois' Medicaid Agency, conducts the following activities:

- The Medicaid Agency reviews and approves all changes to Medicaid policies, rules and regulations.
- Staff from the Medicaid Agency routinely attend quarterly meetings of the Operating Agency's Statewide Advisory Council on Developmental Disabilities, with which all major initiatives and policy issues are discussed.
- The Medicaid Agency conducts and monitors appeals involving waiver services, providing the independent hearing officer for all appeal hearings.
- The Medicaid Agency participates with the Operating Agency in training and informational sessions.
- The Medicaid Agency reviews and provides input into the Operating Agency's utilization reviews and payment rate methodologies.
- The Medicaid Agency conducts routine fiscal and program monitoring.

Staff from the Medicaid Agency are members of the Quality Management Committee. The committee is responsible for the overall coordination of quality management activities.

3. Use of Contracted Entities. Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid Agency and/or the waiver Operating Agency (if applicable) (s*elect one)*:

●	**Yes.** Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid Agency and/or the Operating Agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. *Complete Items A-5 and A-6.*
	Under contract with the Operating Agency, private entities complete eligibility determinations, as well as service coordination and monitoring functions. These functions are done by Qualified Mental Retardation Professionals (QMRPs). In addition, both the Medicaid Agency and the Operating Agency, at times, use contracted vendors, selected in accordance with the State's procurement policies, to assist with functions related to monitoring, consultation and technical assistance, qualifying providers and establishing rates.
○	**No**. Contracted entities do not perform waiver operational and administrative functions on behalf of the Medicaid Agency and/or the Operating Agency (if applicable).

4. Role of Local/Regional Non-State Entities. Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity *(check each that applies)*:

☐	**Local/Regional non-state public agencies** conduct waiver operational and administrative functions at the local or regional level. There is an **interagency agreement or memorandum of understanding** between the Medicaid Agency and/or the Operating Agency (when authorized by the Medicaid Agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid Agency or the Operating Agency (if applicable). *Specify the nature of these agencies and complete items A-5 and A-6:*

☐	**Local/Regional non-governmental non-state entities** conduct waiver operational and administrative functions at the local or regional level. There is a **contract** between the Medicaid Agency and/or the Operating Agency (when authorized by the Medicaid Agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable). *Specify the nature of these entities and complete items A-5 and A-6*:
■	**Not applicable** – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities. Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Department of Human Services, the Operating Agency, assesses the performance of the contracted entities.

6. Assessment Methods and Frequency. Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

The Operating Agency reviews and approves the contracted entities on an annual basis to ensure they are conforming to established standards. Operating Agency staff conducts annual on-site surveys that focus on compliance with the requirements of the Agency's screening manual and ISSA Guidelines, as well as contractual requirements. The survey protocol includes staff qualifications and training, 24-hour accessibility for emergencies, a review of the pre-admission screening process (documentation of required assessments, eligibility determinations, informed choice and selection of services, and conflict of interest), and review of the Individual Service and Support Advocacy process (documentation of required visits, participation in support plan development and approval, and annual re-determinations of eligibility).

Agencies are notified in writing of any deficiencies and are required to submit a plan of correction, including timeframes, if the agency scores less than 90% on their overall performance. Operating Agency staff review the plan of correction and, if acceptable, approve it.

Summary reports of the reviews are shared with and discussed by the state's Quality Management Committee, which includes both Medicaid and the Operating Agency staff, during its quarterly meetings.

7. Distribution of Waiver Operational and Administrative Functions. In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid Agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	☐	■	■	☐
Assist individuals in waiver enrollment	☐	■	■	☐
Manage waiver enrollment against approved limits	☐	■	☐	☐
Monitor waiver expenditures against approved levels	■	■	☐	☐
Conduct level of care evaluation activities	☐	■	■	☐
Review participant service plans to ensure that waiver requirements are met	■	■	■	☐
Perform prior authorization of waiver services	☐	■	■	☐
Conduct utilization management functions	■	■	☐	☐
Recruit providers	☐	■	■	☐
Execute the Medicaid provider agreement	■	■	■	☐
Determine waiver payment amounts or rates	■	■	☐	☐
Conduct training and technical assistance concerning waiver requirements	■	■	☐	☐

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

a. **Target Group(s)**. Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

Included	Target Group/Subgroup	Minimum Age	Maximum Age	
			Maximum Age Limit: Through age –	No Maximum Age Limit
○	**Aged or Disabled, or Both**			
☐	Aged (age 65 and older)			☐
☐	Disabled (Physical) (under age 65)			
☐	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
☐	Brain Injury			☐
☐	HIV/AIDS			☐
☐	Medically Fragile			☐
☐	Technology Dependent			☐
○	**Mental Retardation or Developmental Disability, or Both**			
■	Autism	18 years		■
■	Developmental Disability	18 years		■
■	Mental Retardation	18 years		■
○	**Mental Illness**			
☐	Mental Illness (age 18 and older)			☐
☐	Serious Emotional Disturbance (under age 18)			

b. **Additional Criteria**. The State further specifies its target group(s) as follows:

Participants must be assessed as eligible for ICF/MR level of care, must meet priority population criteria, must reside within the State of Illinois, must need active treatment, and not be in need of nursing assessment, monitoring, intervention, and supervision of their condition or needs on a 24-hour basis.

The number of individuals served each year will be based on available appropriations. New enrollees will be selected from the Prioritization of Urgency of Need For Services (PUNS) database, a database maintained by the Operating Agency of individuals potentially in need of state-funded DD services within the next five years. The selection criteria will provide for selection of individuals on several bases, including urgency of need, length of time on the database, and randomness.

c. **Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit *(select one)*:

●	Not applicable – There is no maximum age limit
○	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (*specify*):

Appendix B-2: Individual Cost Limit

a. Individual Cost Limit. The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual *(select one)*:

❍	**No Cost Limit**. The State does not apply an individual cost limit. *Do not complete Item B-2-b or Item B-2-c*.
○	**Cost Limit in Excess of Institutional Costs.** The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. *Complete Items B-2-b and B-2-c*. The limit specified by the State is *(select one)*:
	○ [ ] %, a level higher than 100% of the institutional average
	○ Other *(specify)*:
○	**Institutional Cost Limit**. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. *Complete Items B-2-b and B-2-c*.
●	**Cost Limit Lower Than Institutional Costs**. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. *Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c*.

For participants requesting home-based supports, total costs are limited based on State statute (405 ILCS 80). The cost limit was developed in 1990 with input from advocates and family members. Since implementation, the cost limit has been updated based on annual cost of living adjustments as prescribed by law. This limit does not apply to residential services. The statutory monthly cost limit for waiver participants who receive home-based supports and are in special education is two times the Supplemental Security Income (SSI) amount for an adult living alone (SSI amount is currently $623 for calendar year 2007). The statutory monthly cost limit for all other waiver participants in home-based supports is three times the SSI amount. These cost limits apply only to participants in the Home-Based Supports option. Within the statutory limits, the participant, Service Facilitator, and other members of the team develop an individual service plan to meet the participant's needs.

If the primary unpaid caregiver is temporarily unable to provide necessary services that may endanger the participant's health and welfare, the participant will be considered for temporary crises services.

Participant-directed home-based supports are available to individuals living in a home owned or leased by the participant or the participant's family member. Participant-directed home-based supports are not intended to meet all of the needs of the participant being served. In combination with natural unpaid supports, generic community resources, and Medicaid State Plan services, home-based supports assist in meeting the needs of the participant. Current State appropriations provide funding at the level specified in the State statute for adults receiving this Waiver service option.

If the health and welfare of the participant cannot be assured on a long-term basis within the cost limit of participant-directed home-based supports in combination with other natural supports and community resources, the participant will be considered for other service options within the Waiver, including residential habilitation.

The cost limit specified by the State is *(select one)*:

- ● The following dollar amount: $ $22,428

  The dollar amount *(select one)*:

  - ● Is adjusted each year that the waiver is in effect by applying the following formula:

    The cost limit for participant-directed home-based supports is based on the support plan of the participant, but in no case may it be more than three hundred percent of the monthly federal Supplemental Security Income (SSI) payment for an individual living alone. Federal SSI payments are indexed to the cost of living. The Waiver home-based supports cost limit is adjusted annually at the start of each calendar year based on changes in the federal SSI payment levels.

  - ○ May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.

- ○ The following percentage that is less than 100% of the institutional average: _____ %

- ○ Other – *Specify:*

b. Method of Implementation of the Individual Cost Limit. When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

Participant-directed home-based supports provided to eligible participants who typically reside with family members are intended to supplement the natural supports available from family members and significant others, other community resources and Medicaid State Plan services. If the health and welfare of the participant cannot be assured within the cost limit of home-based supports in combination with other resources, the participant will be considered for other appropriate adult waiver services that are not subject to this cost limitation. Participants are notified of the opportunity to request a fair hearing if enrollment is denied.

c. Participant Safeguards. When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

☐	The participant is referred to another waiver that can accommodate the individual's needs.
■	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	Subject to prior approval, participants in home-based supports may request crisis services on a temporary basis that exceed the monthly service cost maximum. If approved by the Operating Agency, participants may receive crisis services for a period not to exceed 60 days to provide additional supports to prevent out-of-home placement due to the temporary absence or incapacity of the non-paid primary caregiver. The participant's Service Facilitator must submit a written request to the Operating Agency. The request must include the amount requested, the additional services to be delivered, the identity of the providers of the additional services, start and end dates, reason for the emergency, and efforts to address any long term needs. The maximum amount that may be authorized is $2,000 per month for not more than two months or 60 consecutive days. This amount can be prorated for partial months, not to exceed a total of 60 consecutive days. Family members may not be paid for these additional crisis services.
■	Other safeguard(s) *(specify)*:
	Alternate adult waiver service options are offered to address the needs of the participant. Service options are discussed with the participant and guardian, as appropriate, to determine what alternate waiver services are preferred.

Appendix B-3: Number of Individuals Served

a. Unduplicated Number of Participants. The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	15,225
Year 2	15,225
Year 3	15,225
Year 4 (renewal only)	15,225
Year 5 (renewal only)	15,225

b. Limitation on the Number of Participants Served at Any Point in Time. Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

○	The State does not limit the number of participants that it serves at any point in time during a waiver year.
●	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	14,800
Year 2	14,800
Year 3	14,800
Year 4 (renewal only)	14,800
Year 5 (renewal only)	14,800

c. Reserved Waiver Capacity. The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State *(select one)*:

●	**Not applicable**. The state does not reserve capacity.
○	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:
	The capacity that the State reserves in each waiver year is specified in the following table:

Table B-3-c

Waiver Year	Purpose:	Purpose:
	Capacity Reserved	Capacity Reserved
Year 1		
Year 2		
Year 3		
Year 4 (renewal only)		
Year 5 (renewal only)		

d. Scheduled Phase-In or Phase-Out. Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule *(select one):*

●	The waiver is not subject to a phase-in or a phase-out schedule.
○	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an ***intra-year*** limitation on the number of participants who are served in the waiver.

e. Allocation of Waiver Capacity. *Select one:*

●	Waiver capacity is allocated/managed on a statewide basis.
○	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Individuals potentially in need of these services are enrolled in the State's Prioritization of Urgency of Need for Services (PUNS) database by one of the contracted entities serving as access points. This

database records demographic and clinical information regarding the individual and his/ her circumstances, services currently received, and services needed. As appropriations are available, individuals are selected for authorization for Waiver services via an automated process that focuses on the individual's needs and the family's circumstances (where applicable). Entrance to the Waiver for adults with developmental disabilities of otherwise eligible applicants is deferred via this process until capacity becomes available as a result of turnover or the appropriation of additional funding by the legislature. Selection criteria are based on the priority population criteria below.

The intake assessment tool and corresponding manual regarding PUNS is available upon request from the Operating Agency.

For residential services, the State gives service priority to eligible participants according to the following priority population criteria in priority order, beginning with the most critical need:

1. Individuals who are in crisis situations (e.g., including, but not limited to, participants who have lost their caregivers, participants who are in abusive or neglectful situations);
2. Individuals who are wards of the Illinois Department of Children and Family Services and are approaching the age of 18 and individuals who are aging out of children's residential services funded by the Illinois Department of Human Services, Division of Developmental Disabilities;
3. Individuals who reside in State-Operated Developmental Centers;
4. Bogard class members, i.e., certain individuals with developmental disabilities who currently reside or previously resided in a nursing facility;
5. Individuals with mental retardation who reside in State-Operated Mental Health Hospitals;
6. Individuals with aging caregivers; and
7. Individuals who reside in private ICFs/MR.

For home-based supports, the State gives service priority to eligible participants who have been identified as individuals who are currently not receiving any support services from the Operating Agency (except vocational rehabilitation services). Within this population, if requests exceed available capacity, the State will prioritize:

1. Individuals whose primary caregiver is age 60 or older, but is not yet in crisis; or
2. Individuals who have exited special education within the last five years; or
3. Individuals who are living with only one caregiver.

The number of individuals served each year will be based on available appropriations. New enrollees will be selected from the Prioritization of Urgency of Need For Services (PUNS) database, a database maintained by the Operating Agency of individuals potentially in need of state-funded DD services within the next five years. The selection criteria will provide for selection of individuals on several bases, including urgency of need, length of time on the database, and randomness.

Attachment #1 to Appendix B-3

Waiver Phase-In/Phase Out Schedule

a. The waiver is being *(select one)*:

○	Phased-in
○	Phased-out

b. **Waiver Years Subject to Phase-In/Phase-Out Schedule** *(check each that applies)*:

Year One	Year Two	Year Three	Year Four	Your Five
☐	☐	☐	☐	☐

c. **Phase-In/Phase-Out Time Period**. *Complete the following table:*

	Month	Waiver Year
Waiver Year: First Calendar Month		
Phase-in/Phase out begins		
Phase-in/Phase out ends		

d. **Phase-In or Phase-Out Schedule**. *Complete the following table:*

Phase-In or Phase-Out Schedule			
	Waiver Year:		
Month	Base Number of Participants	Change in Number of Participants	Participant Limit

Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. State Classification. The State is a *(select one)*:

○	§1634 State
○	SSI Criteria State
●	209(b) State

b. Medicaid Eligibility Groups Served in the Waiver. Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the Medicaid State Plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)				
☐	Low income families with children as provided in §1931 of the Act			
☐	SSI recipients			
■	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121			
■	Optional State supplement recipients			
■	Optional categorically needy aged and/or disabled individuals who have income at: *(select one)*			
	●	100% of the Federal poverty level (FPL)		
	○	%	of FPL, which is lower than 100% of FPL	
☐	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII)) of the Act)			
■	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)			
☐	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)			
☐	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)			
■	Medically needy			
☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the Medicaid State Plan that may receive services under this waiver) *specify*:			
Special home and community-based waiver group under 42 CFR §435.217) *Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed*				
●	**No**. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.			
○	**Yes**. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. *Select one and complete Appendix B-5.*			
	○	All individuals in the special home and community-based waiver group under 42 CFR §435.217		

○	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 *(check each that applies)*:				
	☐	A special income level equal to (select one):			
		○	300% of the SSI Federal Benefit Rate (FBR)		
		○	%	of FBR, which is lower than 300% (42 CFR §435.236)	
		○	$	which is lower than 300%	
	☐	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)			
	☐	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)			
	☐	Medically needy without spend down in 209(b) States (42 CFR §435.330)			
	☐	Aged and disabled individuals who have income at: *(select one)*			
		○	100% of FPL		
		○	%	of FPL, which is lower than 100%	
	☐	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the Medicaid State Plan that may receive services under this waiver) *specify*:			

Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

a. Use of Spousal Impoverishment Rules. Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 *(select one)*:

○	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (*select one*):
○	Use *spousal* post-eligibility rules under §1924 of the Act. *Complete ItemsB-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.*
○	Use *regular* post-eligibility rules under 42 CFR §435.726 (SSI State) (*Complete Item B-5-b-1*) or under §435.735 (209b State) (*Complete Item B-5-c-1). Do not complete Item B-5-d.*
❍	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. *Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.*

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

b-1. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. <u>Allowance for the needs of the waiver participant</u> (*select one*):				
○	The following standard included under the Medicaid State Plan *(select one)*			
○	SSI standard			
○	Optional State supplement standard			
○	Medically needy income standard			
○	The special income level for institutionalized persons *(select one):*			
○	300% of the SSI Federal Benefit Rate (FBR)			
○	%	of the FBR, which is less than 300%		
○	$	which is less than 300%.		
○	%	of the Federal poverty level		
○	Other (specify):			
○	The following dollar amount:	$	If this amount changes, this item will be revised.	

○	The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

○	SSI standard		
○	Optional State supplement standard		
○	Medically needy income standard		
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Not applicable *(see instructions)*		

iii. Allowance for the family *(select one)*:

○	AFDC need standard		
○	Medically needy income standard		
○	The following dollar amount:	$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:		
○	Other (specify):		
○	Not applicable (see instructions)		

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-1. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the Medicaid State Plan *(select one)*
  - ○ The following standard under 42 CFR §435.121:
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one)*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ % of the FBR, which is less than 300%
    - ○ $ which is less than 300% of the FBR
  - ○ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The following standard under 42 CFR §435.121
- ○ Optional State supplement standard
- ○ Medically needy income standard
- ○ The following dollar amount: $ If this amount changes, this item will be revised.
- ○ The amount is determined using the following formula:
- ○ Not applicable *(see instructions)*

iii. Allowance for the family *(select one)*

- ○ AFDC need standard
- ○ Medically needy income standard

○	The following dollar amount: $ [ ] The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules *and* elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

- ○ The following standard included under the Medicaid State Plan *(select one)*
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The special income level for institutionalized persons *(select one):*
    - ○ 300% of the SSI Federal Benefit Rate (FBR)
    - ○ ____ % of the FBR, which is less than 300%
    - ○ $ ____ which is less than 300%.
  - ○ ____ % of the Federal poverty level
  - ○ Other (specify):
- ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
- ○ The following formula is used to determine the needs allowance:

ii. Allowance for the spouse only (*select one*):

- ○ The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:

  Specify the amount of the allowance:
  - ○ SSI standard
  - ○ Optional State supplement standard
  - ○ Medically needy income standard
  - ○ The following dollar amount: $ ____ If this amount changes, this item will be revised.
  - ○ The amount is determined using the following formula:
- ○ Not applicable

iii. Allowance for the family *(select one)*:

○	AFDC need standard
○	Medically needy income standard
○	The following dollar amount: $ ____ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:
○	Other (specify):
○	Not applicable (see instructions)

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (*select one*):

○	The following standard included under the Medicaid State Plan *(select one)*			
	○	The following standard under 42 CFR §435.121:		
	○	Optional State supplement standard		
	○	Medically needy income standard		
	○	The special income level for institutionalized persons *(select one)*		
		○	300% of the SSI Federal Benefit Rate (FBR)	
		○	%	of the FBR, which is less than 300%
		○	$	which is less than 300% of the FBR
	○	%	of the Federal poverty level	

	○	Other (specify):	
○	The following dollar amount:	$	If this amount changes, this item will be revised.
○	The following formula is used to determine the needs allowance:		

ii. Allowance for the spouse only (*select one*):

○	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	○	The following standard under 42 CFR §435.121:	
	○	Optional State supplement standard	
	○	Medically needy income standard	
	○	The following dollar amount:	$ If this amount changes, this item will be revised.
	○	The amount is determined using the following formula:	
○	Not applicable		

iii. Allowance for the family *(select one)*

○	AFDC need standard	
○	Medically needy income standard	
○	The following dollar amount:	$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
○	The amount is determined using the following formula:	
○	Other (specify):	
○	Not applicable (see instructions)	

iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

a. Health insurance premiums, deductibles and co-insurance charges

b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

○	The State does not establish reasonable limits.
○	The State establishes the following reasonable limits *(specify)*:

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. <u>Allowance for the personal needs of the waiver participant</u> *(select one)***:**			
○	SSI Standard		
○	Optional State Supplement standard		
○	Medically Needy Income Standard		
○	The special income level for institutionalized persons		
○	%	of the Federal Poverty Level	
○	The following dollar amount:	$	If this amount changes, this item will be revised
○	The following formula is used to determine the needs allowance:		
○	Other (*specify*)**:**		
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. *Select one:*			
○	Allowance is the same		
○	Allowance is different. Explanation of difference:		
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:			
a. Health insurance premiums, deductibles and co-insurance charges. b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*			
○	The State does not establish reasonable limits.		
○	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.		

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

a. Reasonable Indication of Need for Services. In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	**Minimum number of services**. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is *(insert number):*	
	1	
ii.	**Frequency of services**. The State requires *(select one)*:	
	●	The provision of waiver services at least monthly
	○	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

b. Responsibility for Performing Evaluations and Reevaluations. Level of care evaluations and reevaluations are performed (*select one*):

○	Directly by the Medicaid Agency
○	By the Operating Agency specified in Appendix A
○	By an entity under contract with the Medicaid Agency. *Specify the entity*:
●	Other (*specify*):
	Level of care evaluations and re-evaluations are performed by local entities under contract with the Operating Agency.

c. Qualifications of Individuals Performing Initial Evaluation: Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Persons making the initial evaluations must be Qualified Mental Retardation Professionals (QMRPs) as defined in Federal ICFMR regulations.

d. Level of Care Criteria. Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable), including the instrument/tool utilized.

Required assessments and level of care criteria are described fully in the Operating Agency's screening manual for developmental disabilities, which is used by all individuals conducting waiver screening. A copy is available through either the Medicaid or Operating Agency.

Chapter 200 of the manual describes the required assessments and qualifications for professionals conducting the assessments. In brief, the following assessments of waiver applicants are required to make an initial waiver level of care determination:

For applications with mental retardation:

- Valid psychological evaluation by a qualified professional that documents diagnosis, cognitive and functional limitations and age of onset.

For applicants with cerebral palsy or epilepsy, or a related condition:

- Physical examination and medical history that documents the diagnosis.

For applications with Autism:

- Psychiatric evaluation by a licensed psychiatrist and a psychosocial assessment.

For all applications:

- Inventory of Client and Agency Planning (ICAP).
- Medical review consisting of a physical examination by a qualified professional, medical history and medication review.
- Other assessments as needed to determine service needs.

Illinois uses the same process for determining Waiver eligibility as it does for ICF/MR eligibility.

For ongoing re-determination of Waiver level of care, a current ICAP is required.

e. Level of Care Instrument(s). Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care *(select one)*:

●	The same instrument is used in determining the level of care for the waiver and for institutional care under the Medicaid State Plan.
○	A different instrument is used to determine the level of care for the waiver than for institutional care under the Medicaid State Plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

f. Process for Level of Care Evaluation/Reevaluation. Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

The Operating Agency contracts with not-for-profit corporations that employ QMRPs to complete the evaluations and reevaluations.

As part of the initial level of care determination process, staffs of the contracted agencies are responsible for performing or arranging for necessary assessments and collecting other needed information to determine level of care. A qualified mental retardation professional (QMRP) review assessment results and other available information against the level of care criteria and guidance in the screening manual for developmental disabilities. The QMRP uses the totality of the information available and best clinical judgment in making the determination. Assessment information and level of care determinations are documented on forms specified by the Operating Agency. Levels of care determinations are transmitted electronically to the Operating Agency.

The re-determination process is essentially the same, except the ongoing level of car determination is based on a current ICAP, assessments and other information from the service planning process and personal knowledge of the participant. Levels of care re-determinations are documented on a form specified by the Operating Agency and are transmitted electronically to the Operating Agency.

g. Reevaluation Schedule. Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule *(select one)*:

○	Every three months
○	Every six months
●	Every twelve months
○	Other schedule (*specify*):

h. Qualifications of Individuals Who Perform Reevaluations. Specify the qualifications of individuals who perform reevaluations *(select one)*:

●	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are *(specify)*:

i. Procedures to Ensure Timely Reevaluations. Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care *(specify)*:

The Operating Agency has an edit in the computerized payment system to ensure reevaluations are conducted yearly. The edit requires the contracted entity to enter the reevaluation date. If that date is more than one year old, the edit will not allow payments to be made to the entity. Sample reviews are done annually to ensure that documentation exists and coincides with the reevaluation date entered in the payment system. This edit has been found effective in providing an incentive for the contractors to complete annual Waiver reevaluations in a timely manner.

j. Maintenance of Evaluation/Reevaluation Records. Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Evaluation and reevaluation forms are kept by contracted entities for the mandatory three years or more. Results are maintained electronically by the Operating Agency for three or more years.

Appendix B-7: Freedom of Choice

Freedom of Choice. *As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:*

i. informed of any feasible alternatives under the waiver; and
ii. given the choice of either institutional or home and community-based services.

a. Procedures. Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

The QMRPs employed by the Operating Agency's contracted entities inform individuals, and/or their legal guardians, about their options during the level of care determination process. The QMRP presents the individual/legal representative with all service options, including both Waiver and ICF/MR services that the individual is eligible to receive, regardless of availability, in sufficient detail so they are able to make informed choices. If the individual/legal representative does not speak English, has limited proficiency or is not verbal, the QMRP makes accommodations for that. The QMRP is not permitted to make recommendations regarding where services and supports should be provided, or by which provider(s).

The QMRP provides the individual/legal representative with additional information and materials on the service options they choose to pursue and arranges for and facilitates conversations with potential service providers.

The DD-1238 form Choice of Supports and Services specifically documents the decision to choose Waiver services as an alternative to ICF/MR services at this time. This form also states that choice of supports and services may be changed in the future and is signed by the individual/legal representative.

b. Maintenance of Forms. Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

Copies of the DD-1238 forms are maintained by the contracted entity.

Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003):

The entities under contract with the Operating Agency that serve as access points are integrated in their communities and on a daily basis interact with a wide variety of individuals of varying backgrounds, cultures, and languages. The entities have resources available to communicate effectively with participants of limited English proficiency in their community, including bilingual staff as needed, interpreters, translated forms, etc.

The Operating Agency has a website, www.dd.Illinois.gov, and a toll-free number, 1-888-DDPLANS, specifically designed for families' use in learning more about Illinois' DD service system and in contacting their local entity for assistance with access. Each of these information points is available in both Spanish and English.

Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

a. Waiver Services Summary. Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services *(check each that applies)*		
Service	Included	Alternate Service Title (if any)
Case Management	☐	
Homemaker	☐	
Home Health Aide	☐	
Personal Care	☐	
Adult Day Health	■	Adult Day Care
Habilitation	☐	
Residential Habilitation	■	Community Integrated Living Arrangement (CILA) and Community Living Facility (CLF)
Day Habilitation	■	Developmental Training
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	☐	
Supported Employment	■	
Education	☐	
Respite	☐	
Day Treatment	☐	
Partial Hospitalization	☐	
Psychosocial Rehabilitation	☐	
Clinic Services	☐	
Live-in Caregiver (42 CFR §441.303(f)(8))	☐	

Other Services *(select one)*	
○	Not applicable
●	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute *(list each service by title)*:
a.	Personal Support
b.	Home Accessibility Modifications

c.	Vehicle Modifications
d.	Non-Medical Transportation
e.	Adaptive Equipment
f.	Assistive Technology
g.	Emergency Home Response Services
h.	Training and Counseling Services for Unpaid Care Givers
i.	Behavior Intervention and Treatment
j.	Behavioral Services (Psychotherapy and Counseling)
k.	Skilled Nursing
l.	Crisis Services

Extended Medicaid State Plan Services *(select one)*

○	Not applicable
●	The following extended Medicaid State Plan services are provided *(list each extended Medicaid State Plan service by service title)*:
a.	Physical Therapy
b.	Occupational Therapy
c.	Speech Therapy

Supports for Participant Direction *(select one)*

●	The waiver provides for participant direction of services as specified in Appendix E. Indicate whether the waiver includes the following supports or other supports for participant direction.
○	Not applicable

Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	■	Service Facilitation
Financial Management Services	■	(Note: this is a Waiver administrative claim, rather than a separate Waiver service)
Other Supports for Participant Direction *(list each support by service title)*:		
a.		
b.		
c.		

b. Alternate Provision of Case Management Services to Waiver Participants. When case management is not a covered waiver service, indicate how case management is furnished to waiver participants *(check each that applies)*:

☐	As a Medicaid State Plan service under §1915(g)(1) of the Act (Targeted Case Management).

	Complete item C-1-c.
■	As an administrative activity. *Complete item C-1-c.*
☐	Not applicable – Case management is not furnished as a distinct activity to waiver participants. *Do not complete Item C-1-c.*

c. Delivery of Case Management Services. Specify the entity or entities that conduct case management functions on behalf of waiver participants:

All Waiver participants receive Individual Service and Support Advocacy (ISSA) services from independent entities under contract with the Operating Agency. When an individual is enrolled in the Waiver, the Operating Agency notifies the ISSA provider to initiate contact with the new Waiver participant and begin providing ISSA services. ISSAs are Qualified Mental Retardation Professional (QMRP) staff that is responsible for some case management activities. Their responsibilities include annual re-determinations of level of care, participation in the support planning process, approval of all participant support plans, advocacy on behalf of the participant and family, visits with the participant at least four times per year to ensure health and welfare and that needs are being met, and alerting the Operating Agency about issues that require additional monitoring and technical assistance. This administrative case management service is required for all Waiver participants.

In addition all Waiver participants receive direct case management services from QMRPs who are employees of direct service providers. These internal case managers are responsible for developing the individual support plan as part of a planning team that includes the individual, the ISSA and other necessary and optional participants. They are also responsible for day-to-day oversight and implementation of the support plan. In participant-directed home-based supports, the internal case management is called Service Facilitation as defined in Appendix C-3. In day and residential habilitation programs, case management is an integral part of the habilitation service.

Appendix C-2: General Service Specifications

a. Criminal History and/or Background Investigations. Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-*(select one)*:

●	**Yes**. Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the Operating Agency (if applicable):
	Name-based criminal background checks with the Illinois Department of State Police are required for direct service staff hired by agencies providing residential services, Developmental Training, Adult Day Care, Supported Employment, Service Facilitation, Personal Support, or Individual Service and Support Advocacy. These agencies may not knowingly hire or retain any person in a full-time, part-time or contractual direct service position if that person has been convicted of committing or attempting to commit one or more of the offenses in the Illinois Health Care Worker Background Check Act (225 ILCS 64/25), unless the person obtains a waiver of this requirement. Families, through the Financial Management Service entity, are also required to obtain a name-based state criminal background check for individual providers they hire as common law employees on or after July 1, 2007. Verification of staff background checks on a sample basis by the Operating Agency is a component of the provider qualifications review and approval process for agencies providing these services, as well as for the Financial Management Service entity. Verification of criminal background checks for common law employees is a component of the enrollment process by the Financial Management Service entity.
○	**No**. Criminal history and/or background investigations are not required.

b. Abuse Registry Screening. Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry *(select one)*:

●	**Yes**. The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable):

	• Abuse/Neglect screenings are required for all workers who are employed, under contract, or otherwise engaged by organizations providing residential services, Developmental Training, Supported Employment, Service Facilitation, Personal Support or Individual Service and Support Advocacy (administrative claim). Such individuals may not be employed in any capacity until the employer has checked the individual against the Illinois Department of Public Health, Health Care Worker's Registry (formerly known as the Nurse Aide Registry). • Abuse/Neglect screenings are required for all domestic employees hired on or after July 1, 2007, to provide Personal Support or Crisis Services. Such individuals may not be employed in any capacity until the employer has checked the individual against the Illinois Department of Public Health, Health Care Worker's Registry (formerly known as the Nurse Aid Registry). If this state database reflects the existence of or contains information that substantiates/indicates a finding of physical or sexual abuse or egregious neglect against an applicant, the individual may not be employed. Verification of registry checks on a sample basis is a component of the Operating Agency's provider qualifications approval process for agencies providing these services, as well as for the Financial Management Service entity. The state law governing the Health Care Worker's Registry is the Abused and Neglected Long Term Care Facility Residents Reporting Act (210 ILCS 30). The state law governing the State Central Register is the Abused and Neglected Child Reporting Act (325 ILCS 5/1).
○	**No**. The State does not conduct abuse registry screening.

c. Services in Facilities Subject to §1616(e) of the Social Security Act. *Select one*:

○	**No**. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
●	**Yes**. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable). *Complete Items C-2-c.i –c.iii.*

i. Types of Facilities Subject to §1616(e). Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Community-Integrated Living Arrangement	Residential Habilitation	8
Community Living Facility (CLF)	Residential Habilitation	16

ii. Larger Facilities: In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

Community integration is a fundamental goal and component of the participant-centered support plan for all participants in the Waiver, regardless of the size of the living arrangement. Every

participant has an independent Individual Service and Support Advocate (ISSA), part of whose role is to ensure availability of supports to encourage individual choices about participating in specialized and other activities outside the home and within their home communities, developing and maintaining meaningful relationships with friends and family, and participating in organizations and general community life. The Operating Agency and the licensing entity both monitor support plans to ensure that community integration is supported**.** Licensure standards are in place to ensure participants may maintain personal possessions and influence living space.

Residential settings are integrated into their home communities. They are located to promote easy access to stores, religious institutions, services, and activities in the community, by foot, public transportation, or car.

Consistent with each participant's service plan, the residential settings offer a home-like environment, family-style meals and privacy.

iii. Scope of Facility Standards. By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following *(check each that applies)*:

Standard	Facility Type CILA	Facility Type CLF	Facility Type	Facility Type
Admission policies	■	■	☐	☐
Physical environment	■	■	☐	☐
Sanitation	■	■	☐	☐
Safety	■	■	☐	☐
Staff-to-resident ratios	☐	☐	☐	☐
Staff training and qualifications	■	■	☐	☐
Staff supervision	■	■	☐	☐
Resident rights	■	■	☐	☐
Medication administration	■	■	☐	☐
Use of restrictive interventions	■	■	☐	☐
Incident reporting	■	■	☐	☐
Provision of or arrangement for necessary health services	■	■	☐	☐

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

Staff-to-resident ratios

Standards for residential services do not specify staff-to-resident ratios. Instead, the standards employ an outcome-oriented approach to ensure sufficient staff is available to meet the needs of participants. Specifically, the CILA standards require that providers ensure that the number, organization, and qualifications of staff meet the training, care, support, health, safety, and evacuation needs of the participants served by the provider. The CLF standards require that the provider ensure that sufficient staff in numbers and qualifications is on duty all hours of each day

to provide services that meet the total needs of the residents.

d. Provision of Personal Care or Similar Services by Legally Responsible Individuals. A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

●	**No**. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
○	**Yes**. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of ***extraordinary care*** by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.*

e. **Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians**. Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one*:

○	The State does not make payment to relatives/legal guardians for furnishing waiver services.
○	The State makes payment to relatives/legal guardians under ***specific circumstances*** and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*
●	Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

	Payment for Waiver services may be made to any relatives and legal guardians who meet the requirements to provide the service, except for legally responsible relatives (spouses). Parents, other close relatives, and legal guardians may not provide host family services (i.e., foster care and other shared living arrangements) under residential habilitation. This prohibition is specified in Illinois Administrative Code, available upon request from either the Medicaid or Operating Agency. The participant-centered support plan governs the services to be provided. The Financial Management Service (FMS) entity receives billings detailing the date and time of services delivered. The FMS entity conducts routine quality assurance activities. The Operating Agency conducts sample utilization reviews for providers to ensure that payments are made only for services rendered and documented.
○	Other policy. *Specify*:

f. Open Enrollment of Providers. Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Participants in the adult developmental disabilities Waiver and their legal representative, if one has been appointed, together with the Service Facilitator or responsible QMRP, Individual Service and Support Advocate (ISSA), and other members of the support planning team, are responsible for selecting needed services and service providers, as part of the participant-centered planning process. Participant-directed services allow participants, or legal representative (as applicable), to hire common law employees with support from the Financial Management Service (FMS) entity.

Information regarding provider qualifications and program guidelines is continuously available on the Operating Agency's website.

The State does not impose barriers to the free choice of willing and qualified providers.
The Operating Agency (DHS) reviews and approves service providers for participation in the Adult Developmental Disabilities Waiver based on the provider qualifications specified in the Waiver.

The Medicaid Agency enrolls all willing and qualified providers that are chosen by participants in the adult developmental disabilities Waiver and/or legal representatives.

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

Service Specification	
Service Title:	**Adult Day Health (Adult Day Care)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services generally furnished four or more hours per day on a regularly scheduled basis, for one or more days per week, or as specified in the support plan, in a non-institutional, community-based setting, encompassing both health and social services needed to ensure the optimal functioning of the participant. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Transportation between the participant's place of residence and the adult day health (adult day care) center will be provided as a component part of adult day health services. The cost of this transportation is included in the rate paid to providers of adult day health services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Adult day care is typically available to participants who are aged 60 and older. Participants who are not yet 60 may also be served if day habilitation or employment services are determined by the support planning team not to be appropriate because the participant is medically fragile.

For participants who choose home-based supports, this service is included in the participant's monthly cost maximum. See Appendix C-4. Services are subject to prior approval by the Operating Agency.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Payment during any month is limited to a maximum of 115 hours for any combination of day programs.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Community–based agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Agencies	89 Ill. Adm. Code 240		59 Ill. Adm. Code 120 Contract with Department on Aging Contract requirements

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Agencies	Department on Aging	Surveys are conducted once per contracting period (six years), with additional surveys conducted as necessary due to complaints or deficiencies.
	Waiver Operating Agency (DHS)	Verification of contract with the Department on Aging upon enrollment and annually thereafter.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Residential Habilitation**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Residential habilitation means individually tailored supports that assist with the acquisition, retention, or improvement in skills related to living in the community. These supports include case management, adaptive skill development, assistance with activities of daily living, community inclusion, transportation, adult educational supports, social and leisure skill development, that assist the participant to reside in the most integrated setting appropriate to his/her needs. Residential habilitation also includes personal support and protective oversight and supervision. Payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement, other than such costs for modification or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment is not made, directly or indirectly, to members of the participant's immediate family.

Residential Habilitation includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

In addition, residential habilitation may include necessary nursing assessment, direction and monitoring by a registered professional nurse, and support services and assistance by a registered professional nurse or a licensed practical nurse to ensure the participant's health and welfare. These include monitoring of health status, medication monitoring, and administration of injections or suctioning. It also includes administration and/or oversight of the administration of oral and topical medications consistent with the Illinois Nursing and

Advanced Practice Nursing Act (225 ILSC 65) and the Mental Health and Developmental Disabilities Administrative Act. Nursing services are considered an integral part of residential habilitation services. Meeting the routine nursing needs of participants receiving 24-hour residential services is the responsibility of the residential service provider who must employ or contract with a professional nurse to perform their professional duties including the oversight and training of direct support staff. Nursing supports are part-time and limited; 24-hour nursing supports, similar to those provided in a nursing facility (NF) or Intermediate Care Facility for individuals with Developmental Disabilities (ICF/DD), are not available to participants in the Waiver. These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Residential Habilitation services are available to participants who require this intensity of service based on their identified needs. Factors involved in the assessment of the need for this service include the urgency of the situation (e.g., the unexpected loss of a caregiver) and the individual's health and welfare concerns (e.g., an abusive or neglectful situation). To ensure criteria are fairly applied to all initial applicants and to those whose circumstances may change once they are enrolled in the Waiver, the Operating Agency staff convene an internal committee to review each request from a statewide perspective.

This service will not be duplicative of other services in the Waiver. For example, non-medical transportation is an integral component of residential habilitation services.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Community-based agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Agencies	59 Ill. Adm. Code 115 (Community Integrated Living Arrangements - CILA) or 77 Ill. Adm. Code 370 (Community Living Facilities - CLF)		59 Ill. Adm. Code 50 59 Ill. Adm. Code 120 59 Ill. Adm. Code 116 Contract requirements

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-based agencies (CILA)	Waiver Operating Agency (DHS)	Full licensure surveys are conducted at least every three years, with focused surveys conducted more frequently if serious deficiencies are identified.

Community-based agencies (CLF)	Department of Public Health	Annual surveys and ongoing complaint investigations

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Day Habilitation (Developmental Training)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assistance with acquisition, retention, or improvement in self-help, socialization and adaptive skills that takes place in a non-residential setting, separate from the participant's private residence or other residential living arrangement. Activities and environments are designed to foster the acquisition of skills, appropriate behavior, greater independence, and personal choice. Services are furnished four or more hours per day on a regularly scheduled basis for one or more days per week or as specified in the participant's support plan. Meals provided as part of these services shall not constitute a "full nutritional regimen" (three meals per day).

Day habilitation services focus on enabling the participant to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies in the support plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in other settings.

Developmental Training also includes a range of adaptive skills in the areas of motor development, attention span, safety, problem solving, quantitative skills, and capacity for individual living. Developmental training also enhances a participant's ability to engage in productive work activities through a focus on such habilitative goals as compliance, attendance, and task completion. Developmental Training may also include training and supports designed to maintain skills and functioning and to prevent or slow regression.

Developmental Training includes the reduction of maladaptive behaviors through positive behavioral supports and other methods.

Developmental Training does not include the following:

- Special education and related services (as defined in Section 601 (16) and (17) of the Individuals with Disabilities Education Act) which otherwise are available to the participant through a local education agency:
- Vocational rehabilitation services which otherwise are available to the participant through a program funded under Section 110 of the Rehabilitation Act of 1973.

To foster community integration and learning in natural environments, Developmental Training may be furnished in a variety of community-based environments where persons without disabilities are present, as well

as in sites specifically certified for Developmental Training.

Such community-based Developmental Training programs include purposeful and meaningful activities that are designed to improve, maintain, or prevent the loss of independence, skills and functions enabling each participant to access and participate in relationships, activities and functions of community life. Activities may consist of job exploration activities (not paid employment) or volunteer work, recreation, educational experiences in natural community settings, maintaining family contacts and purposeful activities and services where persons without disabilities are present.

Developmental Training (DT) includes transportation between the residence and other community locations where DT occurs. Transportation is provided and billed as an integral part of Developmental Training. Training and assistance in transportation usage are provided as needed.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

The annual rate is spread over a State fiscal year maximum of 1,100 hours for any combination of day programs. Monthly payment is limited to a maximum of 115 hours for any combination of day programs.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Community-based agencies Special Recreation Associations

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Agencies		59 Ill. Adm. Code 119 (Developmental Training)	59 Ill. Adm. Code 50 59 Ill. Adm. Code 120 Contract requirements
Special Recreation Associations		59 Ill. Adm. Code 119	59 Ill. Adm. Code 50 59 Ill. Adm. Code 120 Contract requirements

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Agencies and Special Recreation Associations	Waiver Operating Agency (DHS)	Annual certification survey

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Supported Employment**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Supported employment services consist of intensive, ongoing supports that enable participants, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who, because of their disabilities, need supports, to perform in a regular work setting. Supported employment may include assisting the participant to locate a job or develop a job on behalf of the participant. Supported employment is conducted in a variety of settings; particularly work sites where persons without disabilities are employed. Supported employment includes activities needed to sustain paid work by participants, including supervision and training. When supported employment services are provided at a work site where persons without disabilities are employed, payment is made only for the adaptations, supervision and training required by participants receiving waiver services as a result of their disabilities but does not include payment for the supervisory activities rendered as a normal part of the business setting.

Documentation is maintained in the file of each participant receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.). Federal financial participation is not claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program.
2. Payments that are passed through to users of supported employment programs.
3. Payments for training that are not directly related to a participant's supported employment program.

Supported employment may be provided in integrated and competitive work settings in a business or industry that primarily employs people without disabilities.

Supported employment does not include sheltered work or other similar types of vocational services furnished in specialized facilities.

Supported employment may include services and supports that assist the participant in achieving self-employment through the operation of a business. However, Medicaid funds may not be used to defray the expenses associated with starting up or operating a business. Such assistance may include: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d)

ongoing assistance, counseling and guidance once the business has been launched.

Transportation will be provided between the participant's place of residence and the employment site or between habilitation sites (in cases where the participant receives waiver services in more than one place) as a component part of supported employment services. The cost of this transportation is included in the rate paid to providers of supported employment services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4. Services are subject to prior approval by the Operating Agency.

The annual rate is spread over 1,100 hours for any combination of day programs. Payment during any month is limited to 115 hours for any combination of day programs.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Community-based agencies

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-Based Agencies			59 Ill. Adm. Code 50 59 Ill. Adm. Code 120 Contract requirements

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-Based Agencies	Waiver Operating Agency (DHS)	Annual certification surveys

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification

Service Title:	**Personal Support**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Personal Support includes:

- Teaching adaptive skills to assist the participant to reach personal goals;
- Personal assistance in activities of daily living;
- Services provided on a short-term basis because of the absence, incapacity or need for relief of those persons who normally provide care (typically referred to as respite).

Supports are typically provided in such areas as eating, bathing, dressing, personal hygiene, community integration, meal preparation (excluding the cost of the meals), transportation and other activities of daily living. Supports may be provided to assist the participant to perform such tasks as light housework, laundry, grocery shopping, using the telephone, and medication management, which are essential to the health and welfare of the participant, rather than for the participant's family. Supports may be provided to develop skills in money management or skills necessary to self-advocate, exercise civil rights and exercise control and responsibility over other support services. Such assistance also may include the supervision of participants as provided in the support plan.

Personal Support may include an extension of behavioral and therapy services. Extension of services means activities by the Personal Support worker that assist the participant to implement a behavioral, occupational therapy, physical therapy, or speech therapy plan to the extent permitted by state law and as prescribed in the support plan. Implementation activities include assistance with exercise routines, range of motion, reading the therapist's directions, helping the participant remember and follow the steps of the plan or hands-on assistance. It does not include the actual service the professional therapist provides.

Personal Support is not intended to include professional services, home cleaning services, or other community services used by the general public. Some professional services are covered elsewhere under the home-based supports option.

Personal Support may be provided in the participant's home and may include supports necessary to participate in other community activities outside the home.

The need for Personal Support and the scope of the needed services must be documented in the participant-centered support plan. The amount of Personal Support must be specified in the support plan/Service Agreement.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Personal Support will not be duplicative of other services in the Waiver, i.e., residential habilitation, day habilitation, etc., since Personal Support services are already included in those services.

For participants who chose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4. For participants still enrolled in school, no Personal Support services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

Provider Specifications

Provider Category(s) *(check one or both)*:	■	Individual. List types:	■	Agency. List the types of agencies:
	Personal Support Worker		Community-Based agencies under contract with the Operating Agency that do not also provide Individual Service and Support Advocacy. Special Recreation Associations under contract with the Operating Agency	

Specify whether the service may be	☐	Legally Responsible Person	■	Relative/Legal Guardian

provided by *(check each that applies):*				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Personal Support Worker			Aged 18 or older, and is deemed by the participant or guardian to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the support plan. Workers hired on or after July 1, 2007, must have passed criminal background and Health Care Worker Registry checks prior to employment.
Community-Based Agencies and Special Recreation Associations			The Agency must be under contract with the Operating Agency. Per these contracts, employees must complete Operating Agency-approved direct support personnel training and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel. All employees must have passed criminal background and Health Care Worker Registry checks prior to employment.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Personal Support Worker	Financial Management Service (FMS) entity Waiver Operating Agency (DHS)	Upon enrollment Utilization reviews of a sample thereafter
Community-Based Agencies and Special Recreation Associations	Waiver Operating Agency (DHS)	Annual

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification

Service Title:	**Home Accessibility Modifications**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope):

Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's support plan, that are necessary to ensure the health, welfare and safety of the participant or that enable the participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the adaptive equipment that are necessary for the welfare of the participant. Excluded are those adaptations or improvements to the home that are of general utility, such as carpeting, roof repair, central air conditioning, and are not of direct remedial benefit to the participant. Adaptations that add to the total square footage of the home are excluded from this benefit. Seasonal items such as swimming pools and related equipment are excluded. All services shall be provided in accordance with applicable State or local building codes.

This service is subject to prior approval by the Operating Agency.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service is not included in the participant's monthly cost limit/individual budget.

There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications.

Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. See Appendix C-4.

Provider Specifications

Provider Category(s) *(check one or both)*:	■	Individual. List types:	■	Agency. List the types of agencies:
	Independent contractor		Construction companies	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Independent contractor			Enrolled vendor approved by the Service Facilitator and participant/guardian
Construction companies			Enrolled vendor approved by the Service Facilitator and participant/guardian.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Independent contractor	Financial Management Service entity or Operating Agency	Upon enrollment
Construction companies	Financial Management Service entity or Operating Agency	Upon enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Vehicle Modifications**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Vehicle Modifications are adaptations or alterations to an automobile or van that is the participant's primary means of transportation in order to accommodate the special needs of the participant. Vehicle adaptations are specified by the support plan as necessary to enable the participant to integrate more fully into the community and to ensure the health, welfare and safety of the participant. The following are specifically excluded:

1. Adaptations or improvements to the vehicle that are of general utility, and are not of direct remedial benefit to the participant;
2. Purchase or lease of a vehicle; and
3. Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.

The vehicle that is adapted must be owned by the participant, a family member with whom the participant lives or has consistent and on-going contact, or a non-relative who provides primary long-term support to the participant and is not a paid provider of such services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the waiver. For example, vehicle modifications are within the transportation component of residential services and day habilitation services.

For participants who choose home-based supports, this service is not included in the participant's monthly cost limit. There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications. See Appendix C-4.

This service requires prior approval by the Operating Agency.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Equipment vendor and installer

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Equipment vendor and installer			Enrolled vendor approved by the Service Facilitator and the participant/guardian

Verification of Provider Qualifications		
Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Equipment vendor and installer	Financial Management Service entity or Operating Agency	Upon enrollment

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Non-Medical Transportation**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Non-Medical Transportation is a service offered in order to enable waiver participants to gain access to waiver and other community services, activities and resources, as specified by the support plan. This service is offered in addition to medical transportation required under the Code of Federal Regulations (42 CFR §431.53) and transportation services under the Medicaid State Plan, defined in the Code of Federal Regulations at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services under the Waiver are offered in accordance with the participant's support plan. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge are utilized.

Excluded is transportation to and from covered Medicaid State Plan services. Also excluded is transportation to and from day program services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

This service will not be duplicative of other services in the Waiver. For example, non-medical transportation is an integral component of residential and day services.

No more than $500 of the monthly cost limit may be used for non-medical transportation services.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	■	Individual. List types:	■	Agency. List the types of agencies:
	Individual carriers		Community-based agencies	
			Public and private carriers	
			Special Recreation Associations	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Individual carriers			Drivers must have appropriate state licenses and proof of insurance
Community-based agencies			Drivers must have appropriate state licenses and proof of insurance
Public and private carriers			Drivers must have appropriate state licenses and proof of insurance
Special Recreation Associations			Drivers must have appropriate state licenses and proof of insurance

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Individual carriers	Financial Management Service entity	Upon enrollment
Community-based agencies	Waiver Operating Agency (DHS)	Upon enrollment
Public and private carriers	Financial Management Service entity	Upon enrollment
Special Recreation Associations	Waiver Operating Agency (DHS)	Upon enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification

Service Title:	**Adaptive Equipment**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Adaptive equipment, as specified in the plan of care, includes (a) devices, controls, or appliances that enable participants to increase their ability to perform activities of daily living; (b) devices, controls or appliances that enable participants to perceive, control, access or communicate with the environment in which they live; (c) such other durable equipment not available under the State plan that is necessary to address participant functional limitations; and (d) necessary initial training from the vendor to use the adaptive equipment.

Items reimbursed with Waiver funds do not include any medical equipment and supplies furnished under the State plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of the equipment.

The cost of the service may include the performance of assessments to identify the type of equipment needed by the participant.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based , this service is not included in the participant's monthly cost limit.

There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications and vehicle modifications. See Appendix C-4.

This service is subject to prior approval by the Operating Agency.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Equipment vendors

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Equipment vendors			Enrolled vendor approved by the Service Facilitator and participant/guardian

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Equipment vendors	Financial Management Service entity or Operating Agency	Upon enrollment

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification

Service Title:	**Assistive Technology**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
●	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of participants. Assistive technology service means a service that directly assists a participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes:

1. the evaluation of the assistive technology needs of a participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the participant in the customary environment of the participant.

2. Services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for participants.
3. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices.
4. Coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the support plan.
5. Training or technical assistance for the participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the participant.
6. Training or technical assistance for professionals or other persons who provide services to, employ, or are otherwise substantially involved in the major life functions of participants.

Items reimbursed with Waiver funds do not include any assistive technology furnished by the school program or by the Medicaid State Plan and exclude those items that are not of direct remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation. All purchased items shall be the property of the participant or the participant's family.

The cost of the service may include training the participant or caregivers in the operation and/or maintenance of the equipment.

The cost of the service may include the performance of assessments to identify the type of equipment needed by the participant.

The Waiver will not cover assistive technology that is covered through the State plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is not included in the participant's monthly cost limit.

There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, home modifications, and vehicle modifications. See Appendix C-4.

This service is subject to prior approval by the Operating Agency.

Provider Specifications

Provider Category(s) *(check one or both)*:	☐	Individual. List types:	■	Agency. List the types of agencies:
				Equipment vendor

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Equipment vendor			Enrolled vendor approved by the Service Facilitator and participant/guardian

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Equipment vendor	Financial Management Service entity	Upon enrollment

Service Delivery Method

Service Delivery Method	■	Participant-directed as specified in Appendix E	■	Provider managed

(check each that applies):				

Service Specification	
Service Title:	**Emergency Home Response Services (EHRS)**
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

EHRS is defined as a 24-hour emergency communication link to assistance outside the participant's home for individuals based on health and safety needs and mobility limitations. This service is provided by a two-way voice communication system consisting of a base unit and an activation device worn by the participant that will automatically link the individual to a professionally staffed support center. Whenever the system is engaged by a participant, the support center assesses the situation and directs an appropriate response. The purpose of providing EHRS is to improve the independence and safety of participants in their own homes in accordance with the authorized plan of care, and thereby help reduce the need for institutional care or out-of-home placement in a more restrictive setting.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the waiver. For example, routine supervision and emergency response are an integral component of residential services.

EHRS are limited to participants who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4. No specific service maximum.

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Certified Vendor
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Certified vendor			Certified by the Department on Aging to provide this service or approved by the

			Department of Human Services with a current written rate agreement

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Certified vendor	Department on Aging	Initial Certification and recertification no less frequently than every three years
	Operating Agency (DHS) Division of Rehabilitation Services	Initial approval and re-approval every three years with annual written rate agreements
	Operating Agency (DHS)	Verification of certification or approval upon enrollment and annual certification/approval

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Training and Counseling Services for Unpaid Caregivers**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
●	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a participant served in the waiver. This service may not be provided in order to train paid caregivers or school personnel. Training includes instruction about treatment regimens and other services included in the support plan, use of equipment specified in the support plan, and includes updates as necessary to safely maintain the participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the participant. All training for individuals who provide unpaid support to the participant must be included in the participant's support plan.

Caregivers who are compensated for direct services under this Waiver may not receive services under this service title.

Training furnished to individuals who provide uncompensated care and support to the participant must be directly related to their role in supporting the participant in areas specified in the support plan. Counseling similarly must be aimed at assisting unpaid individuals who support the participant to understand and address participant needs.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the Waiver. For example, residential services include

training and supports for care givers, all of whom are paid.

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.
No specific service maximum.

Provider Specifications

Provider Category(s) *(check one or both)*:	■	Individual. List types:	■	Agency. List the types of agencies:
		Licensed counselors		Specialized Training Providers

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed counselors	225 ILCS 15/1 et. seq. 68 Ill. Adm. Code 1400 225 ILCS 20/1 et seq. 68 Ill. Adm. Code 1470 225 ILCS 55/1 et seq. 68 Ill. Adm. Code 1283 225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375 225 ILCS 20/1 et seq. 68 Ill Adm. Code 1470 225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375		
Specialized Training providers			Training programs, workshops or events deemed qualified by the participant/guardian and approved by the Service Facilitator. Examples include CPR instruction, first aid, and programs on disability-specific topics such as epilepsy, autism, etc.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed counselors	Waiver Operating Agency (DHS)	Upon enrollment Annual check for continuation of licensure.
Specialized Training providers	Operating Agency (DHS) or Financial Management Service entity	Upon enrollment

Service Delivery Method

Service Delivery Method *(check*	■	Participant-directed as specified in Appendix	☐	Provider

each that applies):		E		managed

Service Specification	
Service Title:	**Behavior Intervention and Treatment**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Behavior intervention and treatment includes a variety of individualized, behaviorally based treatment models consistent with best practice and research on effectiveness that are directly related to the participant's therapeutic goals. Interventions include, but are not limited to: Applied Behavior Analysis, Relationship Development Intervention (RDI), and Floor Time. These services are designed to assist participants to develop or enhance skills with social value, lessen behavioral excesses and improve communication skills. Key elements are:

- Approach is tailored to address the specific behavioral needs of the participant;
- Targeted skills are broken down into small attainable tasks;
- Direct support staff and informal caregiver training is a key component so that skills can be generalized and communication promoted;
- Services must be directly related to the participant's therapeutic goals contained in the support plan; and
- Success is closely monitored with detailed data collection.

A behavior consultant assesses the participant, including analysis of the presenting behavior and its antecedents and consequences, and develops written behavior strategies based upon the participant's individual needs. The strategies are a component of the participant-centered support plan and must be approved by the participant, guardian if one has been appointed, responsible QMRP/Service Facilitator, Individual Service and Support Advocate and the other members of the planning team. Trained team members implement the planned behavior services. The behavior consultant monitors progress on at least a monthly basis and more frequently if needed to address issues with the participant's outcomes. A progress report is prepared by the behavior consultant and sent to the support planning team every six months. This progress report is available to State staff upon request to evaluate the efficacy of the treatment.

The behavior consultant supervises implementation of the behavior plan. This includes training of the direct support staff and unpaid informal caregivers to ensure that they apply the interventions properly, understand the specific services and outcomes for the participant being served, and know the procedures for regularly reporting participant progress.

Services are provided by professionals working closely with the participant's direct support staff and unpaid informal caregivers in the participant's home and other natural environments.

Direct support staff and unpaid informal caregivers of participants receiving intensive behavior treatment are vital members of the behavior team. They must be involved in the initial training session to initiate services, and must remain involved with the behavior consultant so that they are able to carry through and reinforce the behaviors being worked on.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost

limit. See Appendix C-4.

There is a State fiscal year maximum of 66 hours.

Provider Specifications				
Provider Category(s) *(check one or both)*:	■	Individual. List types:	☐	Agency. List the types of agencies:
	Behavior consultant			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Behavior Consultant	225 ILCS 15/1 et. Seq. 68 Ill. Adm. Code 1400		Clinical psychologist Masters level professional who is certified as a Behavior Analyst by the Behavior Analyst Certification Board (bacb.com) Bachelor's level professional who is certified as an Associate Behavior Analyst by the Behavior Analyst Certification Board (bacb.com) Professional who is certified to provide Relationship Development Assessment. Information is at rdiconnect.com. Professional with a Bachelor's Degree in a human service field and who has completed at least 1,500 hours of training or supervised experience in the application of behaviorally-based therapy models consistent with best practice and research on individuals with Autism Spectrum Disorder.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Behavior Consultant	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment and annual verification of national certification Annual check for continuation of licensure for clinical psychologists.

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Behavioral Services (Psychotherapy and Counseling)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Psychotherapy is a treatment approach that focuses on a goal of ameliorating or reducing the symptoms of emotional, cognitive or behavioral disorder and promoting positive emotional, cognitive and behavioral development.

Counseling is a treatment approach that uses relationship skills to promote the participant's abilities to deal with daily living issues associated with their cognitive or behavioral problems using a variety of supportive and re-educative techniques.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 60 hours for any combination of psychotherapy and counseling services.

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	☐	Agency. List the types of agencies:
	Licensed therapists			

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Licensed Psychotherapists	225 ILCS 15/1 et. Seq. 68 Ill. Adm. Code 1400 225 ILCS 20/1 et seq. 68 Ill. Adm. Code 1470 225 ILCS 55/1 et seq. 68 Ill. Adm. Code 1283 225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375		Clinical Psychologist Clinical Social Worker Marriage/Family Therapist Clinical Professional Counselor
Licensed Counselors	All licensure categories for psychotherapists, plus: 225 ILCS 20/1 et seq. 68 Ill Adm. Code 1470		Social Worker

	225 ILCS 107/1 et seq. 68 Ill. Adm. Code 1375		Professional Counselor

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Licensed Psychotherapists	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment and annual verification of continuation of licensure Annual check for continuation of licensure for licensed professionals
Licensed Counselors	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment and annual verification of continuation of licensure Annual check for continuation of licensure for licensed professionals

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

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Service Specification	
Service Title:	**Skilled Nursing**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Services listed in the participant-centered support plan that are within the scope of the State's Nurse Practice Act and are provided by a registered professional nurse, or licensed practical nurse under the supervision of a registered nurse, licensed to practice in the State.

These services are in addition to any Medicaid State Plan nursing services for which the participant may qualify.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the Waiver. For example, nursing services beyond those covered in the State Plan, are a component of residential services

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 365 hours of service by a registered nurse and 365 hours of service by a licensed practical nurse.

Provider Specifications				
Provider Category(s) *(check one or both)*:	■	Individual. List types:	☐	Agency. List the types of agencies:
	Registered Nurse or Licensed Practical Nurse, under supervision by a registered nurse			
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Registered Nurse; or Licensed Practical Nurse, under supervision by a registered nurse	225 ILCS 65/1 et seq. 68 Ill. Adm. Code 1300		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Nurse	Operating Agency (DHS)	Upon enrollment and annual verification of continuation of license
	Medicaid Agency (HFS)	Monthly check for continuation of licensure for licensed professionals

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	☐	Provider managed

Service Specification	
Service Title:	**Crisis Services**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
❍	Service is included in approved waiver. The service specifications have been modified.
●	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Crisis Services are provided on an emergency temporary basis because of the absence or incapacity of the persons who normally provide unpaid care. Absence or incapacity of the primary caregiver(s) must be due to a temporary cause, such as hospitalization, illness, injury, or other emergency situation. Crisis Services are not available for caregiver absences for vacations, educational or employment-related reasons, or other non-emergency reasons.

The definition of Crisis Services includes the same activities, requirements and responsibilities as Personal

Support. The participant, legal representative, the service provider and the support planning team may set mutually acceptable rates for Crisis Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The rates must be specified in the Service Agreements and are subject to review and approval by the Operating Agency on either a targeted or a random sample basis.

This service will not be duplicative of other services in the Waiver. For example, crisis services are a component of residential services.

This service is not included in the participant's monthly cost maximum. Crisis Services may not exceed $2,000 in any single month and may not be authorized for more than two consecutive months or 60 consecutive days. No Crisis Services may be delivered during the typical school day relative to the age of the participant or during times when educational services are being provided.

This service is subject to prior approval by the Operating Agency.

Provider Specifications

Provider Category(s) *(check one or both)*:	■	Individual. List types:	■	Agency. List the types of agencies:
		Crisis Service Worker		Community-based agencies under contract with the Operating Agency that do not also provide Individual Service and Support Advocacy Special Recreation Associations under contract with the Operating Agency

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	■	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Crisis Services Worker			Aged 18 or older, has a high school diploma or GED, and is deemed by the guardian or family to be qualified and competent to meet the participant's needs and carry out responsibilities assigned via the support plan. Crisis Services workers hired on or after July 1, 2007, must have passed criminal background and Health Care Worker Registry checks prior to employment.
Community-Based Agencies and Special Recreation Associations			The Agency must be under contract with the Operating Agency. Per these contracts, employees must complete DHS-approved direct support personnel training and pass competency-based training assessments (40 hours of classroom and 80 hours of on-the-job training) and be certified as direct support personnel. All employees must have had criminal

			background and Health Care Worker Registry checks completed prior to employment.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Crisis Services Worker	Financial Management Service entity Waiver Operating Agency (DHS)	Upon enrollment Utilization reviews conducted of a sample thereafter
Community-Based Agency	Waiver Operating Agency (DHS)	Annual
Special Recreation Association	Waiver Operating Agency (DHS)	Annual

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification

Service Title:	**Physical Therapy (Extended Medicaid State Plan)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Physical Therapy services under the waiver differ in nature and scope from physical therapy services in the Medicaid State Plan. The provider qualifications specified in the Medicaid State Plan apply. Waiver Physical Therapy focuses on the long-term habilitative needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Provider Specifications

Provider Category(s) *(check one or both)***:**	■	Individual. List types:	☐	Agency. List the types of agencies:
	Physical Therapist			

Specify whether the service may be provided by *(check each that*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

applies):				

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Physical Therapist	225 ILCS 90/1 et seq. 68 Ill. Adm. Code 1340		Physical Therapist may directly supervise a certified physical therapist assistant.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Physical Therapist	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment Monthly verification of continuation of licensure

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Occupational Therapy (Extended Medicaid State Plan)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Occupational Therapy services under the waiver differ in nature and scope from occupational therapy services in the Medicaid State Plan. The provider qualifications specified in the Medicaid State Plan apply. Waiver Occupational Therapy focuses on the long-term habilitative needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Provider Specifications				
Provider	■	Individual. List types:	☐	Agency. List the types of agencies:

Category(s) *(check one or both)*:	Occupational Therapist	

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Occupational Therapist	225 ILCS 75/1 et seq. 68 Ill. Adm. Code 1315		Occupational Therapist may directly supervise a Certified Occupational Therapist Assistant

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Occupational Therapist	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment Monthly verification of continuation of licensure

Service Delivery Method

Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification

Service Title:	**Speech Therapy (Extended Medicaid State Plan)**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

●	Service is included in approved waiver. There is no change in service specifications.
○	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Speech Therapy services under the waiver differ in nature and scope from speech therapy services in the Medicaid State Plan. The provider qualifications specified in the Medicaid State Plan apply. Waiver Speech Therapy focuses on the long-term habilitative needs of the participant, rather than short-term acute restorative needs. Restorative services are covered under the Medicaid State Plan.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

For participants who choose home-based supports, this service is included in the participant's monthly cost limit. See Appendix C-4.

There is a State fiscal year maximum of 26 hours, unless additional documentation supports the need for additional hours (up to 52 hours).

Services are subject to prior approval by the Operating Agency.

Provider Specifications					
Provider Category(s) *(check one or both)*:	■	Individual. List types:	☐	Agency. List the types of agencies:	
	Speech/Language Pathologist				
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian	

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Speech/Language Pathologist	225 ILCS 110/1 et seq. 68 Ill. Adm. Code 1465		

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Speech/Language Pathologist	Operating Agency (DHS) Medicaid Agency (HFS)	Upon enrollment Monthly verification of continuation of licensure

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	■	Participant-directed as specified in Appendix E	■	Provider managed

Service Specification	
Service Title:	**Service Facilitation**

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

○	Service is included in approved waiver. There is no change in service specifications.
●	Service is included in approved waiver. The service specifications have been modified.
○	Service is not included in the approved waiver.

Service Definition (Scope)**:**

Service Facilitation includes services that assist participants in gaining access to needed Waiver and other State plan services, as well as medical, social, educational and other services, regardless of the funding source for the services. The Service Facilitator assists the participant and guardian if one has been appointed in designing an array of habilitation and support services to meet the participant's needs. The Service Facilitator assists the participant and guardian to convene a support planning team, or may convene the team as directed by the participant or guardian. In addition to the participant, guardian (if applicable), family members and/or other individuals important to the participant, Service Facilitator, and Individual Service and Support Advocate (ISSA), the team may include other professionals and service providers as needed. Based on assessment information and discussion among the participant, guardian, family and other members of the support planning team, the Service Facilitator writes/ updates the participant-centered support plan at least annually or more often if needed. The Service Facilitator assists the participant and guardian in choosing services and service providers as needed. The Service Facilitator is responsible for ongoing monitoring of the provision of services included in the participant's support plan and for ensuring participant health and welfare. The Service Facilitator is responsible for ensuring the completion of Service Agreements between the participant and service providers and monitoring the expenditure of funds according to the individual budget, support plan and Service Agreements. The Service Facilitator also assists the participant in determining individual providers of services, such as Personal Support, Non-Medical Transportation and Behavior Intervention and Treatment, are competent to provide the specific services the participant is receiving.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

This service will not be duplicative of other services in the Waiver. For example, case management/care coordination services are a component of residential services. This service is included in the participant's monthly cost limit. See Appendix C-4. No specific service maximum. The support plan/Service Agreement must set aside at least two hours per month to allow for routine required administrative activities.

Provider Specifications

Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	■	Agency. List the types of agencies:
				Community-based agencies that do not also provide ISSA Services.

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*
Community-based agencies			Entity under contract with the Operating Agency that does not also provide Individual Service and Support Advocacy. Services must be provided personally by a professional defined in federal regulations as a Qualified Mental Retardation Professional.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Community-based agencies	Waiver Operating Agency (DHS)	Annual reviews

Service Delivery Method

Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	■	Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services *(check each that applies).*

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

■	**Limit(s) on Set(s) of Services**. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. *Furnish the information specified above.*
	Maximum for Modifications and Tangible Items There is a $15,000 maximum per participant per five-year period for any combination of adaptive equipment, assistive technology, and home and vehicle modifications. This applies to all Waiver participants. Within the five-year maximum, there is also a $5,000 maximum per address for permanent home modifications for rented homes. Individual program limits were combined to allow participants greater flexibility within the tangible item budget to meet their unique needs. Participants are informed of their right to request a fair hearing, in the event any requests are denied. Participants are notified of the limits in the Operating Agency's Waiver manual. ISSAs assist participants in understanding and managing the limits.
■	**Prospective Individual Budget Amount**. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. *Furnish the information specified above.*

	The home-based supports budget limits are based on the Illinois Home-Based Support Services Law for Mentally Disabled Adults [405 ILCS 80]. The limits are indexed to Social Security benefit levels and are adjusted each January when Social Security benefits are adjusted. These statutory budget limits were set through a public legislative process that included opportunities for public comment by advocates and individuals with mental disabilities and their families. The total amount of Waiver services provided in any month is determined by the support plan of the participant within the statutory maximums. The support plan is developed by the Service Facilitator, with input from the ISSA and other team members, and is based on assessments of the participant's needs. Written notices of changes to limits are sent to all participants/guardians, Financial Management Service entity, Service Facilitation providers and Individual Service and Support Advocacy providers. We expect that this monthly dollar maximum amount, currently $1,869 for calendar year 2007 (or $1,246 if in school), together with natural supports, general community resources, school-based services (for participants between the ages of 18 and 21 and still attending public schools), and Medicaid State plan services will be sufficient to meet the participant's needs.
☐	**Budget Limits by Level of Support**. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. *Furnish the information specified above.*
☐	**Other Type of Limit.** The State employs another type of limit. *Describe the limit and furnish the information specified above.*
☐	**Not applicable.** The State does not impose a limit on the amount of waiver services except as provided in Appendix C-3.

Appendix D: Participant-Centered Planning and Service Delivery
Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title:	Sometimes referred to as Individual Service Plan or Support Plan

a. **Responsibility for Service Plan Development**. Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals *(check each that applies)*:

☐	Registered nurse, licensed to practice in the State
☐	Licensed practical or vocational nurse, acting within the scope of practice under State law
☐	Licensed physician (M.D. or D.O)
☐	Case Manager (qualifications specified in Appendix C-3)
☐	Case Manager (qualifications not specified in Appendix C-3). *Specify qualifications*:
☐	Social Worker. *Specify qualifications:*
■	Other (*specify the individuals and their qualifications):*
	For the participant-directed opinion, home-based supports, the Service Facilitator, who is a QMRP, is responsible. For those receiving residential habilitation services, the QMRP with the licensed provider, is responsible.

b. Service Plan Development Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility for service plan development *may not provide* other direct waiver services to the participant.
●	Entities and/or individuals that have responsibility for service plan development *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. *Specify*:
	All Waiver participants have an Individual Service and Support Advocate (ISSA) who is a QMRP employed by an independent entity under contract with the Operating Agency. This entity may not provide direct services. The ISSA participates in the development and approves the support plan. The ISSA also conducts quarterly visits to the individual to ensure that services in the plan are being fully implemented and are meeting the participants' needs.

c. Supporting the Participant in Service Plan Development. Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

For all Waiver participants, Participant-Centered Support plans are developed by QMRPs, who

work as part of a team that includes the participant being served, the participant's legal guardian (if one has been appointed), the participant's Individual Service and Support Advocate (ISSA), other individuals from the participant's support network as the participant or guardian chooses, and professional consultants as deemed necessary by the provider. The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant, team, or provider; however, the plan must exist in written format.

ISSAs are directed to contact the participant and guardian if one has been appointed prior to any support planning meetings to identify areas of concern, answer questions, and generally prepare for the meeting.

The participant, guardian if one has been appointed, responsible QMRP/Service Facilitator, and the ISSA must approve the plan, in writing.

d. Service Plan Development Process In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Plan Development and Modification

For all Waiver participants, within 30 days after the initiation of services, the responsible QMRP/Service Facilitator shall prepare a written participant-centered support plan for each participant served only after consultation with the following:

- The participant;
- The participant's legal guardian, if one has been appointed;
- Other individuals from the participant's support network (including family members) as the participant or guardian chooses;
- The participant's ISSA; and
- Professional consultants as deemed necessary.

The written plan may be produced in other formats, such as pictures, DVD, etc., to accommodate specific needs of the participant, team, or provider; however, the plan must exist in written format.

The support plan shall:

- Contain a description of the participant's preferences;
- List and describe the necessary activities, training, materials, equipment, assistive technology, and services that are needed to assist the participant;
- Describe how opportunities of choice will be provided, including specifying means for the

following:
  - supporting the participant or guardian, if one has been appointed, to indicate preferences among options presented, by whatever communication methods necessary;
  - providing the necessary support and training for the participant to be able to indicate preferences, including a description of any training and support needed to fully participate in the planning process and other choice making; and
  - assisting the participant or guardian to understand the negative consequences of choices that may involve risk;
- Prioritize and structure the delivery of services toward the goal of achieving the participant's or guardian's preferences;
- Provide for supports for the participant to access generic resources and Medicaid State Plan services; and
- Contribute to the continuous movement of the participant toward the achievement of the participant's or guardian's preferences.

The support plan shall:
- Be dated;
- Be approved in writing by the participant or guardian, if one has been appointed Requirements for approval from or consultation with the participant's guardian shall be considered to have been complied with if the provider documents that it has taken reasonable measures to obtain this approval or consultation and that the participant's guardian has failed to respond;
- Be approved in writing by the responsible QMRP/Service Facilitator; and
- Be approved, in writing, by the participant's ISSA.

The ISSA shall approve only those plans that meet the requirements established in the Waiver. If the ISSA determines that the proposed plan does not meet these requirements, the ISSA shall work with the participant or guardian, if applicable, and provider(s) to ensure the proposed plan is modified as necessary. In the event that conflicts arise that cannot be resolved among the parties involved, the ISSA or responsible QMRP/Service Facilitator shall make a referral to the Operating Agency for technical assistance.

The responsible QMRP/Service Facilitator shall regularly review and revise the plan by following the same procedures as set out above, whenever necessary, to reflect any of the following:
- Changes in the participant's needs and preferences;
- Achievement of goals or skills outlined within the plan; or
- Any determination made that any service being provided is unresponsive.

In developing, modifying, and evaluating the effectiveness of the plan, the responsible QMRP/Service Facilitator shall include assessments made by professionals and shall:
- Include consideration of the expressed opinions of the participant or guardian, as applicable, and other individuals from the participant's support network; and
- Account for the following:
  - the financial limitations of the participant, the provider, and funding sources;
  - the supports and training needed, offered, and accepted by the participant;
  - the participant's medical status,
  - the participant's ability to communicate his or her needs and preferences, and
  - matters identified in Section e below in accordance with imminent danger.
- Next best options may be considered as responsive if the participant or guardian, as applicable, cannot specifically have what is preferred due to limitations identified.

All plans must be updated at least annually.

e. Risk Assessment and Mitigation. Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

For all Waiver participants, the responsible QMRP/Service Facilitator and ISSA must address during the planning process with the participant and guardian if one has been appointed the negative consequences of choices that may involve risk and document the issues concerned and the decisions made. They will describe, when it is necessary to do so, to the participant and the participant's support network, how the preferences might be limited because of imminent significant danger to the participant's health, safety, or welfare based on the following:

- The participant or guardian's, if one has been appointed, history of decision-making and ability to learn from the natural negative consequences of poor decision-making;
- The possible long and short-term consequences that might result to the participant if the participant makes a poor decision;
- The possible long and short-term effects that might result to the participant if the provider limits or prohibits the participant or guardian from making a choice; and
- The safeguards available to protect the participant's safety and rights in each context of choices. Backup plans are developed, if it determined to be necessary, as part of the plan development process.

f. Informed Choice of Providers. Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The ISSA provider, an independent entity under contract with the Operating Agency, verbally informs the participant or guardian if one has been appointed about qualified providers in the service area.

g. Process for Making Service Plan Subject to the Approval of the Medicaid Agency. Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

Staff within the Operating Agency reviews the adequacy of plans during sample and targeted quality assurance reviews and annual surveys. Data from these reviews and surveys are reviewed by Medicaid Agency staff as part of the Quality Management Committee activity. This committee meets quarterly. In addition, the Medicaid Agency conducts sample reviews of service plans to ensure they are developed in accordance with Waiver requirements.

h. Service Plan Review and Update. The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

○	Every three months or more frequently when necessary
○	Every six months or more frequently when necessary
●	Every twelve months or more frequently when necessary
○	Other schedule (*specify*):

i. Maintenance of Service Plan Forms. Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following *(check each that applies)*:

☐	Medicaid agency
☐	Operating agency
☐	Case manager
■	Other (*specify):*
	Responsible QMRP or Service Facilitator (for participant-directed service options) and ISSA.

Appendix D-2: Service Plan Implementation and Monitoring

a. Service Plan Implementation and Monitoring. Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The responsible QMRP/Service Facilitator visits the participant in the home or day program setting at least once every two months to ensure participant's health and welfare. The support plan is reviewed to determine if any changes are needed, including any changes in the participant's preferences, choices of providers, achievement of goals or skills outlined in the plan or any determination made that any service being provided is unresponsive. The QMRP documents the visit in the progress notes and follows up on any issues identified during the meeting including any health care concerns , effectiveness of back up plans, and access to health and other non-waiver services. One visit each year is used to facilitate the annual service planning meeting.

Issues that cannot be resolved locally are referred to the Operating Agency for technical assistance. The Operating Agency conducts sample reviews of plans during licensure and certification surveys. The Operating Agency conducts sample reviews of plans twice per year and reserves the right to conduct targeted reviews as needed should quality issues arise. Data compiled from these reviews are shared with and discussed by the Quality Management Committee during its quarterly meetings.

b. Monitoring Safeguards. *Select one:*

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.
●	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may provide* other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. *Specify*:

In addition to routine monitoring by the responsible QMRP or Service Facilitator, the Individual Services and Support Advocacy (ISSA) provider, an independent entity under contract with the Operating Agency, continually (at least quarterly or more often if necessary) monitors the implementation of the plan using a review checklist provided by the Operating Agency (a copy is available upon request). The ISSA works cooperatively with the service providers and the participant or legal representative, as applicable, to resolve any concerns. In the event that issues cannot be resolved, the provider or the ISSA shall make a referral to the Operating Agency for technical assistance.

Appendix E: Participant Direction of Services

[NOTE: *Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.*]

Applicability *(select one)*:

●	**Yes.** This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
○	**No.** This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

○	**Yes.** The State requests that this waiver be considered for Independence Plus designation.
●	**No.** Independence Plus designation is not requested.

Appendix E-1: Overview

a. Description of Participant Direction. In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The home-based supports uses a participant-centered planning approach directly involving the participant and the participant's guardian, if one has been appointed, as members of the support planning team along with the local Service Facilitator, direct service providers, Individual Service and Support Advocate (ISSA) and any other persons important to the participant (including family members where chosen by the participant). Within established overall cost limits, the Waiver is designed to give participants the opportunity to direct some or all of their services. However, participants have the option of receiving agency-directed services if they desire.

During the initial support planning process, the participant and/or the guardian, if one has been appointed, will receive information about participant-directed services and supports. Information will be presented in both written and other formats to ensure the participant understands the participant-directed options and can make an informed choice. Information is provided about decision-making budget authority up to the approved level of support. Specific information is provided about the roles and responsibilities of the participant or legal representative and the financial management services available as part of participant-directed services. Guidelines for participants hiring personal support workers in the participant's home are distributed and reviewed when participant-directed services are desired.

The State conducted a Request for Proposal (RFP) process to select a Financial Management Service (FMS) vendor. The Operating Agency contracted with a national expert to help develop the RFP for the FMA/Vendor Fiscal/Employer Agent pursuant to Section 3504 of the IRS Code, IRS Revenue

Procedure 70-6 and Proposed Notice 2003-70 and Operating Agency rules and regulations. Qualifications included a financially stable company with at least one year of experience in providing Vendor Fiscal/Employer Agent services directly to individual participants enrolled in self-directed programs similar to the Illinois Waiver program. The Operating Agency is contracting with one FMS vendor statewide. The "per member per month" (PMPM) fee, determined through the RFP process – a competitive bid process – and subsequently negotiated by the State and the successful vendor, will be claimed as an administrative expense under the Waiver.

The participant's choice of the type of supports is documented as part of the participant-centered support plan. Service Agreements are completed for each provider selected by the Waiver participant. Participants selecting participant-directed services are assisted by the local Service Facilitator, the Individual Service and Support Advocate (ISSA) and the Financial Management Service entity. The team members are available to assist the participant and/or legal representative to understand and fulfill their responsibilities. If at any time the participant voluntarily decides he/she no longer want to receive participant-directed services, the participant can request agency-based services and supports. This change is documented in the support plan. The plan would be revised to reflect the change in service delivery and any other changes required as a result of the participant or legal representative's decision to change to no longer direct his/her own services and instead receive agency-based services and supports.

If an investigation determines that the participant or participant's legal representative committed fraud regarding participant-directed program funds, the participant may be involuntarily restricted from participant-directed services. This determination by the State is subject to appeal to the Medicaid Agency. The outcome of the appeal process is final. In this event, agency-based services would be made available and documented in the support plan.

b. Participant Direction Opportunities. Specify the participant direction opportunities that are available in the waiver. *Select one:*

○	**Participant – Employer Authority**. As specified in ***Appendix E-2, Item a,*** the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the co-employer of workers. Supports and protections are available for participants who exercise this authority.
○	**Participant – Budget Authority.** As specified in ***Appendix E-2, Item b***, the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
●	**Both Authorities.** The waiver provides for both participant direction opportunities as specified in ***Appendix E-2***. Supports and protections are available for participants who exercise these authorities.

c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

■	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
□	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.

☐	The participant direction opportunities are available to persons in the following other living arrangements *(specify)*:

d. Election of Participant Direction. Election of participant direction is subject to the following policy (s*elect one):*

○	Waiver is designed to support only individuals who want to direct their services.
○	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
●	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. *Specify the criteria*:
	Participant-directed opportunities are available to all participants in the Waiver who wish to elect the Home-Based Support Services option and want to direct their own services, with or without assistance from family members. The home-based supports option provides opportunities for both employer authority and budget authority.

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

During the level of care evaluation process, the local entities under contract with the Operating Agency provide information about participant-directed opportunities and assist participants and their families in making informed choices from among Waiver options.

Once the participant-directed option is selected, a guide is available for participants and includes guidelines for selecting personal support workers, information on financial management services, rights and responsibilities, and other requirements of the Waiver. The local Service Facilitator provides this guide to all participants in participant-directed services when Waiver services are initiated. The Service Facilitator and the Individual Service and Support Advocate (ISSA) assist the participant and guardian to understand the service options available under the Waiver. The information is reviewed with participants at least annually as part of the support planning process.

A copy of the guide is on file with the Medicaid Agency and is available upon request from the Operating Agency.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative *(select one)*:

○		The State does not provide for the direction of waiver services by a representative.
●		The State provides for the direction of waiver services by a representative. Specify the representatives who may direct waiver services: *(check each that applies)*:
	■	A legal representative of the participant may direct waiver services.
	☐	Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:

g. Participant-directed Services. Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service)*:

Participant-directed Waiver Service	Employer Authority	Budget Authority
Personal Support Services	■	■
Non-Medical Transportation	■	■
Home and Vehicle Modifications, Assistive Technology and Adaptive Equipment	■	■
Training and Counseling for Unpaid Care Givers	■	■
Behavior Intervention and Treatment	■	■
Behavioral Services (Psychotherapy and Counseling)	■	■
Nursing	■	■
Emergency Home Response	■	■
Extended Medicaid State Plan Services (Physical, Occupational and Speech Therapy)		■
Adult Day Care		■
Day Habilitation (Developmental Training)		■
Supported Employment		■
Crisis Services	■	■
Service Facilitation		■

h. Financial Management Services. Except in certain circumstances, Financial Management Services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

●	**Yes**. Financial Management Services are furnished through a third party entity. *(Complete item E-1-i)*. Specify whether governmental and/or private entities furnish these services. *Check each that applies:*
	☐ Governmental entities
	■ Private entities
○	**No**. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. *Do not complete Item E-1-i*.

i. Provision of Financial Management Services. Financial Management Services (FMS) may be furnished as a waiver service or as an administrative activity. S*elect one*:

○	FMS are covered as the waiver service entitled as specified in Appendix C-3.
●	FMS are provided as an administrative activity. *Provide the following information:*

i.	**Types of Entities**: Specify the types of entities that furnish FMS and the method of procuring these services:
	A Financial Management Service vendor (FMS) was selected through a competitive Request for Proposal (RFP) process. One vendor was selected to provide FMS/employer agent services statewide. The criteria used in selecting the vendor included: • Financial stability, with at least one year of experience in providing employer agent services to participants in similar participant-directed options. • Ability to perform all functions in accordance with Federal, State and Department regulations and requirements. • Ability to perform all functions directly without the use of a sub-agent. • Ability to verify, process and pay invoices for goods and services approved in the participant's support plan in accordance with Operating Agency requirements. • Ability to prepare and maintain a comprehensive FMS policy and procedure manual that reflects all tasks performed, Illinois-specific labor, tax and workers' compensation insurance requirements, as well as requirements of the Waiver. • An internal quality management plan that demonstrates sufficient internal controls to monitor FMS performance.
ii.	**Payment for FMS**. Specify how FMS entities are compensated for the administrative activities that they perform:
	The FMS vendor will be compensated based on a per member per month (PMPM) negotiated fee for each participant who uses FMS services. the FMS costs for the first 1,500 participants is less than 5% of the total estimated service cost. The cost percentage for participants after the first 1,500 will drop to approximately 3.25% of the total estimated service cost.
iii.	**Scope of FMS**. Specify the scope of the supports that FMS entities provide *(check each that applies):*
	Supports furnished when the participant is the employer of direct support workers:
	■ Assist participant in verifying support worker citizenship status
	■ Collect and process timesheets of support workers
	■ Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance
	■ Other *(specify):*
	Assist with performing name-based background checks and verify completion of personal support worker individual competency requirements. Collect and process bills for domestic employees and other selected providers.
	Supports furnished when the participant exercises budget authority:
	■ Maintain a separate account for each participant's participant-directed budget
	■ Track and report participant funds, disbursements and the balance of participant funds
	■ Process and pay invoices for goods and services approved in the service plan
	■ Provide participant with periodic reports of expenditures and the status of the participant-directed budget
	☐ Other services and supports *(specify)*:

Additional functions/activities:	
■	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid Agency
■	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid Agency or Operating Agency
■	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
☐	Other *(specify):*

iv.	**Oversight of FMS Entities.** Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.
	The successful bidder must have internal monitoring procedures and processes to ensure contract performance compliance. The State reserves the right to monitor and track vendor performance over the course of the contract. The State and the vendor will jointly develop performance indicators with conditions, milestones, requirements and timetables that must be met before payment is due. The vendor agrees to provide all of the data specified by the State for service payment and claiming purposes. The vendor agrees to cooperate with the State on monitoring and tracking activities which may require the vendor to submit requested progress reports, allow unannounced inspections of its facilities, participate in scheduled meetings and provide management reports as requested by the State. The Operating Agency will review performance on a quarterly basis, at a minimum, and share the results of these reviews with the Quality Management Committee.

j. Information and Assistance in Support of Participant Direction. In addition to Financial Management Services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested *(check each that applies)*:

☐	**Case Management Activity**. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. *Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:*
■	**Waiver Service Coverage**. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: **Service Facilitation**

■	**Administrative Activity**. Information and assistance in support of participant direction are furnished as an administrative activity. *Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:*
	Individual Service and Support Advocates (ISSA) employed by independent entities, under contract with the Operating Agency, are compensated on a fee-for-service basis at a statewide hourly rate. ISSA entities were selected through a request-for-proposal (RFP) process. ISSA staff participates in the development of the participant-centered support plan and approve the final plan, as well as monitor its implementation and the general health and well being of the participant. ISSA entities are surveyed annually by the Operating Agency and are reviewed on a sample basis as part of periodic and targeted quality assurance reviews. A Financial Management Service (FMS) entity, under contract with the Operating Agency and selected through a request for proposal (RFP) process, provides fiscal agent and employer agency services. The FMS entity is compensated on a per member per month basis. The Operating Agency will review the performance of the FMS entity on an annual basis.

k. Independent Advocacy *(select one)*.

○	**Yes.** Independent advocacy is available to participants who direct their services. *Describe the nature of this independent advocacy and how participants may access this advocacy*:
●	**No.** Arrangements have not been made for independent advocacy.

l. Voluntary Termination of Participant Direction. Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

At any time upon request by the participant or guardian if one has been appointed, agency-directed services can be initiated and the participant-directed option can be terminated. Typically 30-day advance written notice is given to the employee, however, this is not mandatory. The participant would select a community agency to provide and direct Waiver services. Any changes are discussed among those responsible for support planning and are documented in the plan. All agreed changes are noted in the participant's support plan, as necessary. The ISSA works with service providers and the Operating Agency as necessary to ensure service continuity and health and welfare during the transition.

m. Involuntary Termination of Participant Direction. Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

If an investigation determines that the participant or guardian, if one has been appointed, has committed fraud regarding participant-directed program funds, the participant may be involuntarily restricted from participant-directed services. This determination by the State is subject to appeal to the Medicaid Agency. The outcome of the appeal process is final. In this event, agency-based services would be made available and documented in the support plan. The ISSA works with service providers and the Operating Agency as necessary to ensure service continuity and health and welfare during the transition.

n. Goals for Participant Direction. In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	**Budget Authority Only or Budget Authority in Combination with Employer Authority**
Waiver Year	**Number of Participants**	**Number of Participants**
Year 1		2,675
Year 2		2,675
Year 3		2,675
Year 4 (renewal only)		2,675
Year 5 (renewal only)		2,675

Appendix E-2: Opportunities for Participant Direction

a. Participant – Employer Authority *(Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)*

i. Participant Employer Status. Specify the participant's employer status under the waiver. *Check each that applies:*

☐	**Participant/Co-Employer**. The participant (or the participant's representative) functions as the co-employer (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. *Specify the types of agencies (a.k.a., "agencies with choice") that serve as co-employers of participant-selected staff:*
■	**Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision-making authority over workers who provide waiver services. *Check the decision-making authorities that participants exercise*:

■	Recruit staff
☐	Refer staff to agency for hiring (co-employer)
☐	Select staff from worker registry
■	Hire staff (common law employer)
■	Verify staff qualifications
■	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Cost of name-based background checks are included in the rate paid to the Financial Management Service entity.
■	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
■	Determine staff duties consistent with the service specifications in Appendix C-3.
■	Determine staff wages and benefits subject to applicable State limits
■	Schedule staff
■	Orient and instruct-staff in duties
■	Supervise staff
■	Evaluate staff performance
■	Verify time worked by staff and approve time sheets
■	Discharge staff (common law employer)
☐	Discharge staff from providing services (co-employer)
☐	Other *(specify)*:

b. Participant – Budget Authority *(Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b)*

i. Participant Decision Making Authority. When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply***:**

■	Reallocate funds among services included in the budget
■	Determine the amount paid for services within the State's established limits
■	Substitute service providers
■	Schedule the provision of services
■	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
■	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
■	Identify service providers and refer for provider enrollment
□	Authorize payment for waiver goods and services
■	Review and approve provider invoices for services rendered
□	Other *(specify):*

ii. Participant-directed Budget. Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

The budget for the home-based supports option is based on the support plan, but may not exceed a maximum set by Illinois statutes as described elsewhere in this document.

The participant-centered support plan specifies the types of and amounts of covered services needed by the participant within the overall cost limits. For some services, statewide rates apply, such as Behavior Intervention and Treatment. For other services, the participant is given the authority, with help from the local Service Facilitator, to negotiate individual rates. The negotiated rates must be specified in the Service Agreements and are subject to review and approval by the Operating Agency on either a targeted or a sample basis. A written Service Agreement is executed between each service provider, the participant and the local Service Facilitator. The Service Agreement defines the terms of the services to be provided including the effective date, the rate of payment, the maximum units of service to be provided each month and the maximum monthly charge. A copy of the Service Agreement is on file with the Financial Management Service entity. Bills submitted in excess of the Service Agreement are rejected for payment. This ensures that the combination of services received is consistent with the support plan and does not exceed the participant's approved monthly service cost limit.

Changes in service delivery must be accompanied by modifications to the individual Service Agreements, consistent with the participant-centered support plan. All changes must be made within the participant's overall monthly service cost limit.

Participants, guardians, local Service Facilitators, Financial Management Service entity and ISSA

staff receive a rate sheet that contains information on the statewide rates and any utilization limits by service type. The rate sheet is updated periodically when rate adjustments are implemented, based on State appropriations.

iii. Informing Participant of Budget Amount. Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

Upon being authorized for Waiver services, the participant or guardian are informed in writing by the Operating Agency and in person by the ISSA about the overall cost limit, participant-directed opportunities, and budget amount authority. Once services have begun, the participant and guardian are notified and kept informed of any adjustments to the overall amount by the Operating Agency, Service Facilitator, and ISSA.

Because the monthly cost limit is set in statute, there are no mechanisms for adjustments to the month limits. The ISSA monitors the health, safety and welfare of the participants and assists in exploring other Waiver service options or services outside the Waiver. In the event services are denied, the participant may request a fair hearing. The participant is informed of this through the consumer guide and ISSA.

iv. Participant Exercise of Budget Flexibility. *Select one:*

●	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
	Participants and guardians may adjust utilization within the monthly allocation without prior review or approval by the State. Adjustments are made, with the assistance of the Service Facilitator, via the use of Service Agreements with providers and by updating the support plan. Changes in services are documented in the support plan and in revised Service Agreements. Changes in Service Agreements must be shared with the Financial Management Service entity and ISSA for monitoring purposes.
○	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

For home-based supports, limits in spending are in place based on the monthly budget. Participants will be encouraged by members of the support planning team to allocate authorized services throughout the month to avoid premature depletion of program funds.

Periodic utilization reviews (at least annually) by the Operating Agency will identify program participants who are consistently underutilizing the program. Local Service Facilitation agencies and Individual Service and Support Advocacy (ISSA) agencies will be contacted to report on the circumstances surrounding underutilization. Quarterly visits by the ISSAs, made to monitor support plan implementation and the participant's general health and well-being, are in place to identify and address issues of concern, including underutilization.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing. Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid Agency.

Notification

The entities responsible for notifying an applicant/participant of adverse actions are:

- Provider agency staff is responsible for informing participants of the right to appeal upon Waiver enrollment. The Operating Agency has developed a standard form, Notice of Individual Right to Appeal (DD-1202) for this purpose. The standard form states: If an appeal request is received within 10 calendar days after receipt of the notice of action, the decision in the notice shall be stayed, pending the results of the appeal.
- Pre-admission screening staff are responsible for written notification when there is:
  - Determination of ineligibility for Waiver services.
  - Denial of choice of Waiver or institutional services.
  - Denial of choice of Waiver services or providers.
- Provider agency staff are responsible for written notification when there is a denial, reduction, suspension or termination of service by that provider.
- Operating Agency staff and Medicaid Agency staff are responsible for written notification when there is an adverse decision in the fair hearing process.

Written notifications contain information on the continuation of services pending the results of the appeal process. Notices of adverse actions and the opportunity to request a fair hearing are maintained by the entity that was responsible for the notifications.

Appeal Process

Participants and guardians, if appointed, are informed by the ISSA of appeal rights when Waiver services are begun, and also upon notice of service denial, suspension, termination or reduction. Appeal rights are also available at any time upon request. 89 Ill. Admin. Code 104 and 59 Ill. Admin Code 120.110 describe the fair hearing request procedures in use for the Adult Developmental Disability Waiver.

If participants receive notice of adverse action, they have ten working days to file an appeal. Once the appeal is filed, the Operating Agency has 30 working days to conduct an informal review of the appealed action. The informal review process can reverse, modify, or leave the action unchanged.

At the conclusion of the informal hearing, the participant and the service provider, if applicable, will be notified in writing of the decision within ten working days. The notice will include clear statements of the action to be taken, the reason for the action, supporting policy references, and the right to appeal the decision to the Medicaid Agency.

The participant has ten working days to appeal the informal review decision to the Medicaid Agency for final administrative action. The request for an appeal to continue existing services will allow those services to continue until the hearing decision is reached or unless the appeal is withdrawn. The Medicaid Agency will appoint an impartial hearing officer to conduct the hearing at the Medicaid Agency or Operating Agency office nearest to the family's home unless all parties agree to an alternate location. The hearing officer may participate by video conference. The Medicaid Agency will notify the participant as well as the Operating Agency. The final administrative decision by the Medicaid Agency may be appealed to the State Circuit Court.

Appendix F-2: Additional Dispute Resolution Process

a. Availability of Additional Dispute Resolution Process. Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one*:

○	**Yes**. The State operates an additional dispute resolution process *(complete Item b)*
●	**No**. This Appendix does not apply (*do not complete Item b)*

b. Description of Additional Dispute Resolution Process. Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid Agency.

Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

●	**Yes.** The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver *(complete the remaining items)*.
○	**No.** This Appendix does not apply (*do not complete the remaining items*)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

The Operating Agency is responsible for the grievance/complaint system.

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

Each participant enrolled in the Waiver meets with ISSA staff a minimum of four times each year, approximately once per quarter.

Participants or their legal representatives may at any time contact ISSA staff to discuss unresolved issues or problems affecting the participant's health and welfare. ISSA staff will work with the responsible QMRP/Service Facilitator to resolve grievances/complaints, particularly those between the participant and service providers. If the grievance continues, ISSA staff will continue the process by involving agency staff of increasing authority, up to and including the executive director of the Service Facilitation or direct service agency. If the grievance cannot be resolved, ISSA staff may contact Operating Agency staff for technical assistance or intervention. Referrals are tracked on a referral database by the Operating Agency.

The referral database includes information on the date the complaint was received by the Operating Agency and dates of follow up actions to resolve the issues. Timeliness of responses is one aspect of follow up that is reviewed by the statewide Quality Management Committee, including both the Operating and Medicaid Agencies.

Both the Waiver manual and the consumer guide contain information that filing a grievance or making a complaint do not affect the participant's appeal rights.

Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

a. State Critical Event or Incident Reporting Requirements. Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

The Abused and Neglected Long Term Care Facilities Reporting Act (210 ILCS 30/6.2) and the Adults with Disabilities Domestic Abuse Intervention Act (20 ILCS 2435) set forth the requirements for prevention of abuse and neglect for Waiver participants, as well as for other individuals. The implementing rules are found at 59 Ill. Adm. Code 50 (for incidents that occur on-site at a developmental disabilities-funded community agency) and 59 Ill. Adm. Code 51 (for incidents that occur in private homes or in non-licensed community homes).

Under both laws, the types of critical incidents that must be reported include any allegation of physical or mental abuse, neglect or financial exploitation committed by anyone against the Waiver participant. Unauthorized use of restraint, seclusion or restrictive interventions is considered abuse and must be reported. Serious injuries that require treatment by a physician or a nurse where abuse or neglect is suspected and medication errors that have an adverse outcome must be reported. Serious injuries that require treatment by a physician or a nurse must be included in a quarterly quality assurance report to the Operating Agency.

Deaths must be reported if the death occurred while the individual was present in an agency program or if the death occurs within 14 days of discharge, transfer or deflection from the agency program. Deaths must be reported within 24 hours from the time the death was first discovered or the reporter was informed of the death (only four hours if abuse or neglect is suspected).

Anyone may make a report under either rule by calling the Operating Agency (DHS) Office of the Inspector General 24-hour hotline (800-843-6154 or 800-447-6404 TTY).

Mandated reporters under Rule 50 (agency sites) include all Medicaid Agency and Operating Agency staff and all community agency employees (including payroll employees, contractual employees, volunteers, and subcontractors). Mandated reporters must report the allegation within four hours of the time it was first discovered by the staff. Mandated reporters must report allegations if they are told about abuse or neglect, if they witness it, or if they suspect it.

b. Participant Training and Education. Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

Participants, and their guardian if one has been appointed, are informed by the responsible QMRP/Service Facilitator and ISSA about protections from abuse, neglect, and exploitation. The information provided includes the process for reporting allegations to the Operating Agency's Office of the Inspector General (OIG). Participants and guardians are informed that anyone who suspects abuse, neglect or exploitation may report an allegation. Information is presented both verbally and in writing, initially and upon request.

c. Responsibility for Review of and Response to Critical Events or Incidents. Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time frames for responding to critical events or incidents, including conducting investigations.

Incidents Reported to the Office of Inspector General

The Operating Agency (DHS) Office of the Inspector General (OIG), which is a semi-independent entity that reports to both the Governor and the Secretary of DHS, investigates alleged abuse, neglect and exploitation of adults with mental, developmental, or physical disabilities in private homes and of adults with mental or developmental disabilities in DHS-funded community agencies.

The Office of Inspector General Adults with Disabilities Abuse Project has statutory authority to respond to allegations related to adults with disabilities between the ages of 18 and 59 who reside in domestic situations. OIG has authority to investigate, take emergency action, work with local law enforcement authorities, obtain financial and medical records, and pursue guardianship. With the participant's consent, substantiated cases are referred to the Operating Agency for development of a support plan to meet identified needs.

When OIG receives an allegation of abuse or neglect regarding an adult at an agency site, OIG bureau chiefs determine whether to conduct an on-site investigation or assign investigation to the agency. OIG may assign primary responsibility for the investigation to an agency only: if the allegation does not involve physical abuse, sexual abuse, or serious neglect; if the agency has an approved investigative protocol that identifies investigators who have been trained by OIG; and OIG determines that the investigators do not have a conflict of interest. OIG may at any time during the course of an investigation decide to take over primary responsibility for the investigation. OIG also reviews each agency investigation and either approves it or returns it to the agency for additional work.

Actions taken regarding allegations will be in compliance with Illinois statutes 405 ILCS 5/3-210, Employee as Perpetrator of Abuse, and 405 ILCS 5/3-211, Resident as Perpetrator of Abuse.

Investigations must be completed and reports submitted to the Inspector General within 60 days from assignment unless there are extenuating circumstances such as the unavailability of witnesses or official documents. Upon receipt of an investigative report, the Inspector General determines whether to accept the findings or require additional documentation or further investigation.

Within 10 calendar days of receiving a complete and acceptable investigative report involving a Waiver participant, the Inspector General is required to notify in writing the complainant, the

individual who was allegedly abused or neglected or his or her legal representative, and the person alleged to have committed the offense.

Within 10 calendar days of receiving a complete and acceptable investigative report involving a Waiver participant, the Inspector General is required to send the report to:

- Equip for Equality, the protection and advocacy organization
- Illinois Guardianship and Advocacy Commission
- If abuse or neglect is substantiated or administrative action is recommended, to the Secretary, developmental disabilities division and licensure bureau of the Operating Agency.

The Waiver provider agency is required to inform the victim and the legal representative whether the reported allegation was substantiated, unsubstantiated or unfounded. If the authorized representative or designee is unable to reach the guardian by phone, a letter of notification must be sent within 24 hours of receiving notice of the finding.

If the investigation substantiates abuse or neglect, meaning a preponderance of the evidence supports that abuse or neglect did occur, the provider is required to submit a Written Response within 30 days for approval to the Operating Agency indicating what actions will be taken to address the issues identified. A copy of the investigative report and the Written Response is forwarded to the Operating Agency for review and follow-up. OIG monitors the timeliness and implementation of the corrective actions set forth in the Written Response. If a finding is substantiated, the perpetrator's name is placed on the Illinois Department of Public Health, Health Care Workers' Registry (formerly known as the Nurse Aide Registry).

Other Incidents Reported to the Operating Agency (DHS)

Quarterly, Community-Integrated Living Arrangements (CILA) providers are required to report all medication errors to the Operating Agency. CILA and day program providers are required to report serious injuries to the Operating Agency quarterly. Reports are analyzed for patterns and trends and are shared with the Quality Management Committee.

Any medication error that results in an adverse outcome is reported to the Operating Agency with seven working days. All reports are reviewed, coordinated with OIG investigation, and followed up as necessary to ensure that adequate safeguards are in place to prevent future occurrences.

d. Responsibility for Oversight of Critical Incidents and Events. Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

Both the Medicaid Agency and the Operating Agency work together through the Quality Management Committee to ensure appropriate oversight of critical incidents and events. The Operating Agency maintains a tracking database of reported incidents and follow-up activities. A report is produced quarterly and is shared with the Quality Management Committee. Other summary data and analytical reports are reviewed and discussed. The Quality Management Committee meets quarterly.

Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

This Appendix must be completed when the use of restraints and/or restrictive interventions is permitted during the course of the provision of waiver services regardless of setting. When a state prohibits the use of restraints and/or restrictive interventions during the provision of waiver services, this Appendix does not need to be completed except for Item G-2-c-ii.

a. Applicability. *Select one:*

○	This Appendix is not applicable. The State does not permit or prohibits the use of restraints or restrictive interventions *(complete only Item G-2-c-ii)*	
●	This Appendix applies. Check each that applies:	
	■	The use of personal restraints, drugs used as restraints, mechanical restraints and/or seclusion is permitted subject to State safeguards concerning their use. *Complete item G-2-b.*
	■	Services furnished to waiver participants may include the use of restrictive interventions subject to State safeguards concerning their use. *Complete item G-2-c.*

b. Safeguards Concerning Use of Restraints or Seclusion

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

In addition to the safeguards outlined for use of restrictive interventions below, the State has the following additional safeguards specific to the use of restraints.

The Mental Health and Developmental Disabilities Code (405 ILCS 5/2-108) contains the following requirements governing the use of restraints. Restraint may be used only as a therapeutic measure to prevent a participant from causing physical harm to himself or physical abuse to others. Restraint may only be applied by a person who has been trained in the application of the particular type of restraint to be utilized. In no event shall restraint be utilized to punish or discipline a participant, nor is restraint to be used as a convenience for the staff.

Except for emergencies, restraint may be employed only upon the written order of a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities. No restraint shall be ordered unless the physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities, after personally observing and examining the participant, is clinically satisfied that the use of restraint is justified to prevent the participant from causing physical harm to himself or others. In no event may restraint continue for longer than two hours unless within that time period a nurse with supervisory responsibilities or a physician confirms, in writing, following a personal examination of the participant, that the restraint does not pose an undue risk to the participant's health in light of the participant's physical or medical condition. The order shall state the events leading up to the need for restraint and the purposes for which restraint is employed. The order shall also state the length of time restraint is to be employed and the clinical justification for that length of time. No order for restraint shall be valid for more than sixteen hours. If further restraint is required, a new order must be obtained.

In the event there is an emergency requiring the immediate use of restraint, it may be ordered temporarily by a qualified person only where a physician, clinical psychologist, clinical social worker, or registered nurse with supervisory responsibilities is not immediately available. In that event, an order by a nurse, clinical psychologist, clinical social worker, or physician must be obtained as quickly as possible, and the participant must be examined by a physician or supervisory nurse within two hours after the initial employment of the emergency restraint. Whoever orders restraint in emergency situations must document its necessity and place that documentation in the participant's record.

Emergencies are situations when restraints are necessary to prevent the individual from causing physical harm to self or others and appropriate authorizing personnel are not immediately available. Emergencies, as all use of restraints, are reviewed by personnel who may authorize use of restraints, the executive director and the Human Rights Committee to ensure the appropriateness of the use of restraint in the emergency situation.

The person who orders restraint must inform the provider's executive director or his/her designee in writing of the use of restraint within 24 hours.

The executive director must review all restraint orders daily and must inquire into the reasons for the orders for restraint by any person who routinely orders them.

Restraint may be employed during all or part of one 24-hour period, the period commencing with the initial application of the restraint. However, once restraint has been employed during one 24-hour period, it may not be used again on the same participant during the next 48 hours without the prior written authorization of the executive director.

Restraint must be employed in a humane and therapeutic manner and the person being restrained must be observed by a qualified person as often as is clinically appropriate but in no event less than once every fifteen minutes. The qualified person must maintain a record of the observations. Specifically, unless there is an immediate danger that the participant will physically harm himself or others, restraint shall be loosely applied to permit freedom of movement. Further, the participant must be permitted to have regular meals and toilet privileges free from the restraint, except when freedom of action may result in physical harm to the participant or others.

Every provider agency that employs restraint must provide training in the safe and humane application of each type of restraint employed. The agency may not authorize the use of any type of restraint by an employee who has not received training in the safe and humane application of that type of restraint. Each agency in which restraint is used must maintain records detailing which employees have been trained and are authorized to apply restraint, the date of the training and the type of restraint that the employee was trained to use.

Whenever restraint is imposed upon any participant whose primary mode of communication is sign language, the participant must be permitted to have his hands free from restraint for brief periods each hour, except when freedom may result in physical harm to the participant or others.

Whenever restraint is used, the participant must be advised of his right to have any person of his choosing, including the Guardianship and Advocacy Commission or the agency designated

pursuant to the Protection and Advocacy for Developmentally Disabled Persons Act notified of the restraint. A participant who is under guardianship may request that any person of his choosing be notified of the restraint whether or not the guardian approves of the notice.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

In addition to routine monitoring by the responsible QMRP/Service Facilitator and the safeguards for restrictive interventions (which include any use of restraints) outlined in Appendix G-2-c-i below, the Individual Service and Support Advocacy (ISSA) provider, an independent entity under contract with the Operating Agency, continually (at least quarterly or more often if necessary) monitors the implementation of the support plan, including the prohibition of restrictive interventions, and works with the service providers, participant, and family to resolve any concerns. Both the QMRP/Service Facilitator and the ISSA are mandated reporters of abuse or neglect, including appropriate or inappropriate use of restraints.

As a component of annual surveys for agency compliance with provider standards, the Operating Agency monitors for:

- Any restriction of individual rights as contained in the Mental Health and Developmental Disabilities Code.
- The required agency process for the periodic review of behavior intervention and human rights issues.

The Operating Agency conducts on-site quality assurance reviews that include a review of any use of restrictive interventions to ensure that requirements in the State's Mental Health and Developmental Disabilities Code, outlined above, have been met.

Both the Medicaid Agency and the Operating Agency work together through the Quality Management Committee to ensure appropriate oversight of restraints. The oversight includes analysis of summary reports to identify trends and patterns. The Quality Management Committee may recommend additional focused reviews by the Operating Agency as necessary to ensure compliance with these requirements, or may develop other strategies or policy clarifications as necessary for improvement.

c. Safeguards Concerning the Use of Restrictive Interventions

i. Safeguards Concerning the Use of Restrictive Interventions. Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid Agency or the Operating Agency.

The Mental Health and Developmental Disabilities Code (405 ILCS 5) prohibits providers from using any of the following interventions:

- Seclusion (time-out in a locked room)

- Withholding food and/or drink
- Electric shock stimuli
- Punishment or discipline

Support Planning Team Approval

Any restrictive interventions employed must be included in the participant's support plan and be approved as documented by signature of the waiver participant, guardian if one has been appointed, the responsible Qualified Mental Retardation Professional (QMRP)/Service Facilitator, the independent Individual Service and Support Advocate (ISSA), and other members of the support planning team. This planning process must include prior attempts to use less restrictive or positive interventions and reasons for the necessary use of the restrictive interventions to be included in the plan, as well as the circumstances in which the interventions may be implemented. Staff are trained to recognize these circumstances and to implement the interventions consistently and correctly. The responsible QMRP/Service Facilitator must review the implementation of the plan, including the effectiveness and continuing need for restrictive interventions, at least every two months.

Human Rights Committee Approval

Provider agencies are required to establish and maintain a human rights committee that is responsible for reviewing and approving any restriction of a participant's rights, whether general rights or specific to behavior management. The committee must have at least five members and is comprised of persons served, guardians or family members of persons served, interested citizens with no conflict of interest, and providers. No more than half of the members of the committee may be employed by the agency, at least one-third of the members must be otherwise unassociated with the agency, and a least one of the members must be a person receiving services from the agency.

The agency must inform the committee of all complaints involving individual rights, including alleged violations and corrective actions. Restrictive interventions used in emergency situations must be reported to the human rights committee immediately.

The committee must review use of psychotropic medications, any medication used to manage behaviors, and any restrictive interventions used to manage behavior issues or to treat diagnosed mental illness. For medications and other restrictive interventions to manage behavior, this review must occur as needed but at least annually.

The committee must maintain minutes, including attendance and decisions made. The committee must ensure that these requirements are met and must report to the agency each instance in which the committee determines that any requirement has not been met.

The agency is required to immediately correct any instance of noncompliance reported by the committee.

Behavior Management Committee Approval

Should an agency choose to do so, it may establish a separate behavior management committee, which reports to the human rights committee, to review the use of psychotropic

medications, any medication used to manage behaviors, and any restrictive interventions used to manage behavior issues or to treat diagnosed mental illness. Membership of the behavior management committee must include persons qualified by training and experience to evaluate published behavior management studies and the technical adequacy of proposed behavior management interventions. When medications to manage behavior issues are used, a professional qualified to evaluate their use must be a member of the committee.

ii. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

In addition to routine monitoring by the responsible QMRP/Service Facilitator and the other safeguards for restrictive interventions, the Individual Service and Support Advocacy (ISSA) provider, an independent entity under contract with the Operating Agency, continually (at least quarterly or more often if necessary) monitors the implementation of the support plan, including the prohibition of restrictive interventions and works with the service providers, participant and family to resolve any concerns. Both the QMRP/Service Facilitator and the ISSA are mandated reporters of abuse or neglect, including appropriate or inappropriate use of restrictive interventions.

As a component of annual surveys for agency compliance with provider standards, the Operating Agency monitors for:

- Any restriction of individual rights as contained in the Mental Health and Developmental Disabilities Code.
- The required agency process for the periodic review of behavior intervention and human rights issues

The Operating Agency conducts on-site quality assurance reviews that include a review of any use of restrictive interventions to ensure that requirements in rules and contracts have been met.

Both the Medicaid Agency and Operating Agency work together through the Quality Management Committee to ensure appropriate oversight of restrictive interventions. This oversight includes analysis of summary reports to identify trends and patterns. The Quality Management Committee may recommend additional focused reviews by the Operating Agency as necessary to ensure compliance with these requirements or may develop other strategies or policy clarifications as necessary for improvement.

Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

●	**Yes**. This Appendix applies *(complete the remaining items)*.
○	**No**. This Appendix is not applicable *(do not complete the remaining items)*.

b. Medication Management and Follow-Up

i. Responsibility. Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Residential providers must have a registered professional nurse, advanced practice nurse, physician licensed to practice medicine in all of its branches, or physician assistant on duty or on call at all times. At least quarterly this professional reviews medication orders, medication labels and medication administration records to ensure that medication labels, and medications administered match those ordered. A part of this review may include review of the appropriateness and effectiveness of medications.

For participants receiving psychotropic medications, a screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, is completed at least every six months by employees trained in performing this type of assessment.

Use of medications to modify or control behaviors is considered to be a restrictive intervention. As such, it is also subject to the provider requirements for oversight by a properly constituted human rights committee as described in G-2.

ii. Methods of State Oversight and Follow-Up. Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

The Operating Agency is responsible for oversight and follow-up of medication management issues. These issues are reviewed during annual quality assurance site reviews of a sample of waiver residential providers by registered nurses and in annual desk reviews of psychotropic medications for participants whose medications are funded by Medicaid. Participant-specific issues are followed up as part of the review process.

Potentially harmful systemic medication management practices that are identified in the course of these reviews are brought to the Quality Management Committee, which includes the Medicaid Agency and meets quarterly, for discussion of appropriate systemic follow-up action.

c. Medication Administration by Waiver Providers

i. Provider Administration of Medications. *Select one*:

●	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. *(complete the remaining items)*
○	Not applicable (*do not complete the remaining items*)

ii. State Policy. Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

General Requirements

When medications are provided or employees of a waiver residential services provider supervise their administration, the provider must ensure that such medications are provided and their administration is supervised in accordance with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65). Waiver residential service providers may allow non-licensed direct support persons to administer medications as long as the provider complies with the Administration of Medication in Community Settings rule (59 Ill. Adm. Code 116). Day program providers may not allow non-licensed direct support persons to administer medications.

Waiver residential providers have ongoing responsibility for monitoring participant medication regimens and ensuring compliance with the Illinois Nursing and Advanced Practice Nursing Act (225 ILSC 65) and its implementing rule (59 Ill. Adm. Code 116). Providers must maintain and implement written policies and procedures that include provisions describing on-going supervision and monitoring of direct support staff who are authorized to administer medications, annual review and any necessary retraining of authorized direct support staff in the theory and practice of medication administration, a systematic review of all medication errors, adverse drug reactions, and incidents to identify contributing factors and plan corrective action, recording and reporting of all instances of retraining and retesting for failure to qualify as an authorized direct support staff.

Rule 116 permits a registered nurse who has successfully completed the Operating Agency/DHS-approved nurse-trainer course for medication administration in the community (6 hours) to authorize direct support personnel to administer medication in residential sites. Authorized direct support personnel must be at least eighteen, have completed high school or G.E.D., demonstrate functional literacy, and have successfully completed required competency-based training and assessment by the nurse-trainer. Training includes specifics related to the participant, medication, dosages, etc. Direct support personnel are authorized to administer only those specific medications to specific participants for which they have successfully completed training and competency evaluations. Authorized direct support personnel are re-evaluated by a nurse-trainer at least annually to ensure competency to administer each medication to each participant.

The waiver residential provider must ensure and document the following:

- A physician must be responsible for the medical services provided to participants, and the management of participants' medications.
- Only a competent medical professional, that is, a physician licensed pursuant to the Medical Practice Act, advanced practice nurse licensed pursuant to the Nursing and Advanced Practice Nursing Act, and physician's assistant licensed pursuant to Physician Assistant's Practice Act, may prescribe and monitor all prescription medications.
- All medications, including patent or proprietary medication, e.g., cathartics, headache remedies, or vitamins, may be given only upon the written order of a competent medical professional. Rubber stamp signatures are not acceptable. All orders must be given as prescribed by the competent medical professional and at the designated time. A registered professional nurse or licensed practical nurse may take telephone orders. All orders must be immediately signed by the nurse taking the order and placed in the participant's record. These orders must be countersigned or documented by facsimile prescription by the competent medical professional within ten working days.

- An individual medication administration record (MAR) must be kept for each participant for medication administered. It must contain at least the following:
  -- the participant's name;
  -- the name and dosage form of the drug;
  -- the name of the prescribing physician, physician assistant, advanced practice nurse, dentist, podiatrist, or certified optometrist;
  -- dose;
  -- frequency or times of administration;
  -- route of administration;
  -- date and time given;
  -- most recent date of the order;
  -- allergies to medication; and
  -- special considerations.

  The MAR for the current month must be kept with the medications or in participant's record. The MAR must be completed and initialed immediately after the medication is administered. Each MAR must have a section that contains the full signature and title of each person who initials it. All changes in medication must be noted on the MAR by a nurse, physician, physician assistant, dentist, podiatrist, or certified optometrist and shared with administering staff prior to the next dose. Participant refusal to take medication must be noted on the MAR and in the individual record.
- For waiver participants who are independently self-administering medications, no MAR is required; however, the provider must track and document that the medications are being taken by the participant.
- A physician must provide the written order for a waiver participant to self-administer medications or participate in a self-administration of medication training program based on the results of the participant's evaluation. The order must become part of the individual record.
- Medication training programs must be implemented and carried out only by a registered professional nurse or a licensed practical nurse under the supervision of a registered nurse and may not be carried out by direct support staff or other unauthorized personnel.
- A competent medical professional must perform an examination of the participant prior to the initiation of psychotropic medications or any medications to manage behavior.
- Screening for and documentation of abnormal involuntary movements, including tardive dyskinesia, in participants receiving prescribed psychotropics for which this is indicated as a possible side effect, must be completed at least every six months by employees trained in performing this type of assessment.
- A competent medical professional must review the medications prescribed and must see the participant at least annually, and every three months if psychotropic medications, or any medications to manage behavior, have been prescribed. Physician documentation within the individual record must include, but is not limited to, the rationale for continuing current medications at current levels and/or initiating new medications; and medication side effects.
- A competent medical professional must evaluate the ability of the participant to self-administer medications. Ability to self-administer medication must be reassessed at least annually. Participants must be evaluated using Department approved screening and assessment tools, in accordance with 59 Ill. Adm. Code 116.

- A psychiatrist must review psychotropic medications as needed, but at least quarterly, and be available for consultation when psychotropic medications have been prescribed.
- When agencies supervise the self-administration of medication training programs or administer the medications, medications must be secured from unauthorized access and only a physician, pharmacist, registered or licensed practical nurse or agency employee authorized to supervise the self-administration of medication training program or administer medications may have access to medications. A physician, pharmacist or registered professional nurse must be available at all times to consult with trained, unlicensed direct support employees administering medications or supervising a self-administration of medications training program for persons with developmental disabilities.
- The qualified mental retardation professional must ensure employees, guardians, and waiver participants have information on expected consequences, potential benefits, and side effects of any prescribed medication.
- All medications must be labeled.
- Participants who are able to self-administer medications independently must have access to their medications.
- Medications must be stored safely and at appropriate temperatures.
- Informed consent must be obtained from the participant or guardian for all medical services and medications arranged by the provider.

iii. Medication Error Reporting. *Select one of the following:*

●	Providers that are responsible for medication administration are required to *both* record and report medication errors to a State agency (or agencies). *Complete the following three items:*
	(a) Specify State agency (or agencies) to which errors are reported:
	Waiver residential providers must report all medication errors to the Operating Agency, the Department of Human Services. Medication errors resulting in an adverse reaction are reported to the Office of Inspector General (OIG).
	(b) Specify the types of medication errors that providers are required to *record:*
	Waiver residential providers are required to record all medication errors.
	(c) Specify the types of medication errors that providers must *report* to the State:
	Waiver residential providers are required to report all medication errors quarterly in a summary report format. Any medication error that results in an adverse outcome is to be reported to both OIG and the Operating Agency. The waiver residential provider must report these types of errors to OIG within four hours and to the Operating Agency within 7 working days.

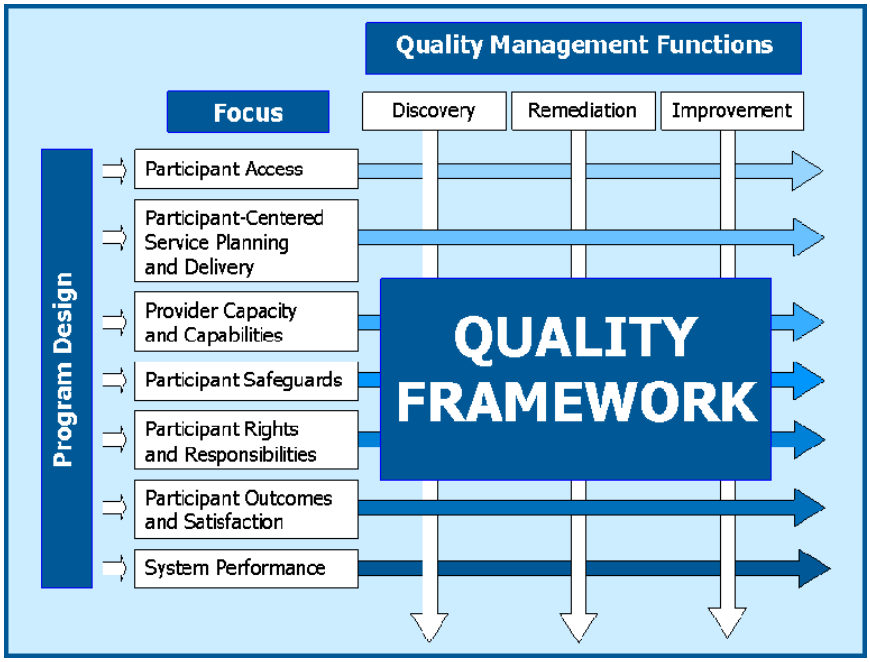
○	Providers responsible for medication administration are required to *record* medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The Operating Agency is responsible for oversight and follow-up of medication administration issues. These issues are reviewed as part of residential licensure surveys that occur at least every three years and during annual quality assurance site reviews of a sample of waiver residential providers by registered nurses. Participant-specific issues are followed up as part of the review process.

Potentially harmful systemic medication management practices that are identified in the course of these reviews are brought to the Quality Management Committee, which includes the Medicaid Agency and meets quarterly, for discussion of appropriate systemic follow-up action.

Appendix H: Quality Management Strategy



Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement. A Quality Management Strategy is explicitly describes the processes of discovery, remediation and improvement; the frequency of those processes; the source and types of information gathered, analyzed and utilized to measure performance; and key roles and responsibilities for managing quality.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

Quality management is dynamic and the Quality Management Strategy may, and probably will, change over time. Modifications or updates to the Quality Management Strategy shall be submitted to CMS in conjunction with the annual report required under the provisions of 42 CFR §441.302(h) and at the time of waiver renewal.

Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is included as Attachment #1 to Appendix H. The Quality Management Strategy should be no more than ten-pages in length. It may reference other documents that provide additional supporting information about specific elements of the Quality Management Strategy. Other documents that are cited must be available to CMS upon request through the Medicaid Agency or the Operating Agency (if appropriate).

1. **The Quality Management Strategy must describe how the state will determine that each waiver assurance and requirement is met.** The applicable assurances and requirements are: (a) level of care determination; (b) service plan; (c) qualified providers; (d) health and welfare; (e) administrative authority; and, (f) financial accountability. For each waiver assurance, this description must include:
   - Activities or processes related to discovery, i.e. monitoring and recording the findings. Descriptions of monitoring/oversight activities that occur at the individual and provider level of service delivery are provided in the application in Appendices A, B, C, D, G, and I. These monitoring activities provide a foundation for Quality Management by generating information that can be aggregated and analyzed to measure the overall system performance. The description of the Quality Management Strategy should not repeat the descriptions that are addressed in other parts of the waiver application;
   - The entities or individuals responsible for conducting the discovery/monitoring processes;
   - The types of information used to measure performance; and,
   - The frequency with which performance is measured.
2. **The Quality Management Strategy must describe roles and responsibilities of the parties involved in measuring performance and making improvements. Such parties include (but are not limited to) the waiver administrative entities identified in Appendix A, waiver participants, advocates, and service providers.**

   Roles and responsibilities may be described comprehensively; it is not necessary to describe roles and responsibilities assurance by assurance. This description of roles and responsibilities may be combined with the description of the processes employed to review findings, establish priorities and develop strategies for remediation and improvement as specified in #3 below.
3. **Quality Management Strategy must describe the processes employed to review findings from its discovery activities, to establish priorities and to develop strategies for remediation and improvement.** *The description of these process(es) employed to review findings, establish priorities and develop strategies for remediation and improvement may be combined with the description of roles and responsibilities as specified in # 2 above.*
4. **The Quality Management Strategy must describe how the State compiles quality management information and the frequency with which the State communicates this information (in report or other forms) to waiver participants, families, waiver service providers, other interested parties, and the public.** *Quality management reports may be designed to focus on specific areas of concern; may be related to a specific location, type of service or subgroup of participants; may be designed as administrative management reports; and/or may be developed to inform stakeholders and the public.*
5. **The Quality Management Strategy must include periodic evaluation of and revision to the Quality Management Strategy. Include a description of the process and frequency for evaluating and updating the Quality Management Strategy**.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the Medicaid State Plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State Plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy.

Attachment #1 to Appendix H

The Quality Management Strategy for the Waiver is:

Waiver for Adults with Developmental Disabilities Quality Management Strategy Overview:

Illinois has a quality management strategy based on the federal assurances in the waiver. Key to the quality management design is the elements of discovery, remediation and systems improvement. The Medicaid Agency and the Operating Agency meet quarterly, for scheduled Quality Management Committee meetings, to discuss waiver oversight and monitoring, including measuring system performance and making system improvements. Participants in this meeting include Healthcare and Family Services (HFS) program and fiscal staff (the Medicaid Agency), and Department of Human Services (the Operating Agency) program and fiscal staff , the Office of Inspector General (OIG), and other key staff.

Discovery activities are described under each federal assurance listed below. State staff conducts discovery activities and review discovery information on an ongoing basis. Discovery information is reviewed and discussed with the waiver providers at the time of discovery. Findings are documented in a written report or entered into a database, for further review and analysis. This information is assimilated and reviewed by both the Operating and Medicaid Agencies. Findings are prioritized for remediation and improvement. This occurs informally through discussion when issues are identified and more formally through interagency meetings including the quarterly Quality Management Committee meetings. As the State moves toward enhancing the overall quality management system, we will be able to better assess the effectiveness of the current quality management system and make revisions as indicated.

The front line of the quality assurance system is the ISSAs. They visit each person quarterly to check on their general health and well-being. The ISSAs use a standard tool and protocol that includes such areas as physical environment, individual rights, health, service plan implementation and behavioral supports. A sample of the completed tools for each ISSA is reviewed on an annual basis by the Operating Agency. The ISSAs must be independent of any direct care providers and are charged with identifying issues and initiating problem resolution as needed. In the event issues cannot be resolved at the local level, the ISSA must refer the situation to the Operating Agency. The ISSAs are provided with a standardized form for these referrals. The Operating Agency tracks such reports and follow up activity in a central referral database. Summary and analytical reports are completed and reviewed by the State's Quality Management Committee for trend identification and system improvement. The Medicaid Agency actively participates in this committee and its reviews and recommendations. Additional information on the complaint referral process is included in Appendix G. Additional information regarding the Medicaid Agency is provided in #5 below.

The Adult DD Waiver quality management plan is part of an overall quality management plan for the three 1915 C) HCBS waivers operated by the DHS, Division of Developmental Disabilities. The other waivers include the newly developed children's support and residential waivers.

Compliance with Federal Assurances:

The state's processes for discovery, remediation, and system improvement are discussed following each federal assurance category below.

1. Level of Care (LOC) Determination

LOC Process and Activities Related To Discovery:

The 18 local independent screening agencies, under contract with the Operating Agency, interview and enroll individuals potentially in need of waiver services in the Prioritization of Urgency of Need for Service (PUNS) database as the first step of the Level of Care (LOC) determination process. As appropriations are available, individuals are selected from PUNS for authorization for waiver services via an automated process that focuses on the individual's needs and the family's circumstances. The independent entities, known as Independent Service Coordination (ISC) agencies, then complete the LOC determinations.

LOC determinations are completed in accordance with the State's pre-admission screening (PAS) manual for developmental disability services, which is used for applications for HCBS waiver, ICF/MR, and nursing facility services. The independent pre-admission screening entities, that also employ the ISSAs, all use the same standard, statewide process.

The results of the LOC determinations are recorded on the Determination of Developmental Disability & Associated Treatment Needs (DDPAS-5) form. This form and supporting documentation are maintained by the contracted entities.

The Individual Service and Support Advocates (ISSA) who are Qualified Mental Retardation Professionals (QMRPs) employed by the same independent screening agencies conduct the redeterminations for eligibility at least annually.

Methods used to determine compliance, remediate issues, and make system-wide changes include:

- The Operating Agency reviews all authorization requests for waiver services to ensure that the applicant has been accurately determined eligible for an ICFMR level of care by the independent entities. During the initial process, QMRPs and other clinical staff, for example a physician, clinical psychologist, or nurse employed by the Operating Agency, provide further review of the LOC determinations, as needed.

- The ISC entities are surveyed annually by the Operating Agency for contract compliance. For these reviews, a stratified sample of individual records is drawn from each of the contracted entities. Surveyors record their findings on a standard tool. The data collected for each of the contracted entities is compiled and summarized via an electronic report.

- State staff reviews LOC determinations for eligibility and timeliness of annual redeterminations during routine onsite monitoring activities.

- State staff reviews system performance at least annually through an analysis of progress or regression in the scope of overall findings and of findings by agency. This typically occurs as part of the annual 372-report process and during routine Quality Management Committee meetings.

When issues are found during the discovery processes, the following occurs:

- The State's Quality Management Committee reviews summary reports of survey findings and recommends corrective action. Corrective action can include training or technical assistance provided to ISC agencies.

2. Service Plan

Plan of Care Process and Activities Related To Discovery:

The team meets at least annually to develop and update the plan of care, which is based on a relevant and timely assessment of participant needs and preferences. QMRPs facilitate the team planning process. In addition to the QMRP, who is either the Service Facilitator or the lead QMRP for the residential or day program provider, the team includes the participant being served, the participant's guardian (if applicable), the Individual Service and Support Advocate (ISSA), direct service provider representatives, and any other persons important to the participant.

The ISSA serving the individual reviews the support plan on a quarterly basis to ensure that the plan is being fully implemented and is meeting the participant's needs.

Methods used to determine compliance, remediate issues, and make system-wide changes include:

- Annually the Operating Agency ensures individual support plans are based on adequate assessments, address the participant's needs and are completed on a timely basis. During the course of these reviews, a sample of support plans is pulled from each provider of ISSA services, as well as the Service Facilitators and Residential Providers. In addition, all new residential habilitation providers must have all service plans reviewed and approved by Operating Agency staff during the first year of operation.

- When support plan inadequacies are found, the Operating Agency takes remedial actions, which include notification of deficiencies and, a plan of correction, if warranted. Systemic actions may include policy or rule changes, clarifications, technical assistance and training.

- The ISSAs refer individual issues that cannot be resolved locally to the Operating Agency for technical assistance and follow-up actions as necessary.

- The Operating Agency maintains a database to track referrals and follow-up actions.

- On the cases sampled for review as part of routine monitoring, the Medicaid Agency reviews service plans.

- The State's Quality Management Committee reviews summary reports regarding the monitoring of support plans for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

Choice:

Plan of Care Process (Choice) and Activities Related To Discovery:

- Local contracted entities are responsible for offering choices and documenting decisions.

During the level of care determination process, QMRPs employed by the Operating Agency's local contracted entities inform participants and/or their legal guardians about their service options. (See Appendix B-7: Freedom of Choice.)

- The QMRPs employed by the local contracted entities ensure informed choice upon initial enrollment in the waiver and annually thereafter.

- The same local contracted entities, as part of their ISSA role, participate in support plan development and review, ensure that participants and guardians are aware of their ongoing options to change waiver services or providers.

The State forms that document choice are:

- The Choice of Supports and Services (DD-1238) form documents the decision to choose Waiver services as an alternative to ICF/MR services.

- The Presentation and Selection of Service Options (DDPAS-10) form documents initial choice of services and providers.

- The Support plan documents ongoing choices.

Methods used to determine compliance, remediate issues, and make system-wide changes include:

- DHS reviews informed choice as a component of the annual review of the local contracted entities for compliance with the contractual agreements.

- On the cases sampled for review as part of routine monitoring, the Medicaid Agency reviews that participants were given informed choice of Waiver services and service providers.

When issues are found during discovery, the following occurs:

- Summary reports regarding support plans are reviewed by the Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

3. Qualified Providers

Provider Qualifications Process and Activities Related To Discovery:

All waiver providers must, at a minimum, enter into a Medicaid waiver provider agreement and be screened against the federal Health and Human Services excluded provider database. Additionally, depending on provider type, other requirements apply. These are identified below.

Licensed Providers:

The Operating Agency will check all professional licensure or registration status for licensed professionals upon waiver enrollment. The State's Department of Financial and Professional Regulation (DFPR) licenses or registers Speech/Language Pathologists, Occupational Therapists, Physical Therapists, Clinical Psychologists, Clinical Social Workers, Marriage/Family Therapists, Clinical Professional Counselors, Professional Counselors, Registered Nurses, Practical Nurses and Dieticians.

The Medicaid Agency will work with DFPR to assure that all licensed professionals are included in the database match between DFPR and the Medicaid Management Information System (MMIS) provider database. The database match is transmitted monthly between the Medicaid Agency and DFPR to verify provider licensure status. If the match finds that the licensure or registration has expired, the provider is disenrolled and the participant is assisted to find other service providers.

Non-licensed Providers:

The State will monitor non-licensed and approved providers such as personal support workers and behavior analysts through targeted desk reviews and on-site visits.

The Operating Agency has specific training criteria for direct support workers who work for community agencies and on-going continuing education requirements for Qualified Mental Retardation Professionals for the current adult with developmental disabilities Waiver. Direct support workers are trained via a protocol developed by the State or via one that is approved by the State as comparable.

Methods used to determine compliance, remediate issues, and make system-wide changes include:

- The Operating Agency monitors direct support training and continuing education requirements on a sample basis.

- The Financial Management Services entity under contract with the Operating Agency or Operating Agency staff verifies that non-licensed/non-certified providers are qualified and have required background checks upon waiver enrollment. Entities that do not meet requirements are not enrolled.

  Documentation of provider qualifications is a component of the Operating Agency review of the Financial Management Services entity for compliance with contractual requirements.

- On the cases sampled for review as part of routine monitoring, the Medicaid Agency reviews provider qualifications and training.

- Summary reports of provider qualification reviews are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

4. Health and Welfare

Health and Safety Oversight Processes and Activities Related To Discovery:

There is an array of different processes in place to identify, address, and seek to prevent abuse, neglect, and exploitation of waiver participants. A brief description of each follows:

- The Office of Inspector General investigates allegations of abuse and neglect for participants age 18 to 21 years of age. Periodically the State's Auditor General reviews the Office of Inspector General.

- The Operating Agency's contract for community providers requires initial and bi-annual (every

two years) training for all staff on the reporting of allegations of abuse and neglect. This practice ensures that staff will be sufficiently trained as changes are made to the statutes regarding reporting requirements.

- ISSAs are assigned to participants to assist with follow up and to ensure the participant is safe from harm and that an adequate plan of care is in place.

- The Operating Agency reviews Service Facilitation and ISSA providers and verifies that staff has been adequately trained in the reporting of allegations of abuse, neglect and exploitation to the appropriate authority.

Methods used to determine compliance, remediate issues, and make system-wide changes include:

- The Operating and Medicaid Agencies participate in interagency meetings with the DHS Office of Inspector General at least quarterly, to discuss findings, issues, and system improvement regarding abuse and neglect investigations and findings.

- The Operating Agency's follow-up activity from OIG substantiated cases and recommendations are documented in the Referral Tracking System (RTS). Quarterly reports are produced from this database and reviewed by management staff within the Operating Agency. The reports are shared with the Medicaid Agency.
- On the cases sampled for review as part of routine monitoring, the Medicaid Agency reviews participants' health and welfare.

- Summary reports of health and welfare findings are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

On an ongoing basis the state identifies, addresses, and seeks to prevent abuse, neglect, and exploitation.

- ISSAs continuously monitor the waiver participant's health, safety and welfare during their required quarterly visits, or more often as needed. The ISSAs refer individual issues that cannot be resolved locally to the Operating Agency for technical assistance and follow-up actions as necessary. The Operating Agency maintains a database to track referrals and follow-up action.

- The Operating Agency reviews Service Facilitation and ISSA providers and verifies that staff has been adequately trained in the reporting of allegations of abuse, neglect and exploitation to the appropriate authority.

- The State will require background checks and abuse/neglect training for personal support workers hired by participants. This requirement will be monitored by the Financial Management Services (FMS) vendor. The Operating Agency will monitor the FMS provider for compliance with these checks.

- The Operating Agency issues written communications on health and safety policies and procedures.

- The Operating Agency provides training on issues where trends and patterns appear to be systemic.

- Summary reports of health and welfare findings are reviewed by the State's Quality Management Committee for identification of concerns, patterns and trends and for development of suggestions for improvements. Selected reports are shared with the Statewide Advisory Council.

5. Administrative Authority

Medicaid Agency Oversight

The Medicaid Agency, as the single state Medicaid agency, has an interagency agreement with the Operating Agency. The agreement covers the Waiver for adults with developmental disabilities. The agreement will be reviewed annually during routine Quality Management Committee meetings. The Medicaid Agency maintains administrative oversight of the HCBS waivers including program and fiscal monitoring.

Medicaid Agency Roles and Responsibilities

The Medicaid Agency works closely with the Operating Agency through an interagency agreement. Activities are designed to determine whether the State meets the statutory assurances of the 1915 (c) waiver and to verify that Operating Agency is fulfilling the obligations of the interagency agreement. Specific areas that are reviewed are:

Monitoring activities
The Medicaid Agency reviews summary and analytical reports of incidents, monitoring activities and provider qualification verification. It provides input into the conduct of these activities and resulting system changes.

Communication
The Operating Agency has ongoing communication with the Medicaid Agency Medical Policy Review regarding administrative rule changes, testing and monitoring claims, participation in training and discussion and approval of policy and system changes.

Quality Management Committee Meetings
Staff from the Medicaid and Operating Agencies participate in quarterly Quality Management Committee meetings. Many issues are discussed, including review findings and follow-up activities, quality management planning, discussion of rules, policy and system changes.

Appeals
The Medicaid Agency makes the final administrative decision on all appeals.

Other Administrative Activities
The Medicaid Agency has systems in place to monitor the overall operation of the waiver, including compliance with the interagency agreement and the implementation of waiver rules and policies. All waiver policy and rule changes must be presented to the Medicaid Policy Review System committee prior to implementation.

6. Financial Accountability

Financial Accountability Oversight Processes and Activities Related To Discovery:

- The Operating Agency conducts targeted reviews of claims, as well as quarterly rate reviews. They also review rate calculations anytime there is a significant change in the computerized information management system.

- As part of its targeted reviews, on an annual basis, the Operating Agency, using a sample of records, ensures that services are delivered in accordance with the service plan, including the type, scope, amount, duration and frequency specified in the service plan.

- The Medicaid Agency works in cooperation with the Operating Agency to monitor the financial aspects of the waiver from a global perspective. Medicaid Agency staff utilizes the Data Warehouse query capability to analyze waiver claims. Staff utilizes an exception review format for financial accountability reviews. Staff constructs database queries that include specific waiver eligibility, coding, and payment criteria. Based on these criteria, all paid claims are analyzed. In addition to the exception reviews of waiver claims, Medicaid Agency staff conducts targeted reviews.

- Findings are discussed at quarterly Quality Management Committee meetings.

Periodic Evaluation And Revision of the Quality Management Strategy

The Operating Agency and the Medicaid Agency continually evaluate the effectiveness of the quality management plan. Quality management strategies and continuous improvement methods are routine agenda items at Quality Management Committee meetings. The Operating and Medicaid Agencies have developed a quality inventory to assess their current processes. The inventory includes the following items: federal assurances; indicators; evidence collected; evidence in need of improvement; and new evidence needed.

Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid Agency or the Operating Agency (if applicable).

Provider agencies that are under contract with the Operating Agency and receive over $500,000 in Operating Agency funding are required to have an independent audit of their financial statements on an annual basis. If the Operating Agency performs rate calculations or expense and revenue analysis, provider agencies are required to submit revenue and expense data by program on a consolidated financial report form prescribed by the Operating Agency, regardless of overall funding level.

This independent audit is an Operating Agency requirement and the Single Audit Act of 1984 (Act) and the Single Audit Act Amendment of 1996 does not apply to this Waiver. Medicaid payments received as reimbursement for providing services to Medicaid eligible individuals are not considered Federal awards under the Act and therefore, providers are exempt from Federal audit requirements for these payments.

The individual providers and businesses that are not under contract with the Operating Agency are not required to have audits completed on their financial information. However, the Operating Agency reserves the right to audit any provider at any time. Copies of the audits and consolidated financial reports are on file with the Operating Agency.

The Operating Agency does desk reviews and a sample of on-site reviews of the independent audits.

The Medicaid and Operating Agencies work cooperatively to review rates and provider claims. The Medicaid Agency has implemented comprehensive oversight procedures that provide increased assurance that Waiver claims are coded and paid in accordance with the reimbursement methodologies specified in the Waiver. These processes enable staff to monitor the financial aspects of the Waiver from a global perspective, rather than review a sample of paid claims. The Medicaid Agency determined that reviewing a sample of paid claims was of limited effectiveness and would not likely disclose problematic billings, patterns and/or trends.

The Medicaid Agency staff uses Data Warehouse query capability to analyze the entire data set of paid Waiver claims. The Medicaid Agency uses an exception review format as a component of the agency's financial accountability activity. Agency staff have constructed database queries that encompass Waiver eligibility, coding and payment criteria. Based on these criteria, twice per year the Medicaid Agency conducts analysis of all paid claims and only the claims that were not paid in accordance with set parameters are identified and extracted. The identified exceptions are printed out with all relevant service data.

In addition to the exception reviews of Waiver claims, Medicaid Agency staff, as well as Operating Agency staff, conduct targeted reviews of individual Waiver services, utilization of Waiver services by individual recipient and billing trends and patterns of providers.

The Operating Agency reviews rate calculations anytime there is a significant change in the computerized information management system. The Medicaid Agency also reviews the residential rate components calculated by the Operating Agency for accuracy and validity whenever residential providers receive a rate increase. Although the room and board component of a residential rate is not claimed for FFP, it is still an integral factor in the calculation of a residential rate and is included in the Medicaid Agency review.

The results of all financial reviews are shared between the two State agencies and discussed during the Quality Management Committee meetings. The Operating Agency advises the Medicaid Agency of corrective actions taken, including adjustments, for Waiver claims identified by the reviews that were not paid in accordance with defined parameters. In addition, results of some reviews may be shared with the Statewide Advisory Council on Developmental Disabilities in order to obtain input from stakeholders regarding corrective actions.

APPENDIX I-2: Rates, Billing and Claims

a. Rate Determination Methods. In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid Agency or the Operating Agency (if applicable).

Rate determination methods for each waiver service are outlined below.

Adult Day Care
The Adult Day Care rate is based on the rate used by the Department on Aging in their elderly waiver program, adjusted to include a transportation factor based on the Department on Aging's transportation rate.

Residential Habilitation
Community-Integrated Living Arrangement (CILA) rates have been calculated using individualized model rate methodologies since 1994. The models (24 hour, host family, intermittent and family) fund components based on individual needs and the size of the home. Rates are based on system-wide provider cost data where possible and proxy values where necessary or appropriate. Rates have been subject to cost of living adjustments when enacted.

Community Living Facility and some CILA rates from legacy programs are calculated based on past individual provider cost reports. Rates have been subject to cost of living adjustments when enacted and may be adjusted based on rate appeals.

Developmental Training
The statewide standard claiming rate is based on historical statewide grant-funded DT average allowable costs. The rate has been subject to cost of living adjustments when enacted. Rates may include add-ons based on individual medical and behavioral needs, subject to prior approval by the Operating Agency.

Supported Employment
The statewide standard claiming rates were based on the historical statewide DT rate with incentives to encourage Supported Employment programs generally and Supported Employment in individual job settings specifically. The rates have been subject to cost of living adjustments when enacted.

Personal Support/Crisis Services
Rates for Personal Support are negotiated between the participants or legal representatives and the providers with assistance from the Service Facilitator. The negotiated rates must be specified in the Service Authorization and are subject to review and approval by the Operating Agency on either a targeted or sample basis. These rates are not subject to cost of living adjustments. The Operating Agency reviews unusually high hourly rates annually to ensure that services provided are within the scope of Personal Support/Crisis Services.

Home and Vehicle Modifications, Adaptive Equipment and Assistive Technology
Rates are usual and customary. Payments are subject to prior approval by the Operating Agency.

Two bids are required for approval. There are per-participant five-year cost limits and specific cost limits on rental housing governing the use of these services.

Transportation
Statewide mileage rates are set by the Operating Agency. Per-trip rates are usual and customary charges. This rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Emergency Home Response Services
These statewide rates for installation and monthly basic service are adopted from the rates established in October 2006 by the Department on Aging for their elderly waiver program.

Training and Counseling For Unpaid Care Givers
The counseling rate is identical to the standard statewide rate currently used in the adult DD waiver for Individual Counseling services. This rate was based on available cost data for licensed social workers on contract with traditional developmental disabilities agencies. This rate is subject to cost of living adjustments when enacted by the General Assembly and signed by the Governor.

Training and workshop rates are usual and customary charges. These rates are not subject to cost of living adjustments.

Behavior Intervention and Treatment
There are two rate levels for this service based on provider qualifications. The higher rate is based on a weighted combination of Bureau of Labor Statistics wage for licensed clinical psychologists, provider survey results and a comparison to bargaining agreement wages for state employees. The lower rate is set at 80% of the higher rate. Both rates are subject to cost of living adjustments when enacted.

Behavioral Services (Psychotherapy and Counseling) and Nursing
These rates are based on available cost data for clinical psychologists and social workers on contract with traditional developmental disabilities agencies. These rates are subject to cost of living adjustments when enacted.

Physical Therapy, Occupational Therapy, and Speech Therapy
These rates are based on rates for these services in the Medicaid State Plan, converted to an hourly rate.

Service Facilitation
The Service Facilitation rate and the ISSA rate are identical because both services are provided by agencies with QMRP staff and are similar in scope and responsibility. They are standard statewide hourly rates. This rate has been subject to cost of living adjustments when enacted.

General
All rate methodologies are established by the Operating Agency and reviewed and approved by the Medicaid Agency. The Medicaid Agency solicits public comments by means of a public notice when changes in methods and standards for establishing payment rates under the Waiver are proposed. The notice is published in accordance with Federal requirements at 42 CFR 447.205, which prescribes the content and publication criteria for the notice. Whenever rates change, a listing of all covered services and corresponding rates is made available to families, Service Facilitators, ISSA and providers. Copies of rate methodologies are on file with the Medicaid Agency and the Operating Agency.

a. Flow of Billings. Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

Provider Payment

Waiver funding is appropriated to the Operating Agency primarily from the State's General Revenue Fund.

The Operating Agency maintains a computerized payment system that includes authorization for each participant, payments to providers, units of service delivered to each participant, and payment and claiming rates per unit of service.

The payment system contains edits to ensure that payments are made only to providers that are properly enrolled for the services delivered and that payment is made at the correct payment rate. There is a three-party Medicaid Waiver provider agreement (HFS 1413A,R-2-01) between the provider, the Operating Agency and the Medicaid Agency. This agreement contains language that the provider voluntarily reassigns payment to the Operating Agency (DHS). If a provider chooses not to assign payment to the Operating Agency, the provider will sign the standard Medicaid provider agreement (HFS-1413).

Payments for some services, such as participant-directed personal support services, will flow through the Financial Management Service (FMS) entity payment system and be paid, before being transmitted to the Operating Agency (DHS) system for claims processing.

Operating Agency Claims Processing

Information from the Operating Agency computerized payment system then feeds into the computerized claiming system that contains edits to ensure that the participant has been determined to meet the ICF/MR level of care prior to the date of service. The Operating Agency claiming system picks up the established claiming rate and compares it with the actual payment rate; the lower of the two is the amount claimed. Finally the Operating Agency claiming system subtracts from the Waiver claim the spenddown obligation of each participant, if any (available on a monthly extract from the Medicaid Agency MMIS system).

Medicaid Agency Claims Processing

The Operating Agency Waiver claiming data are transmitted to the Medicaid Agency via computer tape exchange. The Waiver subsection of the MMIS matches the participant against the recipient eligibility file to ensure Medicaid eligibility on the date of service and matches the provider against the provider enrollment file to ensure that the provider is enrolled as a Waiver provider with the Medicaid agency. The Waiver subsection includes edits for Waiver claims that conflict with other Waiver and hospital, nursing home, hospice facility, or ICF/MR claims and rejects Waiver claims that are duplicative or incompatible.

Federal matching funds are deposited into the State's General Revenue Fund.

c. Certifying Public Expenditures *(select one)*:

○	**Yes**. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (*check each that applies*):

	☐	**Certified Public Expenditures (CPE) of State Public Agencies**. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-a.*)
	☐	**Certified Public Expenditures (CPE) of Non-State Public Agencies**. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (*Indicate source of revenue for CPEs in Item I-4-b.*)
	●	**No**. Public agencies do not certify expenditures for waiver services.

d. Billing Validation Process. Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

Provider billings are validated by the Operating Agency (DHS) to verify the effective date of each Waiver service authorized in the participant's support plan and the participant's level of care eligibility. Providers are required to certify billings are true and accurate.

Provider billings are further validated by applying MMIS processing edits and by conducting Medicaid Agency (HFS) and Operating Agency (DHS) post-payment financial reviews. See also Appendix I-1 for additional information post-payment reviews. Through post-payment reviews, the Operating Agency, on a sample basis, confirms that services were actually provided and were in accordance with the support plan.

e. Billing and Claims Record Maintenance Requirement. Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid Agency, the Operating Agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

APPENDIX I-3: Payment

a. Method of payments — MMIS *(select one)*:

○	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
●	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
	If a provider chooses direct payment from the Medicaid Agency, the bills will be processed through MMIS. This is not anticipated.
●	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
	Under an interagency agreement with the Medicaid Agency, the Operating Agency makes payments from a central computer system. On a monthly basis, Waiver claims are edited and sent to the Medicaid Agency for Medicaid claiming. The audit trail is established through State agency approved rates, support plan authorization, documentation of service delivery, and computerized payment and claiming systems cross-matched with the Medicaid Agency, MMIS system.
○	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities:

b. Direct payment. Payments for waiver services are made utilizing one or more of the following arrangements (*check each that applies*):

☐	The Medicaid Agency makes payments directly to providers of waiver services.
☐	The Medicaid Agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
■	The Medicaid Agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid Agency oversees the operations of the limited fiscal agent:
	Under an interagency agreement with the Medicaid Agency, the Operating Agency or a Financial Management Service entity, as described in Appendix E, will make payments directly to providers of Waiver services. The Operating Agency will then send claims based on these paid services electronically to the Medicaid Agency for further adjudication and Federal Waiver reimbursement purposes.

☐	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.

c. Supplemental or Enhanced Payments. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved Medicaid State Plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

●	**No**. The State does not make supplemental or enhanced payments for waiver services.
○	**Yes**. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

d. Payments to Public Providers. *Specify whether public providers receive payment for the provision of waiver services.*

○	**Yes.** Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. *Complete item I-3-e.*
●	**No**. Public providers do not receive payment for waiver services. *Do not complete Item I-3-e.*

e. **Amount of Payment to Public Providers**. Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one*:

○	The amount paid to public providers is the same as the amount paid to private providers of the same service.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.
○	The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:

f. Provider Retention of Payments. Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

●	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
○	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
○	Providers are paid by a managed care entity (or entities) that is paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.

g. Additional Payment Arrangements

i. Voluntary Reassignment of Payments to a Governmental Agency. *Select one:*

●	**Yes**. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
	The Operating Agency.
○	**No**. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

ii. Organized Health Care Delivery System. *Select one:*

○	**Yes**. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDS and how these entities qualify for designation as an OHCDS; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDS; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDS arrangement is employed, including the selection of providers not affiliated with the OHCDS; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDS meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDS contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDS arrangement is used:
●	**No**. The State does not employ Organized Health Care Delivery System (OHCDS) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

○	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may *voluntarily* elect to receive *waiver* and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid Agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
○	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain *waiver* and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
●	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

a. State Level Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

☐	**Appropriation of State Tax Revenues to the State Medicaid Agency**
■	**Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency.** If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
	The Operating Agency receives the non-federal share through General Revenue Fund appropriations.
☐	**Other State Level Source(s) of Funds.** Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

b. Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs. Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

☐	**Appropriation of Local Revenues.** Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
☐	**Other non-State Level Source(s) of Funds.** Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
■	**Not Applicable**. There are no non-State level sources of funds for the non-federal share.

c. Information Concerning Certain Sources of Funds. Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources. *Check each that applies.*

☐	Provider taxes or fees
☐	Provider donations
☐	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:
■	None of the foregoing sources of funds contribute to the non-federal share of computable waiver costs.

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

○	No services under this waiver are furnished in residential settings other than the private residence of the individual. (*Do not complete Item I-5-b*).
●	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. (*Complete Item I-5-b*)

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The Operating Agency sets payment rates for a participant in a residential habilitation setting based on a methodology that is comprised of the following components:

- Room and Board Component - reimburses community providers for keeping a home in normal operation.
- Program Component - reimburses community providers for providing habilitation services and supports, including training, protective oversight, supervision and other assistance to participants with a developmental disability living in a residential setting.
- Transportation Component - reimburses community providers for providing general transportation to and from community locations that are not day program sites or places where Medicaid State Plan services are delivered.
- Administration Component - reimburses community providers for general staff supervision and overhead related to the delivery of residential supports.
- Individual Supports Component - reimburses community providers for supports that are specific to a participant's needs that are not covered elsewhere.

The Operating Agency sets waiver claiming rates for residential services based on the Program, Transportation, Administration and Individual Supports components of the payment rates. The Room and Board Component is excluded when calculating Waiver claiming rates.

APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.
Select one:

○	**Yes**. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. *The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:*
●	**No.** The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.

APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

a. Co-Payment Requirements. Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services as provided in 42 CFR §447.50. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

●	**No**. The State does not impose a co-payment or similar charge upon participants for waiver services. (*Do not complete the remaining items; proceed to Item I-7-b*).
○	**Yes**. The State imposes a co-payment or similar charge upon participants for one or more waiver services. (*Complete the remaining items*)

i. Co-Pay Arrangement Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services *(if any are checked, complete Items I-7-a-ii through I-7-a-iv):*	
☐	Nominal deductible
☐	Coinsurance
☐	Co-Payment
☐	Other charge *(specify)*:

ii Participants Subject to Co-pay Charges for Waiver Services. Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded. The groups of participants who are excluded must comply with 42 CFR §447.53.

iii. Amount of Co-Pay Charges for Waiver Services. In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge. The amount of the charge must comply with the maximum amounts set forth in 42 CFR §447.54.

Waiver Service	Amount of Charge	Basis of the Charge

iv. Cumulative Maximum Charges. Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant *(select one)*:

○	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
○	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

v. Assurance. In accordance with 42 CFR §447.53(e), the State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

b. Other State Requirement for Cost Sharing. Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

●	**No**. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
○	**Yes**. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income as set forth in 42 CFR §447.52; (c) the groups of participants subject to cost-sharing and the groups who are excluded (groups of participants who are excluded must comply with 42 CFR §447.53); and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care *(specify)*:			ICF/MR				
Col. 1	**Col. 2**	**Col. 3**	**Col. 4**	**Col. 5**	**Col. 6**	**Col. 7**	**Col. 8**
Year	**Factor D**	**Factor D′**	**Total: D+D′**	**Factor G**	**Factor G′**	**Total: G+G′**	**Difference (Column 7 less Column 4)**
1	$29,497	$2,701	$32,198	$74,351	$3,066	$77,417	$45,219
2	$29,497	$2,760	$32,257	$75,217	$3,119	$78,336	$46,079
3	$29,497	$2,820	$32,317	$76,093	$3,173	$79,226	$46,949
4	$29,497	$2,881	$32,378	$76,983	$3,228	$80,211	$47,833
5	$29,497	$2,943	$32,440	$77,884	$3,284	$81,168	$48,720

Appendix J-2 - Derivation of Estimates

a. Number Of Unduplicated Participants Served. Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants

Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
		ICF/MR	
Year 1	15,225	15,225	
Year 2	15,225	15,225	
Year 3	15,225	15,225	
Year 4 (renewal only)	15,225	15,225	
Year 5 (renewal only)	15,225	15,225	

b. Average Length of Stay. Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay is estimated based on the actual length of stay for current waiver participants for State Fiscal Years 2002 – 2006 (Waiver Years 5, and 1 through 4).

c. Derivation of Estimates for Each Factor. Provide a narrative description for the derivation of the estimates of the following factors.

i. Factor D Derivation. The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

Total Waiver capacity and the estimated utilization of each waiver service is estimated based on FY2006 and FY2007 year-to-date actual Waiver enrollment and service utilization patterns and costs for each current Waiver service. Operating Agency staff analyzed data from both the 372 initial report for FY2006 and a database that contains information on paid Waiver services. The database includes the number so users of each paid service and number of units of each service received. For new services, estimated utilization is based on anticipated utilization, rates and costs.

Cost estimates are based on current FY06 claiming rates (Waiver Year 4). There are no budgeted rate increases in FY07 (Waiver Year 5). Estimates for future years do not include potential rate increases at this time.

ii. Factor D′ Derivation. The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor D' is estimated based on analysis of State fiscal Year 2006 Medicaid-funded acute care costs for current waiver participants. A 2.17% increase is based upon the historical average percent of change, which is a component of rate increases and case mix changes. Estimates of

ancillary cost data were adjusted to exclude prescription drugs that will be furnished to Medicare/Medicaid dual eligibles under Provisions of Medicare Part D. This was accomplished by comparing claims for prescription drugs received by the Waiver population and eliminating those claims for drugs furnished to dual eligibles under Medicare Part D.

We recognize that Factor D' is less than Factor G'. We are unsure of the explanation for this at the present time, but will review the data to determine the cause. We suspect that since our Waiver program does not provide 24-hour nursing care and our ICF/MR program does, the average medical needs of individuals in the ICFs/MR program may be greater. We emphasize that overall our Waiver program is significantly cost effective.

iii. Factor G Derivation. The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G is based on historical ICF/MR data for ICF/MR recipients of all ages for State Fiscal Years 2002 – 2006. Factor G estimated for FY2007 – FY2012 is based on the historical percent changes trended forward for all years. The average historical percent change was 1.16%.

iv. Factor G′ Derivation. The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

Factor G' is based on historical Medicaid ancillary services for those individuals in an ICFMR setting for FY2002 – FY2006. The data incorporates individuals of all age groups. Factor G' estimated for FY2007 to FY2012 is based upon historical percent changes trended forward for all years. The average historical percent change was 1.72%. Estimates of ancillary cost data were adjusted to exclude prescription drugs that will be furnished to Medicare/Medicaid dual eligibles under Provisions of Medicare Part D. This was accomplished by comparing claims for prescription drugs received by the Waiver population and eliminating those claims for drugs furnished to dual eligibles under Medicare Part D.

d. Estimate of Factor D. *Select one:* Note: Selection below is new.

●	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
○	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

e. Estimate of Factor D – Non-Concurrent Waiver. Complete the following table for each waiver year

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health (Adult Day Care)	Hour	25	800	$9	$180,000
Residential Habilitation	Day	8,700	335	$102	$297,279,000
Day Habilitation (Developmental Training)	Hour	11,400	950	$10	$108,300,000
Supported Employment – Individual	Hour	550	525	$13	$3,753,750
Supported Employment - Group	Hour	150	425	$11	$701,250
Service Facilitation	Hour	2,675	35	$39	$3,651,375
Personal Support	Hour	2,470	900	$11	$24,453,000
Home Accessibility Modifications	Per Item	75	1	$7,800	$585,000
Vehicle Modifications	Per Item	25	1	$13,600	$340,000
Non-Medical Transportation	Per Item	470	140	$12	$789,600
Adaptive Equipment	Per Item	25	1	$3,200	$80,000
Assistive Technology	Per Item	25	1	$3,000	$75,000
Emergency Home Response Services (EHRS)	Per Month (One Time Installation Fee)	25	10	$30	$7,500
Counseling Services for Unpaid Caregivers	Hour	25	36	$30	$27,000
Training Services for Unpaid Caregivers	Per Event	50	1	$200	$10,000
Behavior Intervention and Treatment	Hour	1,825	60	$65	$7,117,500
Behavioral Services - Psychotherapy – Individual	Hour	700	25	$37	$647,500
Behavioral Services - Psychotherapy - Group	Hour	500	25	$12	$150,000
Behavioral Services - Counseling – Individual	Hour	350	25	$30	$262,500
Behavioral Services - Counseling – Group	Hour	200	25	$10	$50,000
Skilled Nursing	Hour	25	80	$31	$62,000
Crisis Services	Hour	50	360	$11	$198,000
Physical Therapy	Hour	100	25	$37	$92,500
Occupational Therapy	Hour	200	25	$37	$185,000

Waiver Year: Year 1					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Hour	100	25	$37	$92,500
GRAND TOTAL:					$449,089,975
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,225
FACTOR D (Divide grand total by number of participants)					$29,497
AVERAGE LENGTH OF STAY ON THE WAIVER					335

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health (Adult Day Care)	Hour	25	800	$9	$180,000
Residential Habilitation	Day	8,700	335	$102	$297,279,000
Day Habilitation (Developmental Training)	Hour	11,400	950	$10	$108,300,000
Supported Employment – Individual	Hour	550	525	$13	$3,753,750
Supported Employment - Group	Hour	150	425	$11	$701,250
Service Facilitation	Hour	2,675	35	$39	$3,651,375
Personal Support	Hour	2,470	900	$11	$24,453,000
Home Accessibility Modifications	Per Item	25	1	$7,800	$585,000
Vehicle Modifications	Per Item	75	1	$13,600	$340,000
Non-Medical Transportation	Per Item	470	140	$12	$789,600
Adaptive Equipment	Per Item	25	1	$3,200	$80,000
Assistive Technology	Per Item	25	1	$3,000	$75,000
Emergency Home Response System (EHRS)	Per Month (One Time Installation Fee)	25	10	$30	$7,500
Counseling Services for Unpaid Caregivers	Hour	25	36	$30	$27,000
Training Services for Unpaid Caregivers	Per Event	50	1	$200	$10,000
Behavior Intervention and Treatment	Hour	1,825	60	$65	$7,117,500
Behavioral Services - Psychotherapy – Individual	Hour	700	25	$37	$647,500
Behavioral Services - Psychotherapy - Group	Hour	500	25	$12	$150,000
Behavioral Services - Counseling – Individual	Hour	350	25	$30	$262,500
Behavioral Services - Counseling – Group	Hour	200	25	$10	$50,000
Skilled Nursing	Hour	25	80	$31	$62,000
Crisis Services	Hour	50	360	$11	$198,000
Physical Therapy	Hour	100	25	$37	$92,500
Occupational Therapy	Hour	200	25	$37	$185,000

Waiver Year: Year 2					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Hour	100	25	$37	$92,500
GRAND TOTAL:					$449,089,975
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,225
FACTOR D (Divide grand total by number of participants)					$29,497
AVERAGE LENGTH OF STAY ON THE WAIVER					335

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health (Adult Day Care)	Hour	25	800	$9	$180,000
Residential Habilitation	Day	8,700	335	$102	$297,279,000
Day Habilitation (Developmental Training)	Hour	11,400	950	$10	$108,300,000
Supported Employment – Individual	Hour	550	525	$13	$3,753,750
Supported Employment - Group	Hour	150	425	$11	$701,250
Service Facilitation	Hour	2,675	35	$39	$3,651,375
Personal Support	Hour	2,470	900	$11	$24,453,000
Home Accessibility Modifications	Per Item	75	1	$7,800	$585,000
Vehicle Modifications	Per Item	25	1	$13,600	$340,000
Non-Medical Transportation	Per Item	470	140	$12	$789,600
Adaptive Equipment	Per Item	25	1	$3,200	$80,000
Assistive Technology	Per Item	25	1	$3,000	$75,000
Emergency Home Response Services (EHRS)	Per Month (One Time Installation Fee)	25	10	$30	$7,500
Counseling Services for Unpaid Caregivers	Hour	25	36	$30	$27,000
Training Services for Unpaid Caregivers	Per Event	50	1	$200	$10,000
Behavior Intervention and Treatment	Hour	1,825	60	$65	$7,117,500
Behavioral Services - Psychotherapy – Individual	Hour	700	25	$37	$647,500
Behavioral Services - Psychotherapy – Group	Hour	500	25	$12	$150,000
Behavioral Services - Counseling – Individual	Hour	350	25	$30	$262,500
Behavioral Services - Counseling – Group	Hour	200	25	$10	$50,000
Skilled Nursing	Hour	25	80	$31	$62,000
Crisis Services	Hour	50	360	$11	$198,00
Physical Therapy	Hour	100	25	$37	$92,500
Occupational Therapy	Hour	200	25	$37	$185,000

Waiver Year: Year 3					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Hour	100	25	$37	$92,500
GRAND TOTAL:					$449,089,975
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,225
FACTOR D (Divide grand total by number of participants)					$29,497
AVERAGE LENGTH OF STAY ON THE WAIVER					335

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health (Adult Day Care)	Hour	25	800	$9	$180,000
Residential Habilitation	Day	8,700	335	$102	$297,279,000
Day Habilitation (Developmental Training)	Hour	11,400	950	$10	$108,300,000
Supported Employment – Individual	Hour	550	525	$13	$3,753,750
Supported Employment - Group	Hour	150	425	$11	$701,250
Service Facilitation	Hour	2,675	35	$39	$3,651,375
Personal Support	Hour	2,470	900	$11	$24,453,000
Home Accessibility Modifications	Per Item	75	1	$7,800	$585,000
Vehicle Modifications	Per Item	25	1	$13,600	$340,000
Non-Medical Transportation	Per Item	470	140	$12	$789,600
Adaptive Equipment	Per Item	25	1	$3,200	$80,000
Assistive Technology	Per Item	25	1	$3,000	$75,000
Emergency Home Response Services (EHRS)	Per Month (One Time Installation Fee)	25	10	$30	$7,500
Counseling Services for Unpaid Caregivers	Hour	25	36	$30	$27,000
Training Services for Unpaid Caregivers	Per Event	50	1	$200	$10,000
Behavior Intervention and Treatment	Hour	1,825	60	$65	$7,117,500
Behavioral Services – Psychotherapy – Individual	Hour	700	25	$37	$647,500
Behavioral Services – Psychotherapy - Group	Hour	500	25	$12	$150,000
Behavioral Services - Counseling – Individual	Hour	350	25	$30	$262,500
Behavioral Services - Counseling – Group	Hour	200	25	$10	$50,000
Skilled Nursing	Hour	25	80	$31	$62,000
Crisis Services	Hour	50	360	$11	$198,000
Physical Therapy	Hour	100	25	$37	$92,500
Occupational Therapy	Hour	200	25	$37	$185,000

Waiver Year: Year 4					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Hour	100	25	$37	$92,500
GRAND TOTAL:					$449,089,975
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,225
FACTOR D (Divide grand total by number of participants)					$29,497
AVERAGE LENGTH OF STAY ON THE WAIVER					335

Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Adult Day Health (Adult Day Care)	Hour	25	800	$9	$180,000
Residential Habilitation	Day	8,700	335	$102	$297,279,000
Day Habilitation (Developmental Training)	Hour	11,400	950	$10	$108,300,000
Supported Employment – Individual	Hour	550	525	$13	$3,753,750
Supported Employment - Group	Hour	150	425	$11	$701,250
Service Facilitation	Hour	2,675	35	$39	$3,651,375
Personal Support	Hour	2,470	900	$11	$24,453,000
Home Accessibility Modifications	Per Item	75	1	$7,800	$585,000
Vehicle Modifications	Per Item	25	1	$13,600	$340,000
Non-Medical Transportation	Per Item	470	140	$12	$789,600
Adaptive Equipment	Per Item	25	1	$3,200	$80,000
Assistive Technology	Per Item	25	1	$3,000	$75,000
Emergency Home Response Services (EHRS)	Per Month (One Time Installation Fee)	25	10	$30	$7,500
Counseling Services for Unpaid Caregivers	Hour	25	36	$30	$27,000
Training Services for Unpaid Caregivers	Per Event	50	1	$200	$10,000
Behavior Intervention and Treatment	Hour	1,825	60	$65	$7,117,500
Behavioral Services - Psychotherapy – Individual	Hour	700	25	$37	$647,500
Behavioral Services - Psychotherapy - Group	Hour	500	25	$12	$150,000
Behavioral Services - Counseling – Individual	Hour	350	25	$30	$262,500
Behavioral Services - Counseling – Group	Hour	200	25	$10	$50,000
Skilled Nursing	Hour	25	80	$31	$62,000
Crisis Services	Hour	50	360	$11	$198,000
Physical Therapy	Hour	100	25	$37	$92,500
Occupational Therapy	Hour	200	25	$37	$185,000

Waiver Year: Year 5					
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5
	Unit	**# Users**	**Avg. Units Per User**	**Avg. Cost/ Unit**	**Total Cost**
Speech Therapy	Hour	100	25	$37	$92,500
GRAND TOTAL:					$449,089,975
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)					15,225
FACTOR D (Divide grand total by number of participants)					$29,497
AVERAGE LENGTH OF STAY ON THE WAIVER					335